

Independent Evaluation of the Global Fund Allocation Methodology

Final Report

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Independent Evaluation of the Global Fund Resource Allocation Methodology

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Glossary and key definitions

Definitions

Allocation Methodology	Allocation Methodology refers to the methodology used by the Global Fund to determine country resource allocation since 2014. The Allocation Methodology seeks to align Global Fund financing with highest disease burden and lowest economic capacity. This methodology and its evolution since 2014 are detailed in the section 2.2.
Country allocation	The total country allocation is the sum of the allocations for each of its eligible disease components.
Direct RSSH investments	Direct RSSH investments are invested directly in RSSH, as opposed to indirect RSSH investments, which are defined as disease investments that strengthen RSSH.
Disease components	Country components refer, for each country, to a specific disease component (HIV, malaria, or TB).
Incidence rate	Rate of new cases of a condition observed within a given period – affected population – in relation to the total population within which these cases have arisen (in the same period) – the target population.
Initial Calculated Amount (ICA)	Initial Calculated Amount (ICA) refers to the country-disease amount which is the result of the step 1 to 3 in the Allocation Methodology.
MDR-TB	Multidrug-resistant TB (MDR-TB) is TB that does not respond to at least isoniazid and rifampicin, the 2 most powerful anti-TB drugs.
Mortality rate	Ratio of the number of deaths in the year to the average total population at risk in a given year.
Parameters	Parameters are components of the allocation formula, referring to technical parameters of the allocation methodology (disease burden indicators, Country Economic Capacity adjustment, minimum/maximum shares and external financing adjustment) as well as other components (global disease split and scale-up/paced reduction)
Resilient and Sustainable Systems for Health (RSSH)	Resilient and Sustainable Systems of Health (RSSH) refer to “government health systems, as well as services provided by communities, the private sector and other providers, which together should ensure that individuals’ health needs are met wherever they seek care” ¹ . The Global Fund has identified these systems are essential for ending HIV, TB, and malaria as public health threats.
Scale-up/paced reduction	The scale-up/paced reduction is a step in the allocation formula used to deliver on the principle of predictability of funding for countries and programs. The aim is to both ensure scale-up for components that previously received less than their ICA while preventing steep decreases in funding from the previous allocation period. It was also a needed step in the transition from the rounds-based system.
Steps	The term step is used to refer to the five different stages of calculation of the allocation methodology.
Trade-offs implications	Trade-offs implications refer to the implications of alternative approaches for the impact of the Global Fund compared to the current allocation methodology.

¹ [Resilient and Sustainable Systems for Health - The Global Fund to Fight AIDS, Tuberculosis and Malaria](#)

Glossary

AIDS	Acquired Immuno-Deficiency Syndrome
AM	Allocation Methodology
CCM	Country Coordinating Mechanism
CEC	Country Economic Capacity
CELO	Chief Evaluation and Learning Officer
CI	Catalytic investments
CRG	Community Rights and Gender Department
CRSPC	Country/Regional Support Partner Committee
ELO	Evaluation and Learning Office
EM	Evaluation Manager
GAVI	Gavi, the Vaccine Alliance
GC	Grant Cycle
GDS	Global Disease Split
GFF	Global Financing Facility for Women, Children and Adolescents
GFS	Global Fund System
GMD	Grant Management Department
GNI	Gross National Income
HIV	Human Immunodeficiency Viruses
HR	Human Rights
ICA	Initial Calculated Amount
IEP	Independent Evaluation Panel
IHME	Institute for Health Metrics and Evaluation
JWG	Joint Working Group
KPI	Key Performance Indicator
LIC	Low Income Country
MCDA	Multi Criteria Decision Analysis
MDR-TB	Multi Drug Resistant Tuberculosis
MT	Modelling Team
PMRD	Programmatic Monitoring & Risk Division
QA	Qualitative Adjustments
RSSH	Resilient and Sustainable Systems of Health
SC	Strategy Committee
SIID	Strategic Investment and Impact Division
SPH	Strategy & Policy Hub
TAP	Technical Advice and Partnerships
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel

1. Executive Summary

Evaluation Mandate

Background

The Global Fund aims **to attract, leverage, and invest additional resources in order to achieve a world free of the burden of human immunodeficiency virus (HIV), tuberculosis (TB) and malaria** with better and equitable health for all. To achieve that goal, the Global Fund raises and invests funding and allocates aid to eligible countries in support of HIV, TB and malaria programs and the construction of resilient and sustainable healthcare systems. The total amount available for country allocations depends on the funding raised for each three-year allocation cycle.

The Global Fund **resource allocation methodology** was launched for the 2014-2016 allocation cycle as part of its **new funding model**, to ensure funds are channeled to countries with the highest disease burden and lowest economic capacity, and to replace the previous rounds-based system under which funding was awarded based on demand.

Established on a model incorporating indicators of disease burden and economic capacity, the allocation methodology seeks to maximize the impact of Global Fund resources, whilst addressing needs of key and vulnerable populations disproportionately affected by the three diseases². It also seeks to **ensure predictability, flexibility, and simplicity** of the funding approach.

The allocation methodology is structured through five key steps: (1) an initial step dedicated to setting aside a portion of funding for **catalytic investments**; (2) an upfront **Global Disease Split (GDS)** which determines the overall distribution of total available resources across HIV, TB and malaria; (3) **technical parameters** which aim to determine funding allocations to countries disease by disease; (4) a **scale-up/paced reduction** step aiming at ensuring the principle of predictability of funding, and (5) final **qualitative adjustments** to account for key epidemiological, programmatic and other national context-related factors that cannot be mathematically accounted for and which are not fully represented in the allocation formula.

It was during the final decision-making stage on the GDS for the 2023-2025 allocation period that the Board requested, in November 2021, *“an external evaluation of the Global Fund’s approach to resource allocation to maximize impact, to inform evidence-based decision making on these issues ahead of the 8th replenishment, and to support more effective delivery of the Global Fund Strategy”*. The aim of this evaluation was also to look at the way the methodology has been informed by the recommendations of technical partners and reviewed/ updated every three years based on evidence and lessons learned.

Objectives

Commissioned by the Global Fund Evaluation and Learning Office (ELO) with oversight from the Independent Evaluation Panel (IEP), the Evaluation, which was designed to be simultaneously retrospective and forward-looking, had three main specific objectives:

- ▶ **Conduct an in-depth analysis of the current methodology and propose alternatives that may result in greater impact of Global Fund investments** and more effective delivery of the Global Fund Strategy. A specific focus has been put on the effectiveness of an upfront GDS as well as on the relevance of introducing a separate allocation for RSSH
- ▶ **Describe the pros and cons of the proposed alternatives** and their implications to provide contextualized recommendations
- ▶ **Assess and challenge the robustness of the parameters and processes of the cyclical reviews** that lead to final high-level decisions on country allocations and catalytic investments

² [Global Fund/B47/03, May 2022](#)

³ Global Fund, Board Decisions, [GF/B46/DP04](#)

Ultimately, the Evaluation aimed to formulate recommendations based on findings and key takeaways and inform decision making on future allocations ahead of the next replenishment (Grant Cycle 8, 2026-2028).

Methodological approach

The Evaluation was organized around a series of **10 evaluation questions** which ensured the scope of work reflected expectations and challenges.

It should be noted that the evaluation could not quantify **the direct impact of changes to the allocation methodology** on the delivery of the Global Fund's Strategy goal of ending incidence and mortality. Although the feasibility of such analyses was explored during the inception phase of the evaluation, as advised by external technical experts, at present, no model can be used to measure such impact and attribute it to the Global Fund's resource allocation, in part because of the Global Fund's contributive model. In addition, impact modelling may not be suitable to directly inform resource allocation because results vary based on choice of assumptions and methodologies. The decision to not attempt to model impact had bearing on the design and approach of the Evaluation and an Evaluative framework was elaborated in the inception phase depending on the specific nature of the evaluation questions, which is summarized below.

Questions were structured as follows:

- ▶ **Six (6) retrospective questions**, each of which focused on a certain step or component of the methodology, i.e. the approach for determining **catalytic investments**, the **GDS**, the funding of **Resilient and Sustainable Systems of Health (RSSH)**, **other steps of the allocation methodology** and the **cyclical review process**. In addition to these individual components, an **overarching question** aimed at **comparing the Global Fund's allocation methodology to other models** used by international organizations was also formulated. These retrospective questions were answered based on an evaluation framework developed during the inception phase to assess the extent to which the current allocation methodology meets existing needs (relevance), achieves its objectives (effectiveness), and generates intended high-level impact.
- ▶ **Four (4) articulated prospective questions** that aimed to describe, for each of the aforementioned components, recommended changes to the allocation methodology, pros and cons of the proposed changes, and their impact in terms of trade-off implications, intended/unintended consequences at country level as well as the overall allocation process. Answers to these forward-looking questions were developed following a multi-criteria decision analysis (MCDA) approach. It was based on a conceptual framework and a vision on trade-offs and judgement criteria to be considered to overcome the **relative and subjective nature of pros and cons**.

The Evaluation implemented **an extensive data collection and analysis plan** to ensure that the judgments rely on robust and reliable evidence.

- ▶ Consultation activities included **interviews** with Board members (or their alternates), Strategy Committee members, the Secretariat and Technical partners.
- ▶ It also included an **online survey sent to 182 different contacts (representing CCM Chairs, Vice Chairs and Administrative Focal Points)** from 107 eligible countries (including countries eligible for transition funding).
- ▶ It also involved **benchmarking analyses with three other international organizations**, i.e. the International Development Association (IDA), the Vaccine Alliance (Gavi), and the Global Financing Facility (GFF). Despite limited comparability between organizations, some interesting insights have been brought up as regards the approach for setting aside a certain amount of funding ahead of country allocations, a performance-based allocations and vulnerability instruments for IDA, a needs-based approach and a challenge fund for GFF, as well as Gavi's take on health system strengthening.

The Evaluation also relied **on an in-depth documentary review and quantitative data analysis** based on available data collected from the Global Fund, the World Health Organisation (WHO) and the Institute for Health Metrics and Evaluation (IHME). This quantitative analysis included data related to the epidemiological and funding landscapes, as well as modelling of several scenarios based on potential alternatives.

Main findings

From a general viewpoint, it was found that the decisions regarding the Global Fund's resource allocation methodology made since 2013 have demonstrated a **constant willingness to review, challenge, and improve the methodology** to reinforce its contribution to the Global Fund's principles and objectives.

Investigations made at each step of the allocation methodology have led to several findings and recommendations for improvement, as detailed in the following paragraphs concerning the Catalytic Investments, the GDS, the RSSH, the Technical Parameters, the Qualitative Adjustments, and the Cyclical Review Process.

Catalytic investments

The current approach to determining the amount used for **catalytic investments is adequate for informing decision-making on the total amount to be set aside for the catalytic investments**. As confirmed by most stakeholders consulted during the Evaluation, relying on replenishment scenarios is a pragmatic approach that allows informed decision-making around the appropriate balance between catalytic investments and country allocations. The approach strikes a **balance between country-led programs and other initiatives** through which the Global Fund can provide a more catalytic input, and it effectively allows an appropriate amount to be set aside for catalytic investments that protects country allocations and ensures sufficient scale-up for countries with the highest disease burden. As a result, no alternatives are suggested as there is no evidence that the approach for setting aside a portion of total resources for catalytic investments needs to be modified.

Global Disease Split

As the second step of the resource allocation methodology, the GDS is a **relevant component of the allocation methodology and overall serves as a necessary up-front parameter** for determining the distribution of funding across the three diseases. It establishes a stable and widely accepted foundation in a context of competing needs and expectations, and its principle, if not the current split between diseases, is well-accepted by most Global Fund stakeholders. This step is also instrumental for enhancing the predictability and simplicity of the methodology. It is important to note that this upfront disease split in the allocation methodology is not the same as the indicative program split communicated to CCMs in the allocation letter.

However, the current split merits deeper examination. First, it promotes a siloed approach, which can be detrimental to integrated interventions. Second, while it is reviewed every three years, it was updated for the first time during the cyclical review process for GC7. The direction and extent to which it should be updated was highly debated during this process.

The three main criteria which have been used since 2013 to inform the GDS – disease burden, cost-effectiveness, and funding gaps – have considerably evolved since:

- ▶ **The epidemiological landscape has significantly changed**, as demonstrated by a continuous increase in the share of deaths due to TB between 2009 and 2022 worldwide. In 2009, TB already had the highest share in the number of deaths across the three diseases (40%), followed by HIV (39%) and malaria (20%). In 2022, this share of death has increased to 47% for TB and 26% for malaria, while the share for HIV has decreased to 27%⁴.
- ▶ **The concentration of disease burdens across income groups varies significantly** between the three diseases: 58% of the disease burden of malaria is concentrated in the three lowest income deciles (based on 2021 GNI per capita data and disease burden data), compared to 38% for HIV and 18% for TB.
- ▶ While **a dedicated cost-benefit analysis would be required to assess the evolution of cost-effectiveness** since 2013 (although challenging due to limited data availability), it should be noted that new challenges have emerged for TB and for malaria, with an increase in the number of drug-resistant cases and of insecticide-resistant mosquitoes.

⁴ These values are for all countries, including those not eligible for Global Fund financing.

- ▶ **International financing for TB and malaria are highly dependent on the Global Fund**, which is less the case for HIV.

Following these findings, three alternatives to the current /GDS were considered by the Evaluation Team: (1) an alternative with no upfront GDS addresses the structural rigidity and siloed approach of this step, but decreases visibility on the amounts allocated by disease and may jeopardize alignment on highest disease burden, as it would rely on a common indicator to compare diseases in the technical parameters, which may not be equally relevant for each disease; (2) an alternative with a new split (but no update of the underlying methodology) featuring an increased share for TB addresses the current under-appreciation of TB but does not provide a renewed methodological foundation based on which the GDS could be regularly updated; and (3) an alternative maintaining the GDS as an upfront parameter but with a new split based on DALYs.

Based on these alternatives, the Evaluation recommended that the **GDS shall be kept as the second step of the methodology to divide fundings between the three diseases**. Its relevance and utility were confirmed regarding both the strategic management of expectations from donors and the more nuanced consideration of the global health landscape, which has some disease-specific features. Regarding the approach to GDS decision making, it is recommended that GDS decisions for each allocation cycle are systematically informed by technical and scientific evidence on the relative needs of each disease. Although the final decision on the GDS might not be aligned with the result of such analysis, it is nonetheless recommended in order to ensure the Board is systematically provided with updated analyses on trends and to avoid any growing gap between the GDS and the evolution of the epidemiological landscape.

It is also recommended to explore new types of evidence that could nourish debates around the GDS and better exploit prospective analytical capacities in order to account for longer-term needs.

With regards to **the criteria used to decide on the GDS**, there is a need to adjust the current GDS to better reflect the current epidemiological landscape and re-balance the distribution of funding across the three diseases to give more weight to TB⁵. Indeed, WHO DALYs, IHME DALYs, WHO and IHME DALYs weighted by income and number of deaths all show that TB has a share of burden higher than 18%. Ideally, the GDS shall be aligned with the scientific evidence on the relative needs of each disease and reflect as much as possible the result of a systematic approach similar to the one suggested under Alternative 3. However, implementing such an approach cannot be envisaged in the short term as it would significantly compromise the continuity of services in most countries and have a negative effect on lower-income countries. It is thus recommended **to revise the GDS incrementally over several allocation cycles to ensure it increasingly reflects the epidemiological landscape**.

In this context, and also considering it is unrealistic to expect a completely apolitical decision around the GDS, it is recommended to follow an approach similar to Alternative 2 (and/or the one that was applied during cycle 2021-2023 with a revised threshold), with particular attention paid to the need to ensure a stronger alignment of the GDS with the epidemiological landscape cycle after cycle.

Resilient and Sustainable Systems for Health (RSSH)

The Evaluation also sought to determine **whether a separate allocation for RSSH would be relevant and contribute to improving the current methodological approach**. The expected advantage of a separate RSSH allocation is to increase investments in health systems, which would support a more comprehensive and potentially more cost-effective approach to health. This would also send a strong signal to stakeholders regarding the Global Fund's commitment to RSSH, as donors and CCM support a stronger investment in RSSH. In this context, a separate RSSH allocation presents several upsides: it could help increase investments in RSSH by incentivizing countries to invest more in RSSH, increasing predictability and efficiency, and therefore allowing the emergence of a long-term strategy for RSSH funding.

However, views diverge regarding the relevance of introducing a separate RSSH allocation. The Evaluation found that **creating a dedicated share could present several limitations and challenges**. Creating an upfront separate allocation for RSSH at the global level would add rigidity by creating one more silo, thus going against the views of many board members who consider that efforts to strengthen health systems should remain attached to the diseases. It would be faced with the challenge of determining the right trade-

⁵ Whatever the level of replenishment (higher or lower), re-balancing the distribution of funds would imply a proportionate redistribution of funds so as to reduce the gap between the share of funding allocated to each disease and the respective weight of each disease in the epidemiological landscape.

off balance between RSSH on the one side and disease programs on the other, which would add complexity to the initial steps of the methodology (Catalytic investments and GDS). It would face other limitations such as the fact that there is no perfect set of metrics enabling the assessment of RSSH needs and allocating RSSH funding across countries. Lastly, a separate allocation for RSSH would decrease flexibility at the country level, which could lead to low absorption for countries that invested less in RSSH and decrease investments for those that invested more. The strong variability of investments in RSSH, even within income groups, advocates **against a one-size-fits-all approach**.

Three types of alternatives were considered but were not recommended due to their serious drawbacks. A first alternative (**Alternative 1**) would consist in **determining a separate RSSH allocation at global level** (to be taken from the disease allocations), before being allocated to countries. This alternative would address some donors' expectations who support greater efforts on RSSH vs. disease programmes and an increased consideration of RSSH needs in the allocation resources. A second alternative (**Alternative 2**) would consist in **defining a separate allocation for RSSH as a certain percentage of country allocations communicated to countries**. This alternative would not involve the determination of an upfront RSSH component, but instead the determination of revised indicative program splits communicated to countries to add a fourth share for RSSH. This alternative would aim to further encourage countries' efforts to invest more in RSSH (vs. disease programs). A third alternative (**Alternative 3**) would involve **the determination of specific RSSH allocations to countries on a case-by-case basis**. This alternative would change the final allocations to countries as part of the qualitative adjustment process in order to refine allocation amounts for specific RSSH country contexts. This alternative would ensure additional funding is made available to countries with specific RSSH challenges and would provide a response to the one-size-fit-all approach that is detrimental to the effectiveness of allocations.

Considering these alternatives as well as Evaluation findings, the Evaluation recommends supporting the need to increase and improve RSSH investments. It is not recommended, however, that an upfront fourth share dedicated to RSSH (Alternative 1) be defined, as such a fourth share would be more harmful than beneficial. Additionally, in the short term, it is not recommended that a specific RSSH allocation amount be defined as part of the Qualitative Adjustments (Alternative 3), as it would unnecessarily complicate the allocation methodology. It could be recommended instead **to define a certain percentage of country allocations to be dedicated to RSSH, communicated together with the indicative disease split, yet based on a country-by-country adaptation** (Alternative 2, with different percentages). To incentivize tailored RSSH investments at country level, such target percentages, together with qualitative recommendations, would be tailored to country context recommendations based on the historical data and qualitative considerations and should be systematically added to the allocation letters. This would address the need of compensating for the lack of advocacy in favor of RSSH in certain countries, especially within CCMs. Such approach would also take account of the fact that the needs for stronger health systems vary significantly from one country to another and that no "one-size-fits-all approach" is either possible or relevant.

Technical parameters

Focusing on the Technical parameters in the allocation formula, the Evaluation found that **disease burden and Country Economic Capacity (CEC)** are aligned with the objectives of the Global Fund and support the effectiveness and feasibility of the methodology. Gross National Income per capita (GNI pc), the indicator used for economic capacity, presents, of course, several limitations: it does not address inequalities within recipient countries nor capture parameters such as inflation. Nevertheless, it appears as the best primary indicator of economic capacity due to the drawbacks of alternative indicators (as underlined by the 2021 CEPA report).

Considering these findings, the Evaluation recommends, **as a potential consideration**, that GNI pc could be reinforced by an **additional indicator on economic capacity, which would allow for a stronger consideration of countries' ability to mobilize resources to finance health policy**, which is inadequately captured by GNI pc alone, as the CEPA report (2021)⁶ also pointed out. **Public revenue per capita, adjusted for PPG⁷ debt interests**, is a relevant proxy for capturing the perimeter of public resources from

⁶ Cepa (2021), Assessing economic capacity in the eligibility policy and allocation methodology - The Global Fund to fight AIDS, Tuberculosis and Malaria. September.

⁷ Public or publicly guaranteed.

which the government can draw in order to finance the health sector. It could therefore be used to increase the equity and effectiveness of the allocation methodology, by increasing its alignment on lowest economic capacity. The indicator does not generate counterproductive incentives in the sense that it is unlikely that a government would reduce its tax effort or borrow more to benefit from a larger contribution from the Global Fund. However, the indicator does not differentiate between countries with poor or sufficient tax policies, in a way "rewarding" indifferently for the same level of indicator. The same holds for GNI per capita, which depends in part on public policies, both for long-term dynamics and short-term levels, and not only on exogenous factors as the literature makes clear. But in both cases, this is a minor limitation far overshadowed by the relevance and usefulness of the two indicators. The required data can be easily mobilized from the authorities and present an acceptable level of reliability (or, at least, the best currently available).

When it comes to performance, the current allocation process includes indicators to adequately address **performance issues into Global Fund supported programs**. However, program achievements by the Global Fund are **not tightly insulated from their environment**. HIV, tuberculosis, and malaria interventions are becoming less and less vertical, and more and more integrated into healthcare systems, themselves being impacted by the features and implementation of numerous public policies. It is therefore proposed, **in addition to the current program-focused performance indicators** included in the qualitative adjustments, to incorporate into the allocation process **two indicators capturing performance in two important dimensions in which Global Fund-supported programs operate and which are likely to have an impact on their achievements**. The first one proposed, at the macro level, is government effectiveness, capturing the quality of public policies; the second, at the sectoral level, captures the government's financial effort in favor of the health sector.

Finally, **taking into consideration the structural vulnerability of beneficiary countries**, the **Evaluation suggests** taking better account of countries' health financing needs by adding a vulnerability index to the allocation formula. It should be a structural and exogenous vulnerability, not an endogenous one influenced by the domestic policy. The selected index should be simple, clear, and transparent in its construction methodology, and have components in line with the conceptual framework for resource allocation established by the Global Fund. As such, it might be a general index that takes into account the various *ex-ante* risks and structural handicaps that countries face, and which can significantly impact their economic capacity. The index could also be more specific, based on variables reflecting health and epidemiological shocks and the various factors that expose countries to these shocks.

Regardless of whether it is a general or specific index, consensus should be reached on the type of vulnerability composite index to be used, and its composition should be based on a rigorous theory of change derived from the academic literature.

For those three potential considerations, a two-stage phasing approach is proposed to implement them: for the next cycle, it would imply incorporating the indicators into the qualitative adjustments; then in the following cycle, introducing them into the allocation formula. Incorporating these indicators into the formula has an advantage in terms of equity, as there is homogeneity of treatment between beneficiary countries with regard to the indicator considered. This does, however, lead to greater complexity, which is offset by greater transparency, as long as the way in which the indicator is taken into account in the formula is clearly explained. This two-stage phasing gives the Global Fund time to consider the advantages and disadvantages of including the indicator in the allocation formula, as well as the various methodological and technical options and tradeoffs to be considered.

Qualitative adjustments

The Evaluation also focused on **Qualitative Adjustments**, which are an important step to ensure the flexibility of the methodology. Stage 1 of the Qualitative Adjustments ensures more equity in HIV allocations by considering key populations. It is effective at counterbalancing the limitations of the disease burden indicator used for HIV, which does not reflect accurately the needs of all countries depending on their epidemiological context. Due to the lower quality of the data used and the complexity of the analysis, it is justified for this analysis be included in qualitative adjustments only.

Stage 2 of the Qualitative Adjustments refines the analysis of the needs of recipient countries by allowing a more detailed analysis of key epidemiological, programmatic, and other relevant contextual factors (such as vulnerability, human rights, and gender). It also incentivizes performance by considering program performance and absorption; in doing so, it supports the effectiveness of the Global Fund's interventions.

No alternatives nor recommendations have been elaborated as there is no evidence that the Qualitative Adjustments step needs to be modified.

Cyclical review process

Finally, the Evaluation Team also analysed the overall **cyclical review process, which ensures the allocation methodology is reviewed every three years based on evidence and lessons learned**. It appeared that several quality assurance mechanisms contribute to **the overall good acceptance of the allocation methodology process**, such as the intervention of technical partners, the important degree of formalization and documentation of the process, the transparency of allocation criteria, the high level of preparation of the Secretariat, and the good quality of interaction with the Board and the Strategy Committee. Criticisms have however been expressed regarding the opacity of the Qualitative Adjustments stages (although every change made in the Qualitative Adjustments is reported to the Strategy Committee and all changes greater than 15% and USD 5 million are reported to the Board). Additionally, due to the length of the process and its division between various steps, Board and Strategy Committee Members may lack the ability to consider the methodology holistically.

Overall conclusion

Overall, the Evaluation found that the resource allocation methodology is both relevant and effective in contributing to **the delivery of the Global Fund's strategy**. The objectives of the **allocation methodology** and the needs-based approach it follows, which prioritises factors related to disease burden and economic status (ability to pay) of countries, are relevant for **supporting the organisation's strategic vision and pragmatically delivering its mission at the country level**. Each step of the methodology has its own rationale, and each one complements the others, contributing to the overall positive judgment on the allocation methodology process: it is viewed as **an overall transparent process, although sometimes complex**. The allocation methodology thus succeeds in meeting its objectives of ensuring **predictability, flexibility, and simplicity** of the funding approach, whilst aligning financing with highest burden and lowest economic capacity.

The Evaluation thus recommends **only minor and incremental changes to the current allocation methodology as regards to the GDS** (need to update and revise the split to achieve a more balanced and relevant distribution of resources across HIV, TB and malaria) and **technical parameters** (improvement of the indicator on economic capacity as well as slight adjustments to better capture both structural vulnerability and performance of beneficiary countries). It also makes recommendations on ways to strengthen RSSH activities to maximize impact through alternative approaches that would not involve any change in the current allocation methodology itself.

Despite a tight timeline to deploy the Evaluation, the Evaluation Team wanted to **acknowledge and thank all stakeholders for their availability and willingness to contribute** to this strategic and critical reflection. The present report indeed tried to reflect the complexity of this Evaluation as the allocation methodology inherently integrates **many different political dimensions and points of views**, all gathered throughout the data collection plan and reconciled thanks to the triangulation of quantitative and qualitative insights.



Note to the reader

The document consists in **the Final Evaluation Report**. Its aim is first to provide a sound analysis of findings with factually based conclusions, in answer to all evaluation questions formulated for this assignment. Second, the report develops the **recommended changes** based on the envisaged alternatives.

The critical and important recommendations identified shall enable the Global Fund to improve the relevance, adequacy and effectiveness of its resource allocation methodology in the short term, as they are directly implementable and within the control of the organization. For the potential considerations however, their implementation depends on structural evolutions (in particular concerning political consensus and countries' needs) but the necessity to consider and anticipate certain evolutions may increase in the near future to ensure the Global Fund's continued relevance and effectiveness.

A **separate Annex document** has also been elaborated to further detail specific components of this Evaluation, such as the Evaluation Framework, the data collection tools, and the comparison with other models.

2. Background and objectives of the evaluation

2.1. Purpose and scope of the evaluation

2.1.1. Purpose of the Evaluation

The Global Fund launched its **resource allocation methodology** for the 2014-2016 (GC4) as part of its **new funding model**, to ensure the channeling of funds to countries with the highest burden and lowest economic capacity. Based on a model incorporating disease burden and economic capacity indicators, the allocation methodology mainly aims to maximize the impact of Global Fund resources to prevent, treat and care for people affected by HIV, TB, and malaria, and to build resilient and sustainable systems for health, whilst addressing needs of vulnerable populations disproportionately affected by the three diseases. It also seeks to **ensure predictability, flexibility, and simplicity** of the funding approach.

The methodology is broken down into five steps, including an upfront Global Disease Split (GDS) which determines the overall distribution of total available resources across HIV, TB, and malaria. It was during the final decision-making stage on the global disease split for the 2023-2025 allocation period that the Board requested, in November 2021, *“an external evaluation of the Global Fund’s approach to resource allocation to maximize impact, to inform evidence-based decision making on these issues ahead of the 8th replenishment, and to support more effective delivery of the Global Fund Strategy”*⁸. The Evaluation was thus requested by the Board to provide independent input into how the Global Fund has been allocating funding to countries since the introduction of the allocation methodology. It also examines the way in which the methodology has been shaped by the recommendations of technical partners and reviewed/updated every three years based on evidence and lessons learned during the Cyclical Review process.

The Evaluation was launched in an evolving context with regards to the disease burden landscape and health financing. From an epidemiological perspective, total mortality has fallen significantly since 2000, and the relative disease burden has shifted, with a notable rise of tuberculosis (reflected in several data sets, including Deaths and Disability-Adjusted Life Years (DALYs)).

The Evaluation conducted by EY was commissioned and managed by the Global Fund Evaluation and Learning Office (ELO) with oversight from the Independent Evaluation Panel (IEP).

2.1.2. Scope of the evaluation

The scope of this Evaluation complies with the terms of reference and is as follows:

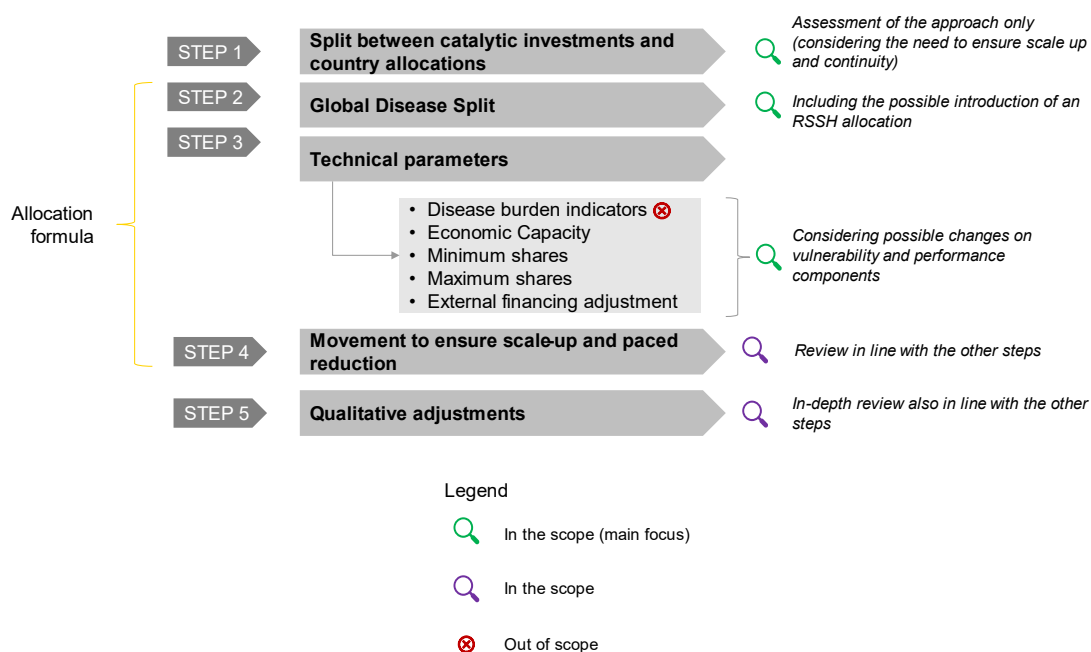
Temporal scope: the evaluation is both retrospective and forward-looking, as it analyzes the history of the allocation methodology while also proposing alternatives for subsequent allocation periods. The Evaluation includes recommendations that will take time to implement in order to avoid disrupting life-saving interventions, in line with the Allocation Methodology’s aim to ensure continuity.

Thematic scope: the Evaluation examines both the Global Fund’s Resource Allocation Methodology and its cyclical review process:

- ▶ All steps and parameters of the allocation methodology have been included in the scope of the evaluation.

⁸ Global Fund, Board Decisions, [Global Fund/B46/DP04](#)

Figure 1: Overview of the steps and parameters of the allocation methodology



Source: EY analysis

- Based on the terms of reference of the Evaluation and scoping interviews, a specific focus has been put on the upfront Global Disease Split (GDS) as well as on the relevance of introducing a separate allocation for Resilient and Sustainable Systems for Health (RSSH).
- In regard to catalytic investments, the Evaluation covers the approach to informing the total amount for catalytic investments vs. country allocations. However, it does not explicitly focus on areas chosen for catalytic investments or the impact of catalytic investments, as both are beyond the scope of the exercise.
- In regard to disease burden indicators used in the technical parameters of the allocation formula, the Evaluation does not suggest any changes to these indicators as they are regularly reviewed by technical partners.
- ▶ In regard to the current cyclical review process, the Evaluation focuses on the processes that ensure the methodology is reviewed and optimized each cycle as needed (see below section 2.3), based on evidence and lessons learned. It encompasses the overall 18-month allocation methodology process⁹ from the inception until the final decisions on country allocations and catalytic investments. Processes related to eligibility, funding requests, grant-making and grant allocations are not within the scope of this Evaluation.

2.2. Background information on the allocation methodology

2.2.1. Rationale and objectives of the resource allocation methodology

In 2014, the Global Fund introduced a new allocation-based funding model for the 2014-2016 allocation period¹⁰. This new model allocates funds for eligible countries, moving away from the previous rounds-based

⁹ The 18-month process is from first discussion with the Strategy Committee on the review for the allocation methodology until the allocation letters are sent in advance of the next Grant Cycle

¹⁰ The 2024-2016 allocation period is referred to as “allocation cycle 1” in the report. Subsequent allocation periods are referred to as cycle 2 (2017-2019), cycle 3 (2020-2022), and cycle 4 (2023-2025). The report also refers to the Grant Cycles (GC): 2014-2016 corresponds to GC4, 2017-2019 GC5, 2020-2022 GC6 and 2023-2025 GC7.

system, under which funding was awarded based on demand and on quality of individual proposals. The new allocation-based model aimed to address the following problems¹¹:

- ▶ **Funding decisions were based on demand** and were therefore not always in line with need. Multiple high burden countries received little funding, while some low burden countries received significant funding. As there was **no maximum amount for each country**, and as allocations were not determined in advance, the rounds-based system gave countries **incentives to seek as much funding as possible, regardless of need**.
- ▶ The rounds-based system **did not favor long-term planning and predictability**, both for the recipient countries and for the Global Fund. The availability of funding for recipient countries depended on the timing of the rounds and the success of grant proposals. There was a **disconnect between the terms of the funding requests (generally five or six years) and the three-year allocation cycles**, which caused the grants commitments made by the Global Fund to extend beyond the funds available.

This allocation methodology has three main objectives, which support the delivery of the Global Fund Strategy¹²:

- ▶ It seeks to **maximize the impact of Global Fund resources** to prevent, treat and care for people affected by HIV, TB, and malaria, and to build **resilient and sustainable systems for health**.
- ▶ It seeks to **align Global Fund financing with highest disease burden and lowest economic capacity**, and address needs of vulnerable populations disproportionately affected by the three diseases.
- ▶ It seeks to ensure **predictability, flexibility, and simplicity** of the funding approach.

2.2.2. Summary presentation of the allocation methodology steps

The allocation methodology is composed of five main steps, each of which has its own rationale:

Table 1: Objectives and main features of each step of the allocation methodology

Step	Objectives/ rationale	Main features of the methodology applied for the 2023-2025 funding period
1. Catalytic investments	To set aside a portion of available funding for programs and activities that are essential for achieving the aims of the Global Fund strategy but which cannot be adequately addressed through country allocations alone, all while continuing to protect country allocations and ensure appropriate scale-up	Amount set upfront and linked to resources
2. Global disease split	To determine the overall distribution of total available resources across HIV, TB, and Malaria (upfront country allocations)	For available funds for country allocation up to and including US\$ 12 billion: HIV 50%, malaria 32%, TB 18%. For available funds for country allocation above US\$12 billion: 45% for HIV, 30% for malaria, 25% for TB.
3. Technical parameters	To allocate funding to countries by disease, in line with the objective of the Global Fund resource allocation methodology	Technical parameters include 5 elements as presented below

¹¹ Global Fund, Evolution of the Global Fund Allocation Methodology; The Final Report of the High-Level Independent Review Panel on Fiduciary Controls and Oversight Mechanisms of the Global Fund to Fight AIDS, Tuberculosis and Malaria. September 2011. https://www.theglobalfund.org/media/5424/bm25_highlevelpanelindependentreviewpanel_report_en.pdf?u=637166002930000000

¹² https://www.theglobalfund.org/media/12051/bm47_03-2023-2025-allocation-methodology_report_en.pdf

Step	Objectives/ rationale	Main features of the methodology applied for the 2023-2025 funding period
Disease burden indicators	To give more weight to countries with the highest disease burden	<p>HIV: the indicator used is the number of people living with HIV</p> <p>TB: a composite indicator considers the incidence of TB and of MDR-TB</p> <p>Malaria: a composite indicator considers the number of malaria cases, of deaths due to malaria, malaria incidence rate and malaria mortality rate</p>
Country economic capacity adjustment	To give more weight to countries with lower capacity to fund their responses to the three diseases. Allocations are adjusted by the CEC factor (based on GNI per capita)	The indicator is based on GNI per capita and weighted according to a smooth curve, for which the value decreases as GNI per capita increases
Minimum shares	To ensure component allocations are a meaningful amount to operationalize and achieve impact	The minimum share is US\$ 500,000 per component for eligible countries
Maximum shares	To ensure component allocations are not overly concentrated in countries with large populations	<p>The maximum share per country component is:</p> <ul style="list-style-type: none"> ▶ 7.5% of the total allocations to countries ▶ 10% of the total amount allocated to countries for each disease
External financing adjustment	To align the distribution of total external financing to the distribution of disease burden and economic capacity	<p>Projections of external financing are discounted by 50% to account for data quality</p> <p>They can influence component allocations by up to 25%</p>
4. Scale-up/ paced reduction	To both ensure scale-up for components that previously received less than their Initial Calculated Amount (ICA) ¹³ while preventing steep decreases in funding from the previous allocation period. It aims to deliver on the principle of predictability of funding	<p>Maximum 90% of previous funding level (formerly maximum 75% of previous funding level)</p> <p>Limit of 7.5% of total funding available for country allocations (from US\$ 800 million limit on movement of funds)</p>
5. Qualitative adjustments	To account for key epidemiological, programmatic, and other contextual factors that cannot be accounted for or are not fully represented in the allocation formula	<p>Adjustment for HIV Key populations</p> <p>Screening through an impact gap/funding change matrix to identify candidates for increases and decreases</p> <p>Holistic consideration of qualitative adjustment factors approved by the Strategy Committee</p>

Source: Global Fund

2.2.3. Allocation methodology review process

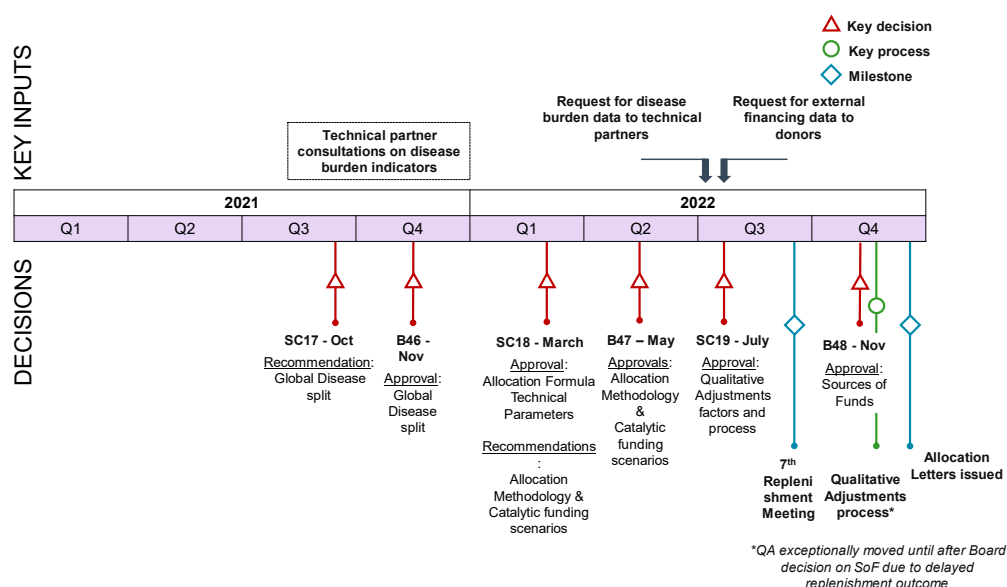
The allocation methodology is reviewed every three years in preparation for the next allocation period. It aims to refine the methodology “as needed to achieve greater impact with available resources”. Each review process is managed by the Secretariat together with the Strategy Committee.

¹³ Initial Calculated Amount (ICA) refers to the country-disease amount which is the result of the step 1 to 3.

Prior to the replenishment meeting for the next allocation period, the Secretariat conduct a review of the current allocation methodology and build on lessons learned from the process and outcomes of the ongoing allocation period. They analyze options for refining the current model as needed and propose recommendations to the Strategy Committee and Board for approval. The review draws on inputs provided by technical partners on disease burden indicators as well as on findings and recommendations from relevant evaluations and audits. This process generally takes 18 months, starting with the GDS, followed by technical parameters, the allocation methodology and catalytic funding scenarios, and lastly qualitative adjustment factors. For Grant Cycle 7 (2023-2025), this process started in March 2021, and final allocations were announced in the allocation letters in December 2022.

After the replenishment meeting, once the final outcome is known, the Secretariat runs the allocation formula to determine the Formula Derived Amounts (FDA), followed by the qualitative adjustments meeting to determine the final country allocations. The formula code is validated by an independent research firm. The research firm runs an independent version of the formula using the same logic and parameters in order to ensure that they calculate identical amounts for country allocations to the Global Fund. Allocation letters are then issued to eligible countries to inform them of the amount they may receive for the allocation period.

Figure 2: Timeline of the allocation methodology process for the 2023-2025 Grant Cycle (GC7)



Source: Global Fund, Briefing on the allocation methodology

2.2.4. Main changes over time

The allocation methodology has undergone several changes overtime. While the **GDS was introduced for the Grant Cycle 4 (2014-2016)** – which allowed the Global Fund to move past its round-based model towards a New Funding Model depending on an allocation formula – most **major changes were introduced for Grant Cycle 5 (2017-2019)** to improve predictability, flexibility, and simplicity of the model, while continuing to align Global Fund financing with highest disease burden and lowest economic capacity and adequately address the needs of vulnerable populations disproportionately affected by the three diseases. The changes included the introduction of funding limits for catalytic investments, the introduction of a smoothened country economic capacity curve, changes to minimum shares, new parameters for the scale up and paced reduction step, as well as a two-step process for qualitative adjustments. At the end of the second cycle, the TERG/TRP/Secretariat Review of the 2017-2019 Allocation Methodology from July 2018 concluded that the allocation model was **working and effective**.¹⁴

For the Grant Cycles 6 (2020-2022) and 7 (2023-2025), refinements mainly focused on areas where evidence and lessons learned suggested improvements. The **next major change was the modification of**

¹⁴ Joint TERG/TRP/Secretariat Review of the 2017-2019 Allocation Methodology, July 2018

the GDS for any additional available funds for country allocation above US\$ 12 billion under Grant Cycle 7 (2023-2025). This change was made in recognition of the increased share of deaths from TB among the three diseases, while preserving funding and ensuring potential for scale-up of HIV and malaria allocations.¹⁵

Table 2: Main modifications of the allocation methodology

Step of the AM		Main changes over time
1. Catalytic investments		Two major changes have been introduced since Grant Cycle 6 (2020-2022): <ul style="list-style-type: none"> ▶ The sequencing of board decisions has been changed: the approval of catalytic investments occurs six months earlier in the process to enable sufficient timing for operationalization. ▶ Previously introduced funding limits (US\$800 million or 15% of available sources of funds for catalytic investments) were removed and replaced with the definition of catalytic investment scenarios linked to the available sources of funds for allocation, to account for the possible replenishment outcomes¹⁶
2. Global disease split		The split defined for Grant Cycle 4 (2014-2016) remained unchanged for Grant Cycle 5 (2017-2019) to Grant Cycle 6 (2020-2022) which is: <ul style="list-style-type: none"> ▶ HIV/AIDS – 50% ▶ TB – 18% ▶ Malaria – 32% For the Grant Cycle 7 (2023-2025), the Board decided to change the split for any additional available funds for country allocation above US\$12 billion, with the following breakdown: <ul style="list-style-type: none"> ▶ HIV/AIDS – 45% ▶ TB – 25% ▶ Malaria – 30%
3. Technical parameters		
	<i>Disease burden indicators</i>	No change under Grant Cycle 4 (2014-2016) to Grant Cycle 7 (2023-2025) on HIV and limited changes under Grant Cycle 5 (2017-2019) (simplification of TB indicator) and Grant Cycle 6 (2020-2022) (revision of the malaria burden indicator) Technical partners recommended maintaining the same indicators for Grant Cycle 7 (2023-2025).
	<i>Country economic capacity adjustment</i>	Introduction of a smoothed CEC curve under Grant Cycle 5 (2017-2019). An external review was conducted in 2021 and concluded that GNI per capita should remain the primary indicator for economic capacity.
	<i>Minimum shares</i>	Minimum shares set to US\$ 500,000 per component under Grant Cycle 5 (2017-2019). No change since Grant Cycle 5.
	<i>Maximum shares</i>	No change since Grant Cycle 4 (2014-2016).
	<i>External financing adjustment</i>	Reduction of the influence of external financing adjustment up to 25%, rather than up to 50% under Grant Cycle 5 (2017-2019). No change since Grant Cycle 5.
4. Scale-up/ paced reduction		Introduction of a limit for the movement of funds during this step and of paced reduction components under Grant Cycle 5 (2017-2019). These parameters were simplified and refined under Grant Cycle 6 (2020-2022) and Grant Cycle 7 (2023-2025).

¹⁵ Global Fund, Evolution of the Allocation Methodology Overview

¹⁶ As a result of the updated sequencing of Board decisions, the Board had to decide on catalytic investments before the Replenishment outcome was known.

5. Qualitative adjustments	<p>Introduction of a two-stage qualitative adjustment process under Grant Cycle 5 (2017-2019).</p> <p>Introduction of an impact gap/funding change matrix under Grant Cycle 6 (2020-2022).</p> <p>Simplification and adjustment of qualitative adjustment factor for each cycle.</p>
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2.3. Methodological approach

2.3.1. Evaluation questions

The Evaluation answers three key overarching questions, each of which relates to one of the three objectives of the Evaluation:

- ▶ **Key Question 1:** To what extent is the current methodology appropriate for ensuring the effective delivery of the Global Fund strategy and maximizing the impact of Global Fund investments? Are there any alternative approaches to the current methodology?
- ▶ **Key Question 2:** What would be the pros and cons of any alternative approaches compared to the current allocation methodology?
- ▶ **Key Question 3:** To what extent is the current cyclical review process that leads to final decisions on country allocations relevant, effective, and efficient? How can it be improved?

These overarching questions cover the relevance, effectiveness, efficiency, and impact criteria, aiming at assessing the extent to which current allocation methodology meets existing needs, achieves its objectives, and expected results, is implemented in an efficient and timely manner, and generates intended (or unintended) high-level effects. Prospective assessment also considers coherence and sustainability as key criteria to evaluate the appropriateness of potential changes to the current allocation methodology.

These questions are composed of a series of **10 more specific evaluation questions**. These include the evaluation questions formulated in the Terms of Reference, which have been completed with additional questions to ensure the scope of work reflects expectations and challenges identified during the inception phase of the Evaluation. These 10 evaluation questions are presented in the table below:

Table 3: Evaluation questions defined for the Evaluation

Key Question 1: To what extent is the current methodology appropriate for ensuring the effective delivery of the Global Fund strategy and maximizing the impact of Global Fund investments? Are there any alternative approaches to the current methodology?
Evaluation question
Q1: Is the approach for setting aside <u>catalytic investments</u> for activities that are essential to achieve the aims of the Global Fund strategy, but which cannot be adequately addressed through country allocations (step 1 of the allocation methodology) adequate? What, if any, alternative approaches could be imagined?
Q2: To what extent does the <u>global disease split</u> (step 2 of the allocation methodology) serve as an effective up-front parameter in the allocation methodology for determining distribution of funding across HIV, TB, and malaria? Are the methodology and process objective and transparent? Are there better alternatives to determining country allocations without requiring a global disease split whilst ensuring countries address diseases effectively and in line with country burden?
Q3: How might a potentially <u>separate allocation for RSSH</u> be determined? What have been the implications of not having a separate RSSH allocation on RSSH and the disease programs? What would be the challenges and benefits in having a separate RSSH allocation, including the consequences for allocations for the 3 diseases?
Q4: Are steps 3, 4 and 5 of the allocation methodology, e.g. <u>technical parameters, scale-up/paced reduction and qualitative adjustments</u> adequate, transparent, and well understood to maximize the impact of the Global Fund investments whilst ensuring it is predictable, flexible, simple, and addressing the needs of the countries with highest disease burden and lowest economic capacity?
Q5: How does the Global Fund Allocation Methodology compare to other models used in global health and development agencies for financial allocations? Are there any lessons to be learned from other models relevant to the Global Fund?
Key Question 2: What would be the pros and cons of alternative approaches compared to the current allocation methodology?

This key question builds upon the result of key question 1 and describes the pros and cons of the proposed alternatives and their impacts to provide contextualized recommendations. The analytical approach suggested to respond to these questions is outlined in section 3.2.2.

Evaluation question

Q6. What changes, if any, to the allocation methodology are recommended to achieve greater investment impact and a more effective delivery of the Global Fund Strategy?

Q7. Based on any recommended changes, what would be the trade-off implications on existing life-saving interventions and programme sustainability, including ethical considerations?

Q8. Would any recommended changes to the Global Fund allocation methodology lead to incidental or unintended consequences at the country level?

Q9. How would any proposed recommended changes to the allocation methodology impact overall timeline and steps in the process to ensure timely high-level decision making? What are the challenges and approaches required for any recommended changes to be adopted through Global Fund Governance?

Key Question 3: To what extent is the current cyclical review process that leads to final decisions on country allocations relevant, effective, and efficient? How can it be improved?

This key question analyzes the relevance, coherence, and effectiveness of the cyclical review process to inform the next programming cycle. The analytical approach suggested to respond to these questions is outlined in section 3.2.1.

Evaluation question

Q10. To what extent are the quality assurance mechanisms built into the overall allocation methodology process, effective in ensuring that high-level decisions on resource allocation are informed by robust and rigorous technical parameters, metrics, and inputs (including the latest epidemiological data)? How, if necessary, can quality assurance mechanisms be strengthened ahead of subsequent allocation periods?

2.3.2. The approach for the Evaluation

Some key decisions were taken during the Inception Phase of the Evaluation that had bearing on the design and approach of the Evaluation. For instance, whilst impact modelling and cost-benefit analyses were initially expected in the Evaluation, it was quickly deemed not possible during the Inception Phase. Several challenges were indeed preventing the Evaluation Team from conducting a cost-effectiveness analysis, which are likely to continue to exist in the future:

- ▶ **There is a complex link between funding and impact, in light with the Global Fund's contributive model**, which implies that the actual impact cannot be directly attributed to the organization as it results from many external factors.
- ▶ **Impact modelling may not be suitable to directly inform resource allocation because results vary based on choice of assumptions and methodologies.**

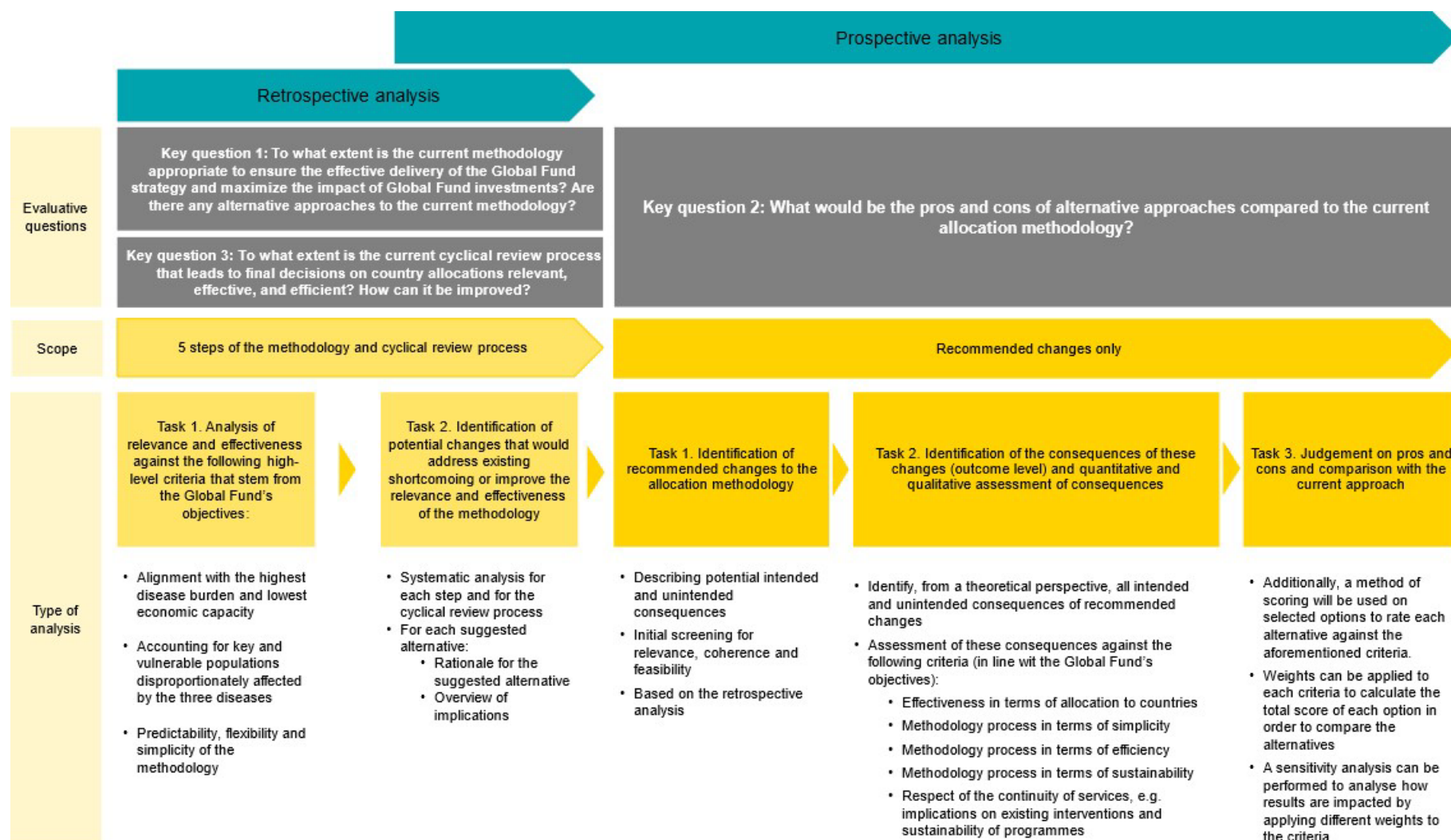
This decision to not attempt to model impact had bearing on the design and approach of the evaluation. A different approach for the evaluative framework has indeed been elaborated depending on the specific nature of the evaluation questions:

- ▶ **For the retrospective questions (including initial formulation of possible changes):** **Evaluation grids** have been developed to frame the answers to the retrospective questions on the allocation methodology (**questions 1 to 4**) and its cyclical review process (**question 10**), which aim to assess the relevance and effectiveness of the current methodology and processes, and look for possible changes relating, for example, to the appropriateness of current steps (GDS in particular), calculation methods and/or indicators currently used. The Evaluation grids present, for each question: (i) understanding of potential issues at stake and specific scope to be covered, (ii) judgement criteria to objectively and transparently lay out the basis on which answers to the Evaluation question are formulated and (iii) information sources and corresponding data collection and analysis tools needed, which makes it possible to link the data collection and analysis plan with the sources and tools identified in the Evaluation framework. If applicable, major limitations and risks are mentioned, as well as suggested mitigation measures. The answers to each retrospective evaluation question follow a similar logical flow:

- o Task 1: The relevance of the step/element/process under scope, e.g. its appropriateness for addressing existing needs and contribution to the Global Fund's strategy objectives; the effectiveness of the step or process under scope, e.g. its ability to contribute to the achievement of the intended outcomes;
 - o Task 2: Potential changes that would address existing shortcomings or that could improve the relevance and effectiveness of the methodology
- **For the prospective questions: A MCDA approach** has been presented to frame the way the Evaluation answers prospective questions (**questions 6 to 9**). It presents a common framework to measure the trade-offs and implications of possible changes to the current allocation methodology and compare them with status quo.
- o **Task 1 - Identification of recommended changes to the allocation methodology** (initial screening): Possible changes are identified as part of the answers to questions 1 to 4. In addition, consistent options for changes combining several alternatives at different steps of the methodology have been developed. Prior to measuring trade-offs, single changes and combined options have been screened to ensure that they address existing shortcomings, meet current expectations for changes and form a consistent approach to avoid overlaps between different elements of the formula and the qualitative adjustments. They are also assessed from a feasibility perspective (robustness and availability of data).
 - o **Task 2 - Identification of the consequences of these changes and quantitative and qualitative assessment of consequences:** For each option which passed the initial screening, the Evaluation Team describes potential consequences, by pointing out the likely outcomes that a change to the current methodology may have. By establishing the causal link between changes and outcomes, the Evaluation aims to identify, from a theoretical perspective, all intended and unintended consequences resulting from any recommended changes to the allocation methodology.
 - o **Task 3 - Judgement on pros and cons and comparison with the current approach:** judgement of pros and cons is based on a common approach on the criteria against which trade-offs shall be considered as “positive” or “negative” (e.g. what shall be considered as a “pro” or “con”) and what weight shall be given to the respective trade-offs. This framework helps compare options with the current approach based on an analysis of their respective pros and cons.
- The articulation between retrospective analysis and prospective analysis allows the identification of shortcomings and alternatives (retrospective analysis) and provides a robust assessment of each alternative (prospective analysis).
- The overall approach articulating the different phases, their scope and the type of analysis conducted for each, is presented below.

*The exhaustive presentation of the Evaluation and Analytical Frameworks for both the retrospective and prospective Evaluation Questions can be found in **Annex 1** of the separate Annex document.*

Figure 3: Evaluative and analytical framework of the Evaluation



Source: EY elaboration

2.3.3. Data collection tools used

A number of tools were used to gather data for this Evaluation and aimed to gather both qualitative and quantitative data through primary and secondary data collection. The choice of tools was made on the basis of a stakeholder mapping conducted during the Inception Phase. For instance, the Evaluation aimed at consulting a **diversity of stakeholders** through both interviews and a targeted e-survey (for CCMs only), to ensure that relevant stakeholders had the opportunity to contribute to this formative exercise. In relation to the data gathered, no specific gaps were identified.

An overview of these tools is presented below.

Documentary review

A thorough document analysis was conducted to identify the main debates regarding the Global Fund's allocation methodology. This document analysis included:

- ▶ Analysis of strategies, evaluations, and other reports
- ▶ Analysis of documents pertaining to the cyclical review process (Board decisions, Strategy Committee recommendations and decisions)

*The complete list of documents is available in **Annex 4** of the separate Annex document.*

Interviews

The Evaluation consulted a diversity of stakeholders¹⁷ through a series of 51 semi-structured interviews:

- ▶ **15 Board Members (or a designated representative speaking on their behalf)**, were interviewed regarding their expectations towards the allocation methodology (RSSH, performance & vulnerability components, etc.), its rationale and objectives, their views on each step of the current process, their perception of the credibility and robustness of the current methodology, as well as their perception of the cyclical review process. All Board Members, along with their designated representatives, were contacted to take part of the present Evaluation; however, not all of them agreed to be interviewed.
- ▶ **13 Members of the Strategy Committee (SC)** were interviewed regarding their perception of the current allocation process, its strengths and weaknesses, the potential changes that shall be considered (RSSH, performance & vulnerability components, etc.) and their perception of the cyclical review process. All SC Members were contacted to take part of the present Evaluation; however, not all of them wished to share their insights with the Public Policy Evaluation Team.
- ▶ **17 Members of the Secretariat** were interviewed regarding their perception of the current allocation process, its strengths, and weaknesses, particularly on the current qualitative adjustment process, the GDS, the diseases burdens indicators, and the cyclical review process. These stakeholders were also interviewed regarding the potential changes that shall be considered (RSSH, performance & vulnerability components, etc.). The Public Policy Evaluation Team identified the key persons of interest during the stakeholders mapping in the Inception phase.
- ▶ **5 Technical Partners (1 HIV situation room, 3 TB situation room, 1 CRSPC)** were interviewed regarding their perceptions on the allocation methodology, specifically the disease burden indicators, qualitative adjustments and RSSH, and on their implication within the cyclical review process.
- ▶ **1 Professor at Imperial College London**, as the purpose of this interview was to support with rationale of why impact modeling was not to be pursued in this Evaluation and to gather other relevant suggestions regarding the allocation methodology.

*The complete list of the interviews conducted is available in **Annex 5** in the separate Annex document.*

The organisation of the interviews for the Evaluation was largely successful, with stakeholders from all stakeholder groups participating in the interviews. Part of the success of those interviews was due to the numerous reminders being sent by the Evaluation Team and with the support of ELO.

Online survey

An online survey targeted CCM Chairs and members. It was sent to **182 different contacts (representing CCM Chairs, Vice Chairs and Administrative Focal Points) from 107 eligible countries** (including

¹⁷ All Board and Strategy Committee members have been reached out to for interview in order to be part of this Evaluation.

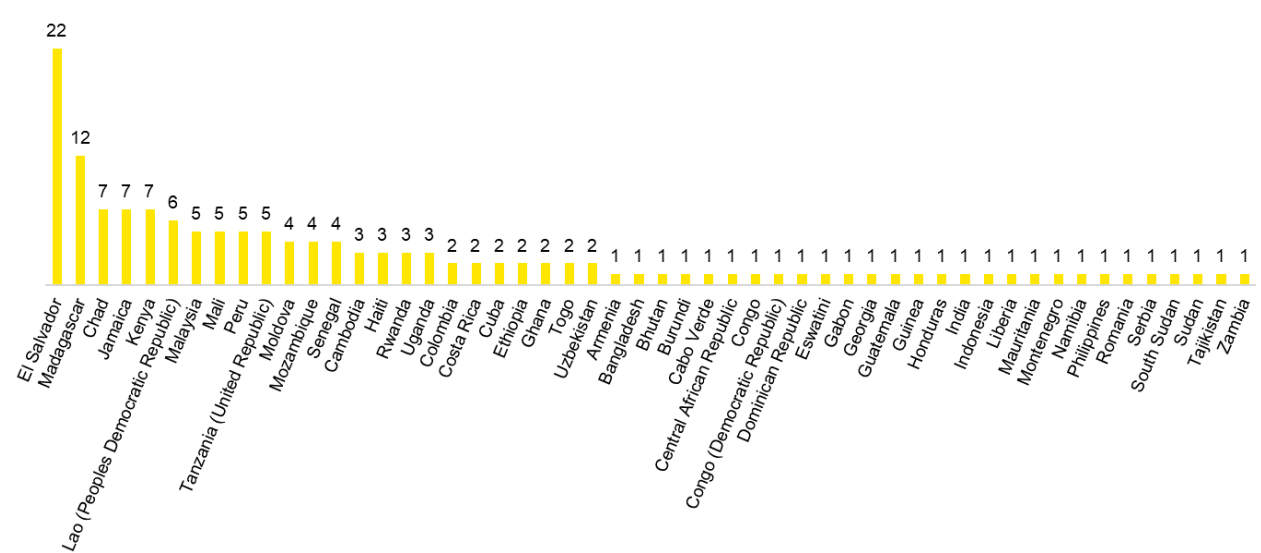
countries eligible for transition funding). Each contact was asked to circulate the survey further within the CCM in order to collect as many responses as possible from CCM members.

The survey was deployed following rigorous testing and piloting with CCM members from two countries (Belarus (in English) and Djibouti (in French)) and reviewed by the Global Fund Secretariat to ensure the appropriate technical language in line with information received by CCMs.

The survey remained active for nearly 4 weeks, from the 31st of October to the 27th of November 2023.

A total of **214 individual participations** were registered on the closing of the survey. After cleaning of incomplete contributions, **147 actionable answers¹⁸ from 52 different countries could be analyzed. The number of answers received by country varies from one answer only from most countries to 12 responses in Madagascar and 22 responses in El Salvador.**

Figure 4: Number of respondents per country



Source: online survey

Overall, the 52 respondent countries represent 57% (US\$ 7,473,504,974) of the total amount of country allocations for GC7 (2023-2025).

Box 1: Methodological note on the interpretation of the survey

Readers must be cautious while reading the survey findings as several refinements occurred as the Evaluation Team analyzed the responses.

▶ **Results must be put into perspective** as there are around 4,000¹⁹ CCM members and alternates world-wide and only 147 of them answered the survey. **To avoid confusion, in this document the CCMs individuals who answered the survey are referred to as CCM respondents.**

▶ **The survey was aimed to collect the perception from individual CCM members.** The results of the survey thus **only reflect individual opinions, and do not intend representing any official view from a national perspective.** Depending on the number of respondents in a certain country, aggregated answers cannot be considered as sufficiently representative to draw one single CCM view per country (for instance responses from countries with only 1 respondent can hardly be considered as robust as countries with more than 10 respondents such as Madagascar and El Salvador).

▶ **Views may be largely influenced by national contexts and specific funding situations. For this reason, individual answers have been systematically cross-tabulated with countries to**

¹⁸ There are around 4,000 CCM members and alternates world-wide

¹⁹ correspondence with the CCM Hub manager from 15.11.2023

identify national trends and ensure bias caused by several respondents answering from a certain country is adjusted. This over-representation of certain countries has been considered while analyzing the survey responses as follows: the results obtained in terms of percentage considering all individual responses have been compared with the results obtained considering the average opinions expressed by country. Additional details and/or an approach by country has been preferred when this comparison has detected clear bias. This is the case when the views expressed in the over-represented countries, i.e. in El Salvador and in Madagascar, show clear specificities than do not compare with the overall trends and may change the overall statement of the evaluation.

Considering the above-mentioned observations, the results of the survey should be considered with caution as: (i) on the one hand, the individual perceptions are not representative of the diverse country situations and can be skewed by opinions coming over-represented countries; (ii) And on the other hand, analyzing the average opinion at country level can be misleading in most countries with a too low number of respondents (only 1 or 2), as these may not represent the general views within their CCM. Both risks have been mitigated as much as possible.

*More precisions on the deployment of the survey and on the respondents analysis can be found in **Annex 2** as well as the list of interviews undertaken in **Annex 5.2** of the separate Annex document.*

As a second step, the deployment of the online survey was complemented in phase 3 with **follow-up interviews with 4 countries**, to go further into the topics discussed in the survey. The selection criteria for those follow-up interviews included an in-depth analysis of country allocations' variations and an analysis of the results of the survey (especially the answers to the open questions). Out of a total of twenty interview requests sent, four countries answered positively and ended-up being interviewed (Ethiopia, Madagascar, Rwanda, and Chad). It is important to note that the information obtained from these interviews was not generalized to the overall portfolio of recipient countries, rather, it was used to illustrate the implications of the trade-offs considered for specific countries.

Benchmarked organizations

In order to conduct the Benchmarking exercise, a **documentary review** was carried out for all the considered international organizations as well as some interviews with key members. **Three interviews** were conducted with the following organizations:

- ▶ **IDA**, interview with the IDA Strategy and Operations Manager
- ▶ **Gavi**, joint interview with a member of the Gavi Policy Team, the Manager of the technical support allocation, the Manager of the HSS cash support, and a member of the Program Support Team
- ▶ **GFF**, interview with a Senior Partnership Specialist, member of the Executive Secretariat of the GFF

For those benchmarks, the exercise highlighted some best practices and limitation factors of other international organizations' methodologies. The main insights highlighted via those benchmarks are presented throughout the report. Additional descriptive information on each benchmarked organization have been added in the Annex document²⁰.

*The detailed benchmarked organizations as well as the list of the interviews conducted with the Benchmarked Organizations can be found in **Annex 3** and **Annex 5.2** of the separate Annex document.*

2.4. Limitations

2.4.1. Limitations on the overall approach to the Evaluation

Additional limitations on the overall design and approach to the Evaluation have been identified:

- ▶ **The Evaluation has not been able to quantitatively measure all trade-offs.** Qualitative appreciations have been established to assess, for instance, ethics considerations or impact of possible changes on ongoing programs. In particular, the Evaluation was not able to assess the

²⁰ The annexes regarding the benchmarked organizations have been sent back to the interviewees for final validation. At this stage, no feedback has been received.

direct impact of changes to the allocation methodology on the delivery of the Global Fund Strategy goal of ending mortality and incidence rates. Indeed:

- o The Evaluation cannot rely on any existing model from the Global Fund to measure potential trade-offs in terms of expected impact of investment and potential contribution to the Global Fund's strategy goals of ending AIDS, TB, and Malaria by 2030.
 - o The Global Fund funding relies on a contributive model which recognizes that actual impact is conditioned by many external factors. Most importantly, **the Global Fund is only one amongst other important actors in the field. Therefore, the impact of US\$1 spent by the Global Fund to fight HIV, TB or Malaria cannot be assessed due to financing and co-financing from other organizations for the same disease in the same area.**
 - o Whilst modelling work has been undertaken to link funding with impact at the beginning of the Evaluation, the wide range of approximations led us to conclude that this sort of modelling was not appropriate to inform decision-making.
- ▶ **The Evaluation has not been able to rely on the Global Fund's strategy outcome KPIs for which data is insufficient.** Indeed, for some KPIs which were selected for the new Strategy, there is no sufficient historical data at the country level to be used to establish potential correlations between funding level and performance. The KPIs have been included in the Evaluation depending on the availability and quality of the Global Fund's data.
- ▶ **The Evaluation also had to consider the relative and subjective nature of pros and cons,** depending on the priorities and expectations of different stakeholders, especially among Board members. The definition of an analytical framework (*presented under **Annex 1** of the separate Annex document*) which includes a shared vision on how trade-offs should be measured, and which judgement criteria would have to be considered, was crucial to ensure the validity and credibility of final recommendations.

2.4.2. Limitations of data collection tools

The following limitations have been identified throughout the different phases of the Evaluation:

- ▶ **Concerning the organization of the interviews:** Some challenges were recurrent in the organization of the interviews. These related to:
 - o **The availability of stakeholders**, as some of them refused to be interviewed and/or were unreachable.
 - o **The identification of relevant individuals within the different benchmarked organizations**, and especially within the Pandemic Fund where no interview has been conducted.
- ▶ **Concerning the stakeholders' level of knowledge of the allocation methodology:** Stakeholders' knowledge was variable among Board and Strategy Committee members. This constitutes a limitation as not all interviewed stakeholders were in position to express their perception on the allocation methodology due to limited knowledge. At the same time, it also appears as a genuine finding (in terms of simplicity, clarity, and transparency of the allocation methodology). To mitigate this phenomenon, a reminder of the allocation methodology was sent prior to the interviews.
- ▶ **Benchmarking the Global Fund with other organizations' allocation methodologies had to cope with limitations due to low comparability.** The allocation methodologies of the three benchmarked organizations (Gavi, GFF, IDA) reflect their own strategic objectives and priorities. It was thus difficult to compare formulas based on their impact and relevance which vary greatly from one organization to another. However, they can be compared from an efficiency, transparency, and equity perspective. In addition, their key features (rationale, lessons learned/changes in their allocation formulas, inclusion of a performance metric or not, existence of minimum/maximum shares, etc.) was interesting to analyze.
- ▶ **Regarding the survey**, it was aimed to collect the perception from individual CCM members. As mentioned in the Methodological note, the results of the survey thus only reflect individual opinions, and do not intend representing any official view from a national perspective. Thus, results must be put into perspective as there are around 4,000 CCM members and alternates world-wide and only 147 of them answered the survey. Depending on the number of respondents in a certain country,

aggregated answers cannot be considered as sufficiently representative to draw one single CCM view per country (for instance responses from countries with only 1 respondent can hardly be considered as robust as countries with more than 10 respondents such as Madagascar and El Salvador). Also, views may be largely influenced by national contexts and specific funding situations. For this reason, individual answers have been systematically cross-tabulated with countries to identify national trends and ensure bias caused by several respondents answering from a certain country is adjusted.



Note to the reader

The structure of this Final Report reflects a **thematic approach** that arises from the **five retrospective Evaluation Questions**, namely: Catalytic Investments (QE1), Global Disease Split (QE2), RSSH (QE3), Steps 3, 4 and 5 (QE 4) and Cyclical review process (QE10). The main parts of this Final Report are therefore aligned with this thematic approach. Whilst the comparative analysis with benchmarked organizations (QE5) is a transverse element of the report, further details on benchmarks can be found in the separate Annex document.

For ease of reading purposes, the answers to the **Prospective Evaluation Questions** regarding the potential changes (Q6), their trade-off implications (Q7) and consequences and timeline of recommended changes (Q8 and Q9) have been integrated into the five thematic parts.

3. Catalytic investments

Q1: Is the approach for setting aside catalytic investments for activities that are essential to achieve the aims of the Global Fund strategy, but which cannot be adequately addressed through country allocations adequate? What, if any, alternative approaches could be imagined?

Methodological introduction

Setting aside a portion of available funding for catalytic investment is the first step of the current allocation methodology. Catalytic investment funding aims to fund programs and activities that are essential to achieve the aims of the Global Fund strategy, but which cannot be adequately addressed through country allocations alone.

In the past two allocation cycles, the approach to determining catalytic investment amounts, which are decided by the Board before the replenishment outcome is known, was linked to the total available sources. It has indeed been based on an analysis of scenarios showing the trade-offs between ensuring a “sufficient” level of scale up in country allocations and potential impact of catalytic investments.

In the context of the Evaluation, special emphasis was put on evaluating the adequacy of the approach for determining the total amount for catalytic investments, considering the objectives of the allocation methodology and the need for protecting country allocations and ensuring appropriate scale-up. The Evaluation was not aimed to analyze the areas chosen for catalytic investments or the impact of catalytic investments: it was thus not intended to assess the appropriateness of the approach to effectively address funding needs for catalytic activities. Additionally, it did not analyze how areas for catalytic investments are chosen (which includes discussions on priorities for catalytic investments that happen in parallel to defining the different scenarios of amounts), nor did it assess the performance and impact of catalytic investments.

The answer to this evaluation question mainly relies on an in-depth review of the approach as well as on individual inputs and perceptions from stakeholders, mainly Board and SC members.

Summary of findings

The current approach is sufficient for informing decision-making on the total amount to be set aside for the catalytic investments. *Relying on replenishment scenarios is a pragmatic approach that allows informed decision-making around the appropriate balance between catalytic investments and country allocations. It effectively enables an appropriate amount to be set aside for catalytic investments that both protects country allocations and ensures sufficient scale-up for countries with the highest disease burden.*

Two alternatives have been considered which shall not be recommended due to their drawbacks. A fixed amount or percentage dedicated to catalytic investments (as was the case before the 2020-2022 allocation cycle) would increase the efficiency of the process but would negatively impact country allocations in case of low replenishment. A fixed amount defined upfront based on estimated needs for catalytic funding would face the same drawback; moreover, it would be challenging to implement due to the lack of available inputs at the time the decision has to be made.

3.1. Findings

Stakeholders confirm that catalytic investments are critical for leveraging impact, but have diverging views on the right balance between catalytic investment amounts vs. country allocations

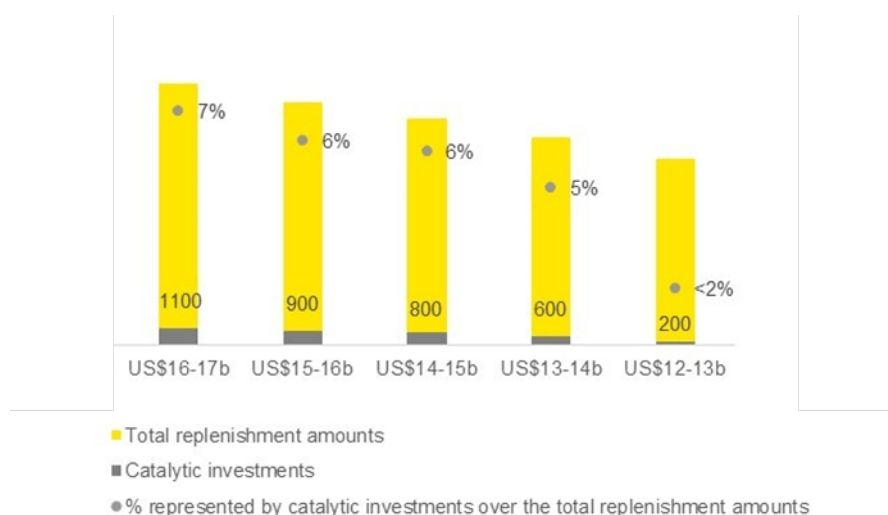
All stakeholders interviewed during the Evaluation confirmed that catalytic investments are key to supporting the implementation of the Global Fund strategy, and to fund global or regional-level strategic initiatives whose impact cannot be achieved through country allocations alone. It is also recognized that catalytic investments have a strong potential to leverage more impact from country-level investments. This justifies the need to determine a certain amount of funding dedicated for these catalytic investments as part of the allocation methodology. However, this first step of the methodology is a **critical area for discussion** as it is not formula-based and the views and perceptions on the relative importance of catalytic investments vs. country

allocations differ across Board constituencies. Whilst most agree with the need to allow for as much funding as possible to countries and ensure sufficient scale-up of country allocations, some would like to increase the proportion accorded to catalytic investments, considering the leveraging effect on country-level investments and their potential for global impact.

- **The current approach effectively allows to set aside a total amount for catalytic investments that protects country allocation and ensures sufficient scale-up for countries with the highest disease burden**

In this context, the approach for determining catalytic investments, which was revised from the 2020-2022 allocation cycle, has been based on various replenishment scenarios, and guided by the principle of ensuring appropriate scale-up of country allocations in each scenario (aiming to capture scale up in highest burden countries and mitigating steep decreases in the rest of the portfolio in the lowest funding scenarios). As shown in the graph below, the share dedicated to catalytic investments thus varies depending on the different funding scenarios of total replenishment amount. In case of low replenishment, the amount dedicated to country allocations is prioritized (it may decrease in amount but its overall dedicated share increases) to maintain and protect funding continuity.

Figure 5: Catalytic funding scenarios for the 2023-2025 allocation period



Sources: [GF/B47/04 Revision 1](#)

Two out of the three benchmarked organizations (IDA and the GFF) have a similar approach to set aside a certain amount of funding ahead of country allocations:

- ▶ **IDA's "windows"²¹ are really close to the GF's catalytic investments:** A third of their total pot goes to its "Windows" which reflect donors' priorities and enables IDA to not only secure funding for its Performance-Based Allocations to countries but also reflect donors' priorities. The discussion for the split between IDA's "windows" and countries allocation occurs during the replenishment (not in advance based on scenario as it is the case for the Global Fund).
- ▶ **Since December 2023, the GFF has implemented a "challenge fund"²²** which can be compared to the Global Fund's catalytic investments as it enables the GFF to fund more innovative projects. Similarly, the challenge fund is outside of the GFF's funding cycles.
- ▶ **When it comes to Gavi, additional health system strengthening funds may be provided under the Fragility, Emergency and Displaced Populations Policy²³.** These funds are additional to the HSS ceiling amounts and they represent 10% of the total HSS envelop. The funds are taken from the underspent resources and are not set aside from the start. Those 10% are allocated to countries

²¹ Source: Interview with IDA

²² Source: Interview with the GFF

²³ Sources: [Fragility, emergencies and displaced populations policy \(gavi.org\)](#) and interview with Gavi

which are recognized as either facing chronic fragility, under an exceptional emergency or having to deal with a high burden of displaced population.

■ **The current approach is relevant and effective for informing decision-making on the total amount to be set aside for the catalytic investments**

Whilst most interviewed stakeholders were satisfied with the approach adopted to determine catalytic investments over the last two cycles, it also appears particularly relevant and effective considering that:

- ▶ **This approach is a good compromise** between the need to fund country-led programs dedicated to the three diseases and other initiatives which provide opportunities for accelerated impact, through which the Global Fund can provide a more catalytic input.
- ▶ **This approach is relevant considering that it would be difficult to come to an “ideal” catalytic value.** It is both a “smart”, “pragmatic”, and efficient way to avoid endless debates and temptation from some donors to flag investments towards certain priorities at the allocation methodology stage (yet this does not prevent donors from discussing these aspects at the stage of operationalizing catalytic investments)
- ▶ **The approach is also the most appropriate** considering that it would be difficult to base decisions on information related to needs or effectiveness from previous initiatives that could not be available at the time they are made.

3.2. Potential alternatives

■ **Although the current approach has a few weaknesses...**

Several weaknesses have been underlined during the Evaluation when it comes to setting aside catalytic investments:

- ▶ The determination of funding scenarios for catalytic investments does not use any comprehensive reporting regarding the effectiveness of past actions due to limited data availability at this stage of the process²⁴. This in turn impacts opportunities for optimizing the process based on results from previous cycles. This is mostly due to the fact that, for many catalytic investments, the implementation is on a later cycle than the allocation. Moreover, it is important to note that catalytic investments areas may vary from one cycle to another in order to address the latest context and align with the Strategy, which means that results from previous cycles are not always relevant to determine the total catalytic funding envelope for the next cycle. Interviewed stakeholders have indeed underlined the lack of data on the previous cycles as a barrier to improving future cycles and are unsure about the way decisions have been prioritized. However, it should be noted that relying solely on previously obtained results can be limiting for two reasons: First, catalytic priorities can change from cycle to cycle, so results from the previous cycle are not always relevant in determining the upfront split for the next cycle. Second, as the different catalytic modalities (strategic initiatives, matching funds, catalytic multi country) are very different in nature, their results cannot be directly compared/aggregated to inform the total amount for all three priorities.
- ▶ As the share of resources dedicated to catalytic investments varies significantly with the replenishment amount, this step is highly dependent on the replenishment outcome. Since the cycle 2020-2022 (GC6), the Board has been asked to approve catalytic investments six months earlier in the process in order to enable sufficient timing for their implementation. As a result of this updated sequencing, catalytic investments have since been decided before the Replenishment outcome is known, which in turn complicates the decision-making process.
- ▶ Moreover, while catalytic investments are an important part of the process, they may be **insufficiently integrated in the overall cyclical review process**. For the 2023-2025 cyclical review process, recommendations regarding catalytic funding scenarios were made in March 2022, while recommendations for the Global Disease Split were made in October 2021. As a result, decisions surrounding catalytic investments may appear to some Board Members to be made in a vacuum from decisions regarding the Global Disease Split, rather than in synergy²⁵. There are, however,

²⁴ Source: Interviews. More data on catalytic investments are yet considered at a later stage in the prioritization of catalytic investment priorities.

²⁵ Source: Interviews.

connections between the GDS and catalytic investment decisions: for instance, the Board decision for the cycle 2023-2025 (GC7) included a statement to explore opportunities in catalytic investments to increase TB funding²⁶.

Regardless of the approach for setting aside the total amount dedicated to catalytic investments, several Board and SC members expressed concerns about the lengthy and cumbersome general process of identifying and prioritising the catalytic investments (outside the scope of the evaluation), especially in view of the amounts involved. Separating the determination of the catalytic investments amount from these discussions by letting the Board approve scenarios based on the sources of funds available for allocation is a relevant approach to avoid likely lengthy debates on what would be the “ideal” amount of funding considering the divergent views and priorities amongst Board members.

■ However alternative approaches would not lead to an improved benefits-drawbacks ratio

Other approaches could include the definition of a **fixed amount or percentage dedicated to catalytic investments** (which corresponds to the approach implemented until cycle 2017-2019 (GC5)) or a **fixed amount defined upfront based on estimated needs for catalytic funding**. However both approaches would negatively impact country allocations in case of low replenishment and limit scale up opportunities. In addition, determining the amount to be set aside for catalytic investments based on an analysis of needs and priorities would be hardly feasible due to the lack of available inputs at the time the decision has to be made.

3.3. Recommended changes

No alternatives are suggested as there is no evidence that any alternative could improve the approach.

²⁶ GF/B46/04, 8-10 November 2021.

4. Global Disease split

Q2. To what extent does the global disease split serve as an effective up-front parameter in the allocation methodology for determining distribution of funding across HIV, TB, and malaria? What alternative methodology could be used to determine country allocations without any GDS?

Methodological introduction

The Global Disease Split (GDS) is the second step of the allocation methodology. It aims to determine the overall distribution of total available resources across HIV, TB, and malaria.

The initial split (50% for HIV, 32% for malaria and 18 for TB) was informed by the assessment made by three expert institutions in 2013: the Health Economics and HIV/AIDS Research Division (HEARD), Imperial College, and the Institute for Health Metrics and Evaluation (IHME)²⁷. These institutions were asked by the Global Fund to propose approaches for determining the upfront global distribution of resources across the three diseases. They used different approaches (based on demand, weighted capitation payments and disability-adjusted life years, etc.) that included the following common criteria:

- ▶ *Criteria related to **epidemiological data** for each disease (HEARD, Imperial College, IHME). To evaluate epidemiological burdens, HEARD used formulas that are almost identical to those currently used by the Global Fund. The Imperial College and IHME relied on DALYs, among other indicators, to determine epidemiological burdens.*
- ▶ *Criteria related to **cost and cost-effectiveness of interventions** (HEARD, Imperial College, IHME). The Imperial College set cost-effectiveness threshold according to resources available while the IHME assessed the cost effectiveness based on regression model of past development funds and impact on DALY's.*
- ▶ *Criteria related to the **ability to pay and available funding**: income of countries (IHME), domestic and external contributions (HEARD, Imperial College)*

For the 2023-2025 allocation period, the Board decided to allocate a greater share to TB (25% vs 18%) for available funds for country allocation above US\$12 billion. This decision was made in recognition of the increased share of deaths from TB among the three diseases, while preserving funding and ensuring potential for scale-up of HIV and malaria allocations. According to information provided by the Secretariat thus far, this revised funding split does not only rely on disease burden but considers the effectiveness of investments, the current funding landscape, and existing Global Fund funding in countries.

The Evaluation analyzed the relevance and effectiveness of having an upfront Global Disease Split and identified potential alternative approaches:

- ▶ *Should there be a Global Disease Split? Is it relevant to ensuring a balanced distribution of funds across diseases overall/at the global level? The Evaluation also investigated the relevance of having an upfront global disease split vs. subsequent country disease splits only. It also checked how a new approach would impact the allocation methodology and what the outcome would be on final allocations.*
- ▶ *To assess the current GDS and alternative approaches, what is the relevance of other metrics that could better reflect the funding needs of each disease? What could be the alternatives to the disease burden calculation recommended by expert institutions? What common metrics could be considered to inform the GDS (DALYs, mortality, incidence) and why (including the strengths/limitations of each)?*
- ▶ *Should other metrics be considered to replace/compliment the disease burden indicators (financing, impact on investment, estimated program split, etc.)? Initial inputs provided by the Secretariat highlight that any changes in the GDS are faced with challenges with regards to data quality and comparability across diseases*

²⁷ Health Economics and HIV/AIDS Research Division (HEARD) at the University of KwaZulu-Natal; Imperial College London ; Institute for Health Metrics and Evaluation (IHME) at the University of Washington.

The answer to these Evaluation questions relied extensively on the work already undertaken by the Secretariat for the 2023-2025 cycle (GC7). The Secretariat has indeed analyzed several options based on various rationales and has measured their impact on final allocations. The Board considered two options that were ultimately assessed against the need to align more closely with disease burden, to ensure continuity of service and scale-up potential, and to permit a significant increase in TB allocations.

Summary of findings

Having an up-front GDS is key to facilitating the distribution of funding across the three diseases by providing a stable and (to some extent) accepted basis in a context of competing needs and expectations. It also contributes to predictability, while simultaneously allowing for flexibility and simplicity. There is a generally satisfactory acceptability of the principle of a global disease split among Global Fund stakeholders.

Nevertheless, in the current situation, **the GDS calculation and metrics raise questions**. While it is reviewed every three years, it was first updated during the cyclical review process for GC7. The direction and extent to which it should be updated was highly debated during this process. The three main criteria which have been used since 2013 to calculate the GDS (disease burden, cost-effectiveness, and funding gaps) have considerably evolved since. The analyses of this evolution consistently show an under-appreciation of the share of TB and/or an over-appreciation of the share of HIV:

- ▶ The epidemiological landscape has significantly changed, as demonstrated by a continuous increase in the share of deaths due to TB between 2009 and 2022. In 2009, TB already had the highest share in the number of deaths across the three diseases (40%), followed by HIV (39%) and malaria (20%). In 2022, this share of death has increased to 47% for TB and 26% for malaria, while the share for HIV has decreased to 27%.
- ▶ The concentration of disease burdens across income groups varies significantly between the three diseases: 58% of the disease burden of malaria is concentrated in the three lowest income deciles (based on 2021 GNI per capita data and disease burden data), compared to 38% for HIV and 18% for TB.
- ▶ While a dedicated cost-benefit analysis would be needed to assess the evolution of cost-effectiveness of interventions since 2013, it should be noted that new challenges have emerged for TB and for malaria, with an increase in the number of drug-resistant cases and of insecticide-resistant mosquitoes.
- ▶ Additionally, while international financing for TB and malaria are highly dependent on the Global Fund, this is less true for the case of HIV.

In this context, decisions made on the GDS over the previous allocation cycle have remained highly political. Whilst the challenge is not necessarily to define an 'ideal split' (which would anyway differ according to the different constituencies) but what is the most appropriate split for the next grant cycle, as well as the need to ensure continuity of life-saving interventions, it is recommended to:

- ▶ **Keep an upfront GDS**
- ▶ **Ensure the GDS is updated at each allocation cycle and that the decision is systematically informed by technical and scientific evidence.**
- ▶ **Adjust the current GDS to better reflect the epidemiological situation and re-balance the distribution of funding across the 3 diseases to give more weight to TB.** A recommended pragmatic approach that would keep the continuity of services would be to apply a similar approach to the one used during cycle 2023-2025, yet with a revised (i.e. lower) threshold and a closer alignment with the epidemiological landscape.

4.1. Findings

4.1.1 Having a disease split is important for ensuring consistent access to funding for each of the three diseases

- ▶ In a context of competing needs and expectations, a Disease Split provides a stable and (to some extent) accepted basis for the distribution of funds

The Global Disease Split (GDS) is an important step of the Global Fund's resource allocation methodology, in which each step and component has a specific objective to achieve. Within this framework, the aim of the GDS is to distribute resources between the three diseases. Research and consultations made during this Evaluation confirm this specific role for the GDS and reinforce the rationale behind having such a disease split.

Beyond the technical aspect of the formula, having a disease split **ensures that all 3 diseases are able to consistently access funding**. In a context of competing needs, the GDS is useful to manage the various expectations of donors, constituencies and CCMs and to provide a basis for the distribution of funds. As the fight against HIV tends to benefit from stronger political support at local level, having a disease split can be a way to make sure, to some extent, that malaria and TB benefit from consistent funding as well. This ability to act as a potential safeguard is recognized and appreciated by the Governance of the Global Fund and by technical partners²⁸.

Country-specific splits communicated in the allocation letters, derived from the GDS, drive to a large extent the in-country programming split

The country-specific splits as communicated to recipient countries in the allocation letters play a key role in the final use of the Global Fund's resources at the national level and contribute to simplicity and predictability for recipient countries.

This role is reflected in the fact that, whilst flexibility is allowed, it does not lead to significant changes in the final use of funding by disease. During the GC6 (2020-2022), from the 123 eligible countries²⁹, **only 32 changed the Program Split** compared to the split that was communicated in the allocation letters (26%). From the US\$ 12,71 billions of funds of the 6th replenishment, **US\$ 455.6M were moved from a disease to another across the 123 countries (3.8%)**³⁰. On average, countries which changed the use of their funds from the indicative split communicated in the allocation letters moved US\$ 15M, with a maximum of US\$ 94M in South Africa which increased the share of TB from 8% to 26%. Overall, HIV allocation decreased by US\$ 224.9M, Malaria allocation decreased by US\$ 145.2M, while TB allocation increased by US\$ 119.7M and RSSH stand-alone component gained US\$ 250.4M.

CCM respondents mostly considered the communicated disease split to be well aligned with the weight of the actual disease burden in their country: 77%³¹ of the respondents either agree or strongly agree with this statement. The average results at country level show a positive or very positive opinions in 36 out of the 40 countries³² where respondents have answered the survey question.

This guidance is needed to secure as much as possible funding to each disease and limit any bias on programming decisions at the country level

Although not systematically utilized in most recipient countries, **the CCM respondents see the Program Split Flexibility as a key component of the Global Fund funding model**: 79%³³ of the respondents consider the current Program Split Flexibility adequate to adjust the Communicated Program Split (received in the allocation letter to the CCMs) as needed. The average results at the country level show positive or very positive opinions in 38 out of the 45 countries where respondents have answered the survey question.

²⁸ Source: Interviews.

²⁹ For 2020-2022 funding period, there were actually 128 eligible countries but 123 countries received allocations.

³⁰ This includes funding dedicated to standalone RSSH investments, overall 32 portfolio program split changes were made during GC6.

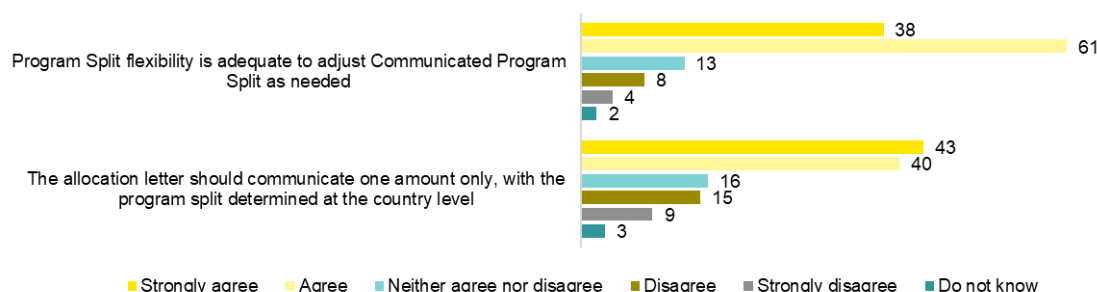
³² Respectively 86% and 83% in Salvador and Madagascar vs. 77% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 36 countries, positive opinions are equal or above 50% of all responses. The 4 remaining countries are single-answers African countries. Overall, negative opinions expressed by 10 respondents from 9 different countries are based only in African countries.

³² Respectively 86% and 83% in Salvador and Madagascar vs. 77% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 36 countries, positive opinions are equal or above 50% of all responses. The 4 remaining countries are single-answers African countries. Overall, negative opinions expressed by 10 respondents from 9 different countries are based only in African countries.

³³ Respectively 82% and 83% in Salvador and Madagascar vs. 79% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 38 countries, positive opinions are equal or above 50% of all responses. The 3 remaining countries are single-answers countries. Overall, negative opinions were expressed by 12 respondents from 8 different countries.

66%³⁴ of the respondents go to the extent³⁵ of wishing for a **unique allocation by country where the split between the eligible diseases would take place at the country level. The average results at country level show a positive or very positive opinions** in 35 out of the 45 countries where respondents have answered the survey question.

Figure 6: Although CCM respondents are satisfied with the current program split flexibility, some CCMs would prefer the allocation letter to communicate one amount, with program split determined at the country level



Source: CCM Survey

Although flexibility is important to ensure ownership and to allow recipient countries to better adapt funding to their local needs, Board and Strategy Committee members of the Global Fund raised concerns during the interviews that such flexibility might not be used in the most relevant and effective way, highlighting the necessity to ensure some restriction, guidance and monitoring of flexibility mechanism by the Global Fund Secretariat. This is explained by two main reasons:

- ▶ **CCMs are not all at the same stage of maturity: some deficiencies may exist in the way some CCMs operate, and challenges exist in terms of inclusiveness and transparency.** The functioning of the CCMs of the different recipient countries is heterogenous as their level of resources vary significantly. While some CCMs have numerous members who operate on a full-time basis and represent a wide range of interests, other CCMs function with a limited number of members who lack time to tackle all the subjects. Moreover, some recipient countries do not have a defined CCM. In this context, giving the responsibility of splitting the funds among the 3 diseases to countries could contribute to enhancing inequity.
- ▶ Another concern raised by the technical partners interviewed is that **HIV benefits from stronger political support than TB and malaria.** HIV advocates are often more influential at the national level, where they can sometimes benefit from the support of specific departments in national Ministries of Health. Thus, letting the recipient countries determine the split represents a risk – although not confirmed as there is no hard evidence - of decreased funding for malaria, TB, and to a certain extent, RSSH, compared to HIV.

4.1.2 Having an upfront overall distribution of available resources across HIV, TB and malaria is well accepted and important for the strategic management of resources at a global level

The GDS allows for a strategic distribution of resources and supports the debates between advocates of specific diseases

Interviews with the main stakeholders indicated a **generally satisfactory acceptability of the GDS**, as they considered it represents a necessary and useful step of the methodology, due to several facilitating factors. First of all, the GDS, as an upfront and early step in the allocation methodology, relies on a **“top-down” approach** for allocating resources across the three diseases. Having such an overall split by disease is

³⁴ Respectively 77% and 67% in Salvador and Madagascar vs. 66% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 35 countries, positive opinions are equal or above 50% of all responses. The 7 remaining countries are single-answers countries. Overall, negative opinions were expressed by 24 respondents from 19 different countries.

³⁵ The respondent did not have to choose between both answers as they provided their level of agreement on each statement (cf. Question 3.3. of the survey), thus the answers might seem contradictory, but they may reflect the satisfaction of the CCMs regarding the current approach and their openness to change.

relevant for considering the specific situation and needs associated with the fight against each of the three diseases at a global level, taking account of existing international strategies (ex. the “End-TB” strategy), and potentially facilitating coordination and complementarities with other international organizations.

The GDS also allows, to a certain extent, for the consideration of **political and strategic priorities** as it **informs the investment case for the replenishment**, which donors use to determine their funding pledges to the Global Fund. This political aspect of the GDS has been confirmed by almost all board members, who consider the GDS necessary “for political reasons”.

Finally, the **vertical funding approach** which stems from a rigid distribution of funds between the three diseases undoubtedly runs the risk of creating competition between advocates of specific diseases for increased funding and incentivizing disease-specific investments. However, it is viewed as a necessary step, which can be overcome by a clear and robust approach to distributing funds across diseases (see next section regarding the GDS calculation and metrics).

The GDS as an upfront step facilitates the downstream calculation of allocations of resources by country

The primary function of the GDS is to distribute funds across diseases, a function which cannot be met by the disease burden indicators due to the different nature of the diseases. Indeed, this implies that the relevant disease burden indicators to capture country needs are different for each disease (incidence, prevalence and/or mortality) and use different formulae to allow for capturing their specificities (see *Table 3 below*). Moreover, whilst those disease burden indicators are reviewed every three years by technical partners and updated as needed, data quality differs per disease burden measure and across diseases. Within this framework, the GDS is therefore necessary to allow distribution across diseases.

Table 3: Disease burden indicators: indicators, formulas, and units of measure

Disease	Indicator	Formula	Unit of measure
HIV	Number of people living with HIV	Number of people living with HIV	Number of individuals
TB	Weighted incidence of TB and multi-drug resistance TB (MDR-TB)	[1*TB incidence] + [10*MDR-TB incidence]	No standardized unit of measure
Malaria	Weighted indicator combining malaria cases and deaths (adjusted for latest Population-at-risk), and malaria incidence rate and mortality rate (data from 2000-2004)	<p>[1 * number of malaria cases * Population-At-Risk ratio] + [1 * number of malaria deaths * Population-At-Risk ratio] + [0.05 * incidence rate] + [0.05 * mortality rate]</p> <p>NB: the full formula takes into account the epidemiological peak of 2000-2004</p>	No standardized unit of measure

Source: Global Fund data

4.1.3 The evolution of the epidemiological landscape calls for an adjustment of the GDS

Stakeholders hold divergent views on the current calculation of the GDS. Although the GDS is reviewed every three years and was recently updated for the 2023-2025 allocation cycle (resulting in a revised split), **a reassessment and update of the GDS remains an expectation** of many interviewed Board Members³⁶. For instance, while the GDS is decided on by the Board every cycle, **its calculation was only revised once**, for the 2023-2025 allocation cycle, as the Board agreed that a revision was needed based on the evidence provided. Despite the long and complex process required to review the GDS, the Evaluation found it would

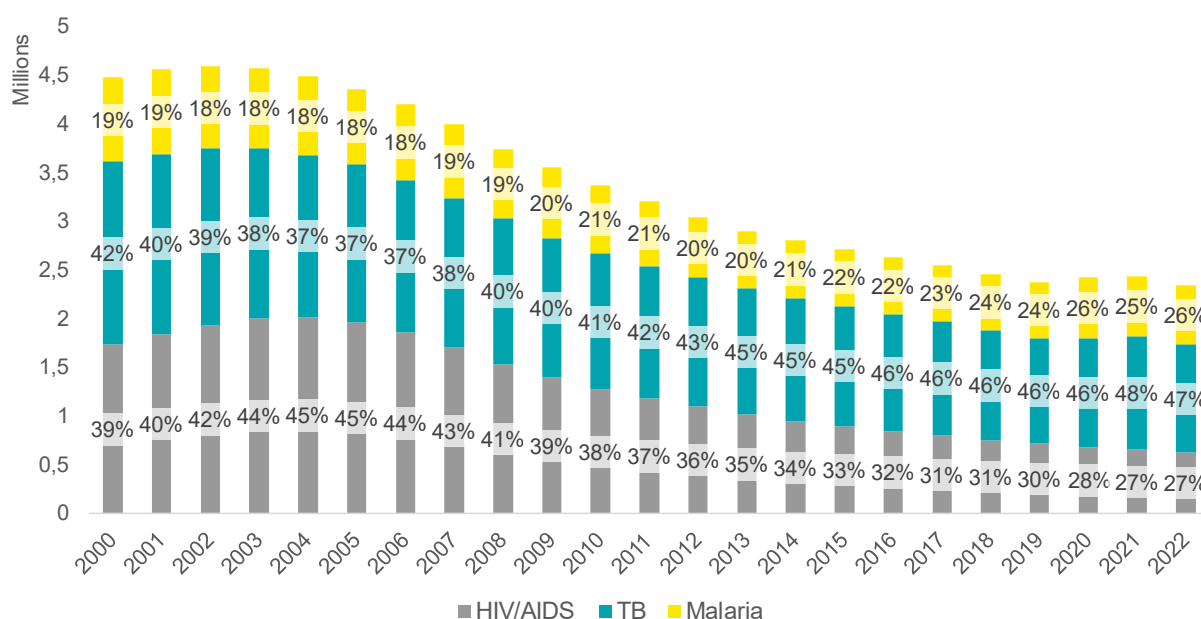
³⁶ Source: Interviews.

need to continue to be reviewed on a regular basis, at the risk of lagging behind the evolution of key metrics related to the disease burdens, cost-effectiveness of interventions and other donors or evolutions in domestic funding.

The share of deaths caused by TB in the total number of deaths caused by the three diseases has been higher than the shares of HIV and malaria since 2009 and has continued to increase over time. In 2009, TB already had the highest share in the number of deaths across the three diseases (40%), followed by HIV (39%) and malaria (20%). In 2022, this share of death has increased to 47% for TB and 26% for malaria, while the share for HIV has decreased to 27%. The total number of deaths has dropped for the three diseases. Nonetheless, there is a stronger decrease in the number of deaths due to HIV/AIDS due to the availability of ARVs. The incidence and spread of malaria are however foreseen to increase in the coming years because of climate change, drug and insecticide resistance and the emergence and spread of new vectors³⁷.

In recent years, the **COVID-19 crisis** has significantly impacted the fight against the three diseases. It has considerably worsened the diagnostic and treatment coverage and increased the vulnerability to TB³⁸. Action against malaria was also affected by the COVID-19 crisis, with a 31% drop in malaria diagnosis. Half of Global Fund countries have reported disruptions in their malaria programs.³⁹. Interventions against HIV were also disrupted by the crisis.

Figure 7: Evolution of the share of deaths worldwide due to tuberculosis, malaria, and HIV/AIDS from 2000 to 2022



Source: WHO and UNAIDS, 2022 data

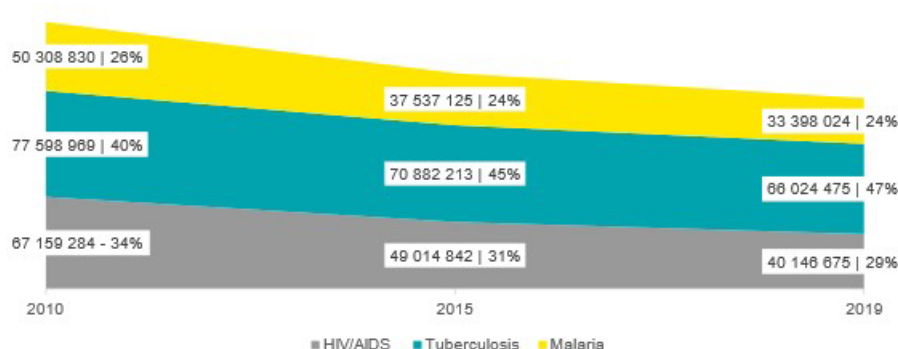
When analyzing DALYs, a similar trend appears: **TB caused more DALYs than HIV and malaria in 2010**, which was also the case in 2019 (for more information on DALYs, see Box 1 below). Moreover, the gap between TB and the two other diseases has widened. However, compared to the number of deaths, the share of malaria is higher across the same period.

³⁷ IPCC (2018). [Global Warming of 1.5°C: An IPCC Special Report on the Impacts of Global Warming of 1.5°C Above Pre-industrial Levels and Related Global Greenhouse Gas Emission Pathways, in the Context of Strengthening the Global Response to the Threat of Climate Change](#).

³⁸ [Tuberculosis deaths and disease increase during the COVID-19 pandemic \(who.int\)](#)

³⁹ Source: Global Fund data.

Figure 8: Evolution of the number of DALYs worldwide due to tuberculosis, Malaria and HIV/AIDS since 2010⁴⁰



Source: [Disease burden by Cause, Age, Sex, by Country and by Region, 2000-2019. Geneva, World Health Organization; 2020](#)

Box 2: Methodological note on DALYs

DALYs (disability-adjusted life years) are a **measure of overall disease burden**, expressed as the number of years lost due to ill-health, disability, or early death. Whereas mortality gives a limited picture of the burden of disease borne by individuals in different populations, DALYs provide a more detailed perspective.⁴¹

DALYs are calculated by adding the years of life lost due to premature mortality and the years lived with a disability due to prevalent cases of the disease or health condition in a population. DALYs are used by the World Health Organization to assess the burden of disease across diseases and across countries.

In this evaluation, DALYs are **used to compare the general health impact across the three diseases**. WHO DALYs were selected because **WHO produces its own HIV and TB DALYs loss estimates** while using IHME measures for most of the other diseases, including malaria.

Using DALYs within the resource allocation methodology has numerous benefits:

- ▶ DALYs combine the effects of **morbidity** and **mortality** in one measure; thus, DALYs enable experts, health policymakers, and researchers to assess the burden of diseases on a population and take a large-scale view of how these conditions can affect the ability of individuals to live full, healthy lives.
- ▶ DALYs allow the **comparison** between different health hazards. Using the same unit of measure, DALYs enable comparison of population health over time and assess equity in health between different groups in a population.
- ▶ Measuring DALYs allows for the assessment of the **impact of prevention strategies**, as DALYs can be used to estimate the cost-effectiveness of health intervention⁴² by comparing the cost of the intervention to the number of DALYs it has averted.

However, DALYs also present several **limitations**:

- ▶ The calculation of DALYs relies on **estimates**, which reduces the quality of data obtained. Reliable data is essential for accurate DALY calculations. However, in many parts of the world, especially in low-income countries, data quality and availability remain major challenges.
- ▶ DALYs are **modelled** (which implies they are not a direct measure of burden) and the results vary by choice of assumptions (weights, discounting, life expectancy) and have wide uncertainty ranges.
- ▶ DALYs may **oversimplify complex states of health**. They might not capture the full impact of multi-morbidity or the nuances of different disease progressions.

⁴⁰ The analysis Includes all countries for which data is available and is not limited to countries eligible to the Global Fund's funding.

⁴¹ [Disability-adjusted life years \(DALYs\) \(who.int\)](#)

⁴² [Disability Adjusted Life Years \(DALY\) - Health Analytics](#)

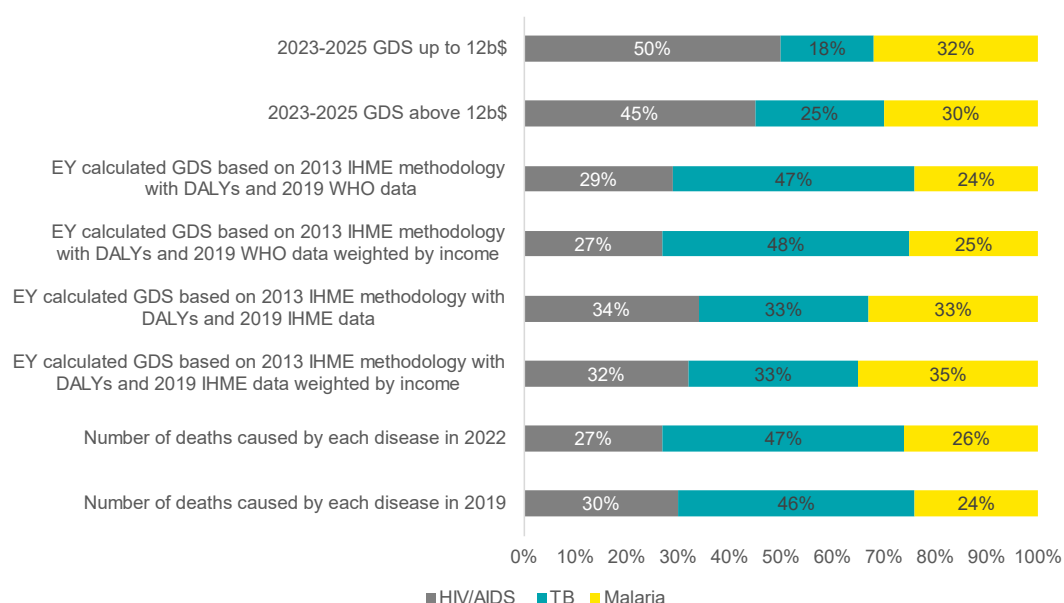
- ▶ While DALYs attempt to integrate quality of life through disability weights, the primary focus remains on the length of life, which can contribute to **undervaluing the importance of quality of life**.
- ▶ DALYs focus solely on health, excluding the **social impact of diseases**.
- ▶ DALYs are **not updated annually**.

Analyses show an under-appreciation of the share of TB and an over-appreciation of HIV

Using three different methodologies based on the number of deaths, DALYs and DALYs weighted by income, the share of TB is consistently higher compared to its share in the 2023-2025 GDS:

- ▶ TB represents more than half of the total number of deaths caused by the three diseases.
- ▶ DALYs analysis suggests that the TB share of burden weighted by income is significantly greater than current split.
- ▶ When weighting DALYs by income there is little change. Malaria gets a slightly higher share of the funds (+1 or +2 points of %).

Figure 9: 2023-2025 Global Disease Splits and alternatives based on number of deaths, WHO and IHME DALYs, and WHO and IHME DALYs weighted by income



Source: WHO for number of deaths, WHO and IHME data for DALYs

Box 3: Methodological note on IHME methodology

In the graphic above, the different reassessments of the GDS using different variables and methodologies are presented.

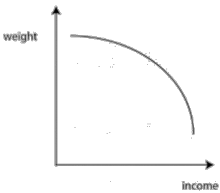
For non-income-weighted GDS, the 2013 IHME methodology relies on calculating a split based on the relative DALYs between the three diseases at the international level.

There is a significant difference between WHO and IHME DALYs at the international level which leads to different GDS. This is due to the fact that the WHO produces its own HIV and TB DALYs estimates while using IHME measures for most of the other diseases, including malaria.

When calculating the income weighted GDS, the following formula is used:

$$\text{share of disease}_i = \frac{\sum_c (DALY_{country_c \& disease_i} \times w(INCOME_c))}{\sum_{i=3} (\sum_c DALY_{country_c \& disease_i} \times w(INCOME_c))}$$

Where $w(INCOME_c) = \sqrt{1 - (\frac{GNI_c}{GNI})^2}$. \overline{GNI} represents the level of wealth at which a country is least likely to depend on contributions from the Global Fund, it is suggested to setting it at US\$ 12,736⁴³ per capita. Countries above this threshold would receive a weight of 0.05. Otherwise, the weight is proportional to the GNI per capita:



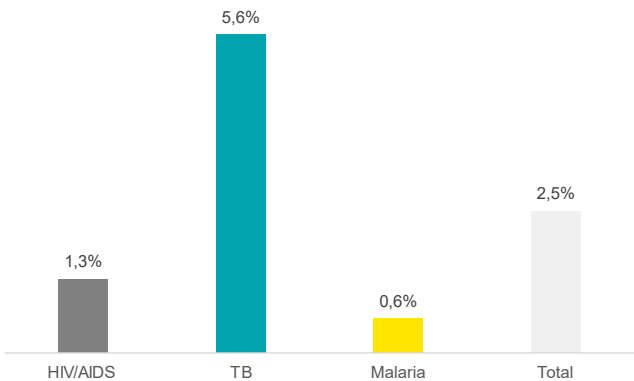
This way of calculating GDS incorporates the ability to pay of countries.

Disease burden indicators show that TB had the highest increase in disease burdens over the last two cycles

From the perspective of disease burden indicators, which also account for the cost of care, TB had the highest increase (5.6%) over the last two cycles, compared to an average increase of 2.5% across the three diseases. Considering the stronger increase of TB’s burden, the fact that its share did not increase in the GDS below US\$12 billion might reinforce the idea that there is a misalignment between the GDS and the current epidemiological landscape.

The graphic below underlines the percentage change of absolute burden for all eligible countries from GC6 to GC7 (the burden indicators are used to calculate a share of total need). It should however be noted that the TB burden fell by 7% from GC5 to GC6, while HIV increase by 5%. The increase in HIV disease burden also must be considered while recognizing that the HIV burden metric measures prevalence rather than incidence.

Figure 10: Percentage change in the disease burdens as measured by disease burden indicators for all eligible countries between cycle 2020-2022 (GC6) and cycle 2023-2025 (GC7)



Source: Global Fund data

Box 4: Methodological note on disease burden indicators

In the absence of an updated common model to compare the disease burden of each disease, the disease burden indicators reviewed by technical partners are an interesting tool to approach the financial burden

⁴³ It is suggested to use the 2021 High Income Threshold, as the GNI per capita used for the 2023 allocation methodology is also that of 2021.

of disease, which is not entirely captured by indicators such as mortality or prevalence⁴⁴. More specifically, the disease burden indicators consider the following elements related to financial burdens:

- ▶ For tuberculosis, the cost of treating TB and multi-drug resistance TB (MDR-TB), through the weighted incidence of MDR-TB
- ▶ For HIV, the financial requirement for treatment continuity, through the number of people living with HIV. However, this indicator does not consider prevention needs, which are taken into account through qualitative adjustments.
- ▶ For malaria, the current risks in regard to malaria's epidemiological peaks, through a weighted indicator combining malaria cases and deaths (adjusted for latest population-at-risk), and malaria incidence rate and mortality rate at its peak (data from 2000-2004).

Nota bene: The evolution of the malaria disease burden indicators captured through this graph should be regarded critically. Indeed, for malaria disease burden calculation, data for 2000-2004 was used for both cycles for all data points in the malaria burden indicator except for the population-at-risk, which uses both historical and latest data. As a result, the evolution for malaria captures (1) methodological changes to the historical burden data and (2) population-at-risk growth.

4.1.4 As the concentration of disease burden across income groups varies between the three diseases, changing the GDS would allow more countries with the lowest economic capacities to be targeted

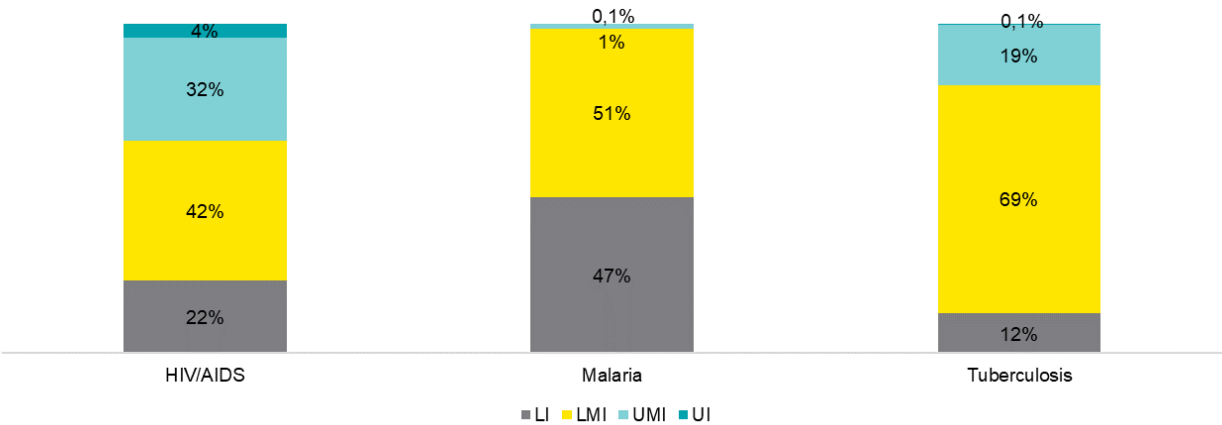
Malaria's burden is almost exclusively concentrated in low-income and lower-middle income countries, whereas the two other diseases are more spread out:

- ▶ **Malaria is the disease whose burden weighs the most on low-income countries.** It is almost equally split between low-income countries (51%) and lower-middle income countries (49%) (*Figure 16*). Moreover, almost all the disease burden (95%) is concentrated among the 50% poorest countries (*Figure 17 and 18*). There is a significant negative correlation between GNI per capita and disease burden for malaria, which is not the case for other diseases.
- ▶ **HIV's disease burden is spread out** among low-income countries, lower-middle income countries and upper-middle income countries. It is strongest in lower-middle income countries (41%), followed by upper-middle income countries (33%) and low-income countries (26%) (*Figure 16*). HIV disease burden is concentrated in the first four GNI per capita deciles (52%) and the 8th decile (24%) mainly due to the presence of South Africa (*Figure 17 and 18*).
- ▶ **TB is the disease which weighs the least on low-income countries** (13%). More than three quarters of TB's burden (79%) weighs on lower middle-income countries (*Figure 16*). This is reflected by the fact that tuberculosis is spread across the deciles with a concentration between the 4th and the 7th (43%) (*Figure 17 and 18*). It should, however, be noted that within countries, poverty and living in rural areas are determinants of TB, due to the lack of access to medical care, living conditions, malnutrition, and co-infection with HIV⁴⁵.

⁴⁴ It should however be acknowledged that disease burden indicators are not made for comparative purposes across diseases, but to distribute funds within each disease.

⁴⁵ [6.3 TB determinants \(who.int\)](#)

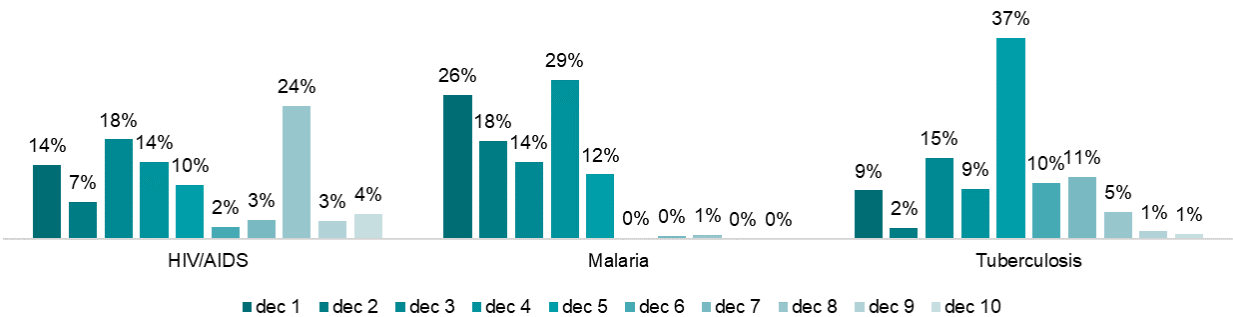
Figure 11: Distribution of the disease burdens by country income classes for each disease, based on 2022 GNI per capita



Source: Global Fund data

For each disease, it is important to note that one country represents about a fifth to a third of the disease burden: South Africa represents 23% of HIV's disease burden, India 32% of the disease burden for TB, Nigeria 19,5% of the disease burden for Malaria (*Figure 17*). Indeed, these countries significantly influence the distribution of burden across income groups.

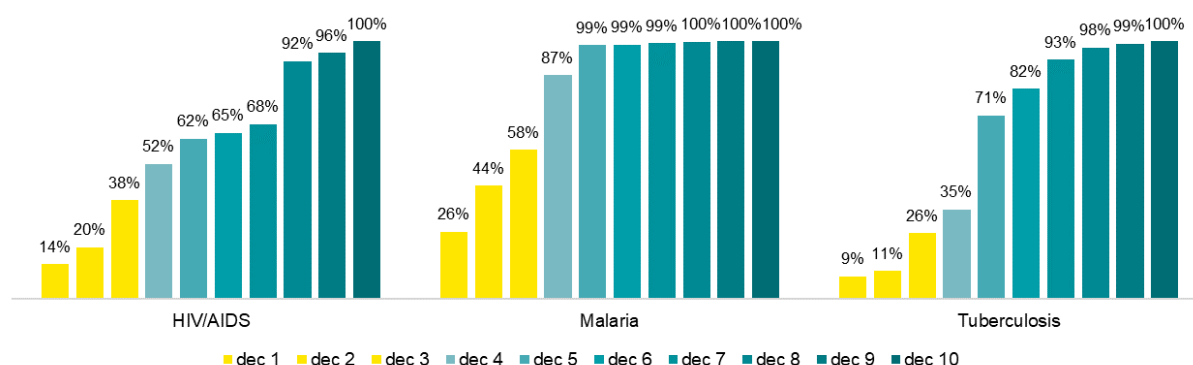
Figure 12: Repartition of the disease burdens by income deciles of countries for each disease, based on 2021 GNI per capita



Source: Global Fund data

The cumulative disease burdens for the first three deciles (*Figure 18*) reflect the important differences for each disease: the countries which form the three poorest deciles represent 38% of the disease burden for HIV, 58% for malaria, 18% for TB.

Figure 13 : Cumulative repartition of the disease burdens by income deciles of countries, based on 2022 GNI per capita, for each disease



Source: Global Fund data. The first three deciles are highlighted in yellow.

4.1.5 Contextual challenges also plead in favor of a revalorization of TB and malaria in the upcoming years

New challenges arise in fighting TB and malaria as the numbers of drug-resistant cases and insecticide-resistant mosquitoes increase

Innovations in treatments and development of resistance in pathogenic agents and disease vectors may have changed the relative costs of treating and preventing each disease⁴⁶:

- ▶ **HIV requires long-term treatment**, as it is a lifelong condition. The cost of ART has decreased over the years due to the availability of generic drugs. Funding for public health and societal enablers (including RSSH, equity and human rights) represents a key point of future interventions against HIV. While the share of Global Fund funding for HIV has been increasing in these areas, treatment, care, and support constitute the bulk of investments, with 50% attributed during the 2020-2022 funding cycle, up slightly to 60% during the current 2023-2025 cycle⁴⁷. On the other hand, the share of human rights-based investments has increased from 0.5% to 1.8% during the same period (according to Global Fund data). While critical for increasing the impact of prevention and treatment programs, the causality link between the interventions and the impact cannot be as easily quantified as the effects of these interventions are more diffuse and less output driven. Therefore, beyond the health sector, addressing human rights and gender equity will be key to implementing more effective interventions.
- ▶ **TB treatments typically take 6-12 months**, while treatments for multi drug-resistant strains of TB are longer and more expensive. In 2022, 3.3% of people infected with TB with no previous history of TB treatment were MDR/RR and 17% of people infected with TB with a previous history of TB treatment were MDR/RR⁴⁸.
- ▶ **Treatments for malaria take a few days**. The cost of ACTs has fluctuated over the last several years, with a notable decrease thanks to improved production methods⁴⁹. However, in the case of malaria, a larger share of funding has been dedicated to vector control and malaria prevention than to treatments, in order to respond to new challenges: insecticide resistance, new vectors (such as *Anopheles stephensi*) and new vector behaviors (such as outdoor biting). The development of new tools against insecticide and drug resistance is a major challenge to increasing the impact of treatments.

⁴⁶ A complete cost-effectiveness analysis of treatments for each disease is out of the scope of the Evaluation.

⁴⁷ Source: Internal Global Fund data and several interviews with stakeholders.

⁴⁸ Source: Internal Global Fund data and several interviews with stakeholders.

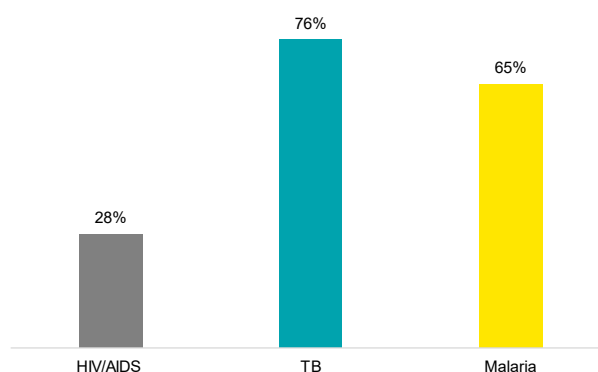
⁴⁹ Source: Internal Global Fund data and several interviews with stakeholders

Considering these numerous evolutions for the three diseases, a cost-effectiveness analysis of preventing and treating each disease would be valuable for informing the Global Fund's future allocation decisions. As explained in the Limitations section of this report, such an exercise, whilst useful, was not possible at the moment of the Evaluation.

International financing for TB and Malaria is highly dependent on the Global Fund, which is less true for HIV

According to its 2023 Results Report, the Global Fund provides three quarters of the international financing for TB (76%), and more than half for Malaria (65%), while it provides less than a third of total international financing for HIV (28%). For TB, the reliance on the Global Fund is stronger for low-income and lower-middle income countries; 87% of domestic resources come from eligible BRICS countries⁵⁰. It is also important to note that the funding picture may change in the future [for example, the current debate in the United States regarding the reauthorization of the President's Emergency Plan for AIDS Relief (PEPFAR), one of the largest funders of HIV efforts in the world, might have a significant impact on the global health effort in the fight against HIV].

Figure 14: Global Fund's share of total international financing for HIV/AIDS, TB, and malaria programs



Source: Global Fund, [Results Report 2023 - The Global Fund to Fight AIDS, Tuberculosis and Malaria](#)

4.2. Potential alternatives

What alternatives were considered and why?

Three alternatives were considered based on Evaluation findings, as presented below:

- ▶ **An alternative (alternative 1) without an upfront GDS.** This alternative would aim to solve some of the limitations resulting from an overly siloed and rigid approach of splitting the total available resources across the three diseases at a global level. It would also address the expectations of some stakeholders who showed an interest in exploring alternative approaches without a GDS. This alternative would involve directly allocating resources to countries, based on a common and comparable indicator reflecting the disease burdens of the three diseases (see below).
- ▶ **An alternative (alternative 2) maintaining an upfront GDS with a new split which would not result from any updated methodology.** This alternative would mainly address the need of updating the current GDS and ensure TB is better supported. Whilst the resource allocation methodology applied an adjusted split above US\$ 12b under the 2023-2025 cycle (GC7), this alternative would imply applying this adjusted split to the full funding envelope (below and above US\$ 12b).
- ▶ **An alternative (alternative 3) keeping an upfront GDS and updating the split based on DALYs.** This alternative would aim to ensure the GDS relies on a technical analysis of the epidemiological

⁵⁰ Source: Global Fund. Of the BRICS countries, Brazil, Russia, and China are not eligible for Global Fund TB financing.

landscape which could be updated on a regular basis. The split would be informed by a single indicator such as the WHO DALYs, which is the most relevant indicator available to reflect the disease burden of all diseases in a comparable way (despite some limitations, as underlined in the *Box 1 on DALYS*).

4.2.1 Alternative 1: resource allocation methodology without an upfront GDS

Presentation of the alternative:

Under alternative 1, the resource allocation methodology would no longer include an upfront global disease before determining the country allocations. It would imply using a **variable with a single unit of measure** that would be common to the three diseases to allocate fundings to all eligible countries. This common indicator could be DALYs which is the simplest available indicator. It would yet be even more relevant to rely on an aggregated indicator encompassing several variables (rate of incidence, number of deaths, age of death, etc.), that would allow to better capture the full picture of disease burden. In any case, the single common indicator would have to be focused on specifically demonstrating disease burdens, as financing capabilities are already captured by country economic capacity.

Box 5: Methodological note on the technical implications of the fungibility of funds in the context of an allocation without GDS

This alternative would have concrete consequences for the functioning of the methodology, as:

- ▶ The country allocation formula would start with using the technical parameters, namely disease burden and CEC. Instead of the separate funding channels per disease determined by the GDS, this option would result in a single funding channel for the three diseases.
- ▶ Steps 4⁵¹ and 5⁵² would be able to move funding across countries but also across diseases, whereas these adjustments across diseases are not possible with methodologies including a GDS.

Pros and cons: The **main advantage of this alternative is that it would address the rigidity of the current formula and the siloes created by the disease split** throughout the entire methodology, as discarding the GDS would imply increased fungibility of funds across the three diseases.

In parallel to the aforementioned advantages, this alternative also presents **several major drawbacks in relation to the findings of the Evaluation on the relevance of having an upfront GDS:**

- ▶ The alignment on the countries and the diseases with the highest disease burdens would depend entirely on the common indicator used to compare diseases. This indicator may be less relevant for each disease than the specific disease burden indicators established by technical partners.
- ▶ Without a GDS, there would be **less visibility regarding the amounts allocated by disease**. While the GDS provides clear information on the distribution of funds across diseases, in the context of an allocation without a GDS and with a single component, this information would only be known after going through with the entire methodology. It would therefore not be available before the replenishment, which may in turn negatively impact donors' potential contributions. This is especially true since the modelling for the Investment Case, which is the document donors use to determine their contributions to the Global Fund. As a result, this option has low compatibility with the expectations of stakeholders.
- ▶ This alternative is **potentially less attentive to ethical considerations than the current GDS**, which is based on studies which have considered the available funding and financial capacities of countries, through the income of countries (IHME) or through domestic and external contributions (HEARD, Imperial College).
- ▶ **Regarding the availability and quality of data**, the proposed data points (DALYs, QALYs, etc.) may not be as robust and reliable as the current GDS, since a common indicator for disease burdens

⁵¹ Min, Max, scale-up, paced down and other donors' mechanisms

⁵² Qualitative adjustments

as widely recognized by experts is currently not available. The availability of this indicator for all countries and its update on a regular basis are not guaranteed.

Conclusion: Overall, this option presents important risks regarding the continuity of funding and the organization of current programs. The overall amount allocated to each disease would only be known *ex post*.

4.2.2 Alternative 2: methodology that keeps the upfront GDS with a revised split (HIV: 45%; malaria: 30%; TB: 25%) applied to the full funding envelope and to all funding scenarios

Presentation of the alternative:

This alternative 2 would keep the upfront GDS but would aim to channel a higher amount of funding toward the fight against TB via a revised split. Since 2014, when the GDS was first established, the epidemiological situation of each disease has evolved both at the global level and within countries. For the 2023-2025 allocation cycle, the allocation methodology used a GDS of 45% for HIV, 25% for tuberculosis and 30% for malaria for funds greater than US\$ 12 billion over a US\$ 13.128 billion replenishment budget. Using this split for the overall replenishment budget (and for all funding scenarios) **would address the under-appreciation of TB in the GDS and the lack of support for TB from other international donors and domestic financing, considering that:**

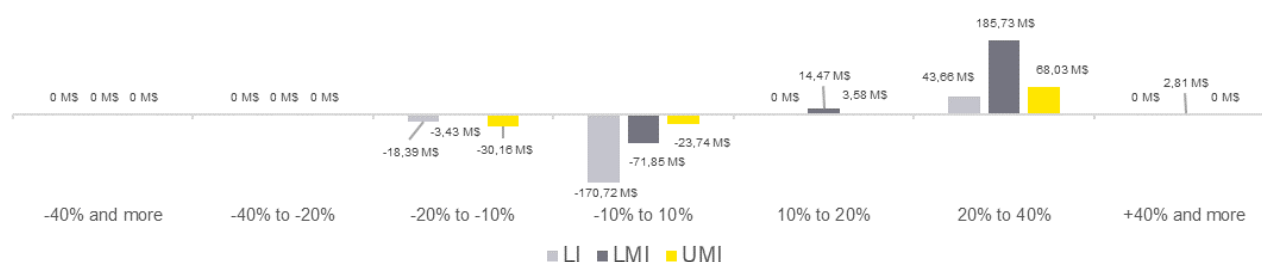
- ▶ The number of deaths, DALYs, DALYs weighted by income, and the evolution of disease burden indicators used in the Global Fund's formula all indicate that TB is under-funded.
- ▶ International financing indicates that there is little support for TB beyond the Global Fund's contributions; additionally, analyses of domestic resources indicate that low-income countries themselves rely heavily on the Global Fund's financing in the fight against TB.

Pros and cons:

This GDS with a more important share for TB would address the current imbalance of the GDS as defined in 2013, **without threatening the continuity of services**, considering the limited change to country allocations:

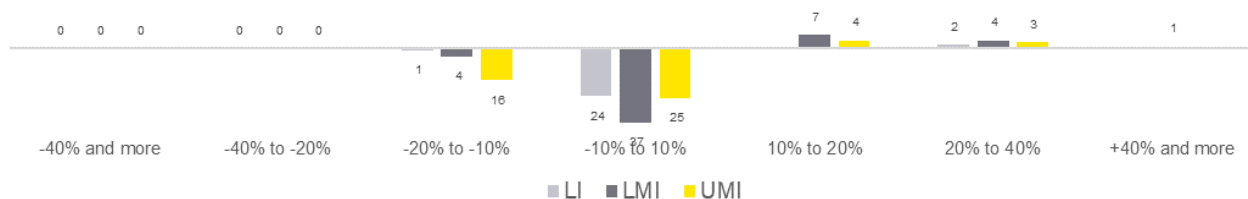
- ▶ Comparing the allocations with the two different GDS, **the 15 countries with the most important disease burdens wouldn't show much change in their allocations:** -1% of HIV allocations for the 15 countries with the highest HIV burdens, -2% of malaria allocations for the 15 countries with the highest malaria burdens, +4% of tuberculosis allocations for the 15 countries with the highest TB burdens.
- ▶ Overall, **low-income countries would be disadvantaged** by the allocations built on this alternative GDS as they would lose US\$ 145.4M (-1,11%) at the benefit of LMI and UMI countries.
- ▶ As shown in the graphs below, no country would lose 20% or more of its allocation, compared to *status quo*.

Figure 15: Evolution of countries allocation amounts by percentage per income groups



Source: Global Fund model with EY inputs

Figure 16: Number of countries impacted by country allocation evolutions by magnitude and income groups



Source: Global Fund model with EY inputs

Even if a country were to face a strong decrease in malaria or HIV allocations, the flexibility at country level would enable it the autonomy to protect its most important programs.

Additionally, this alternative would be **simple and efficient**. However, it would not provide any robust and sustainable alternative methodology based on which the GDS should be changed on a triennial basis. This alternative would also have some other limitations and drawbacks:

- ▶ While the GDS would be closer to the epidemiological landscape, **it would still not reflect it accurately**. For instance, it decreases the share of malaria, while malaria-related needs are actually on the rise.
- ▶ Moreover, the alternative **would not provide a solid methodological basis for subsequent reviews**, which will rely on discussions between the Secretariat, Board Members, and the Strategy Committee.
- ▶ Due to the way the alternative split is determined, **limitations may be identified in regard to the quality and availability of data**, as the data points utilized are not provided by widely recognized sources. In the absence of the use of a single and predetermined indicator, this alternative could, however, be **reviewed every three years with up-to-date data available at the country level**.

Conclusion: This option would only offer a partial solution to the challenges of the GDS. The fact that it would not provide a solid methodological basis for subsequent reviews prevents it from being used as a long-term recommendation.

4.2.3 Alternative 3: methodology that keeps the upfront GDS with a revised split based on regularly updated methodologies

Presentation of the alternative:

This alternative would consist in maintaining an upfront GDS and updating the split based on DALYs. The disease burden indicators within each disease envelope would also be maintained. Despite some limitations, DALYs can be considered a relevant and reliable indicator that would ensure the GDS is founded on a sound technical analysis of the epidemiological landscape and updated on a regular basis (based on WHO DALYs). WHO DALYs were chosen over IHME DALYs since data for HIV and TB are reassessed on a regular basis.

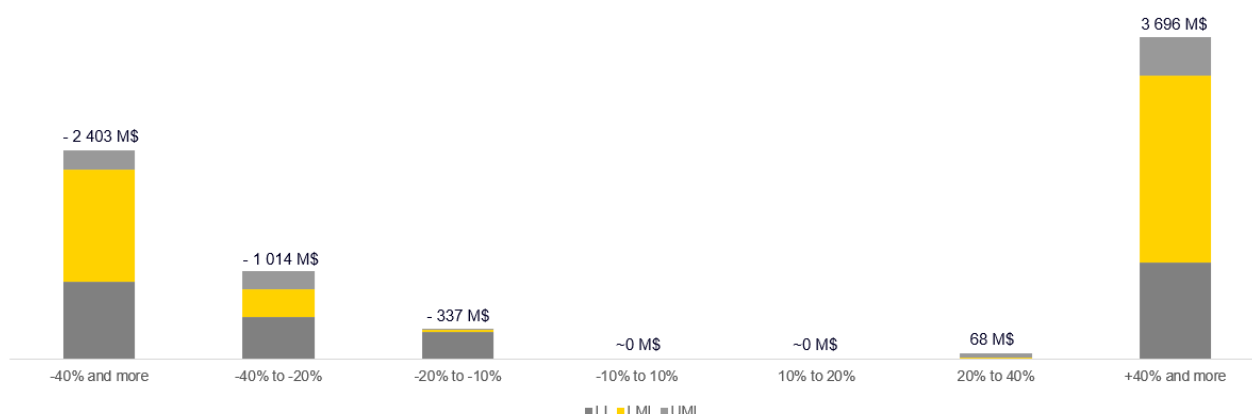
Pros and cons:

This option would ensure that the GDS remains based on an updated analysis of the epidemiological landscape. By maintaining **the disease burden indicators reviewed by the technical partners**, this alternative ensures that the specificity of each disease is taken into account when considering their respective disease burden. As a result, the distribution of funding across countries within each disease component is likely to be based on a more accurate reflection of the true disease burden of each country. Due to this balance, this alternative would likely benefit from **high acceptability from the Global Fund's stakeholders**.

This alternative would have a **positive impact on the alignment of disease burdens**: Overall, using a GDS based on DALYs for the Global Fund's eligible country populations (which yields a split of HIV/AIDS: 27,7%; Malaria: 25,0%; TB: 47,3%), 80 countries would observe an increase in their allocations and 38 a decrease. **The 15 countries with the most important disease burdens see a drastic change in their allocations**: -39% of HIV allocations for the 15 countries with the highest disease burdens for HIV, -20% of malaria allocations for the 15 countries with the highest disease burdens for malaria, and +153% of tuberculosis allocations for the 15 countries with the highest disease burdens for tuberculosis.

The alternative would, however, have a negative impact on the alignment of countries with the lowest economic capacity, an impact which would be limited thanks to the scale-up/paced reduction mechanism. Overall, **low-income countries are disadvantaged** by the allocations built on this alternative GDS as they would lose US\$ 579,8M (-4,42%) at the detriment of LMI and UMI countries.

Figure 17: The DALYs based GDS generates major evolutions in the countries' allocations



Source: Global Fund model with EY inputs

This alternative would also have several drawbacks and methodological limitations:

- ▶ **The absence of an annual update:** Since DALYs are not updated annually, **the GDS would continue to lag behind the reality of the epidemiological landscape**. By the time the next allocations are produced (towards the end of 2025), 2021 DALYs data will be available, which is three years behind other disease burden data that will be available at the time.
- ▶ This GDS would not consider the **other factors taken into account in the 2013 studies used to determine the GDS**, such as cost-effectiveness and funding gaps.
- ▶ Regarding feasibility, while DALYs are produced by recognized experts (WHO, IHME), two versions of the DALYs coexist, which differ significantly depending on which of the two institutions is used as a source. **In the absence of sufficient information to discriminate between the two sources, the ability to rely on DALYs would be limited.**

Conclusion: Considering the different limitations mentioned above as well as the magnitude of the changes created in country allocations, this alternative would pose a **threat to the principle of continuity of services**.

4.3. Recommended changes and their consequences

4.3.1 Recommendations

Recommendations and reasoning

As regards keeping or not a GDS:

- ▶ **It is recommended to keep an upfront GDS** to distribute funding between the three diseases. Its relevance and utility were confirmed to facilitate the strategic management of expectations from donors and take better account of the global health landscape. The absence of GDS (alternative 1) would threaten the continuity of services and decrease transparency for donors and countries. It would also increase the complexity of the methodology, as it would require the definition of an alternative disease burden indicator uniting the three diseases under common metrics to allocate funding to countries. However available indicators allowing comparison across the three diseases, such as WHO DALYs, are not optimal to support the methodology in reaching its objective of aligning the Global Fund financing with highest disease burden.

As regards the approach for deciding on the GDS:

- ▶ **It is recommended to ensure decision made on the GDS for each allocation cycle is systematically informed by technical and scientific evidence** on the relative needs of each disease. Although the final decision on GDS might not be aligned with the result of such analysis, it is recommended to ensure the Board is systematically provided with updated analyses on trends and the GDS is updated to minimize the gap with the evolution of the epidemiological landscape.
- ▶ Ideally, it is recommended the **technical and scientific evidence is provided by the Secretariat supported by external technical partners** which could be those involved in the determination of 2013 initial split (IHME, HEARD and Imperial College). Alternatively, it is recommended to run, as a minimum, the approach proposed under alternative 3.
- ▶ **It is also recommended to explore new types of evidence** and make a stronger use of **prospective analytical capacities** to take account of future and longer-terms needs. Several board members have recommended to inform the GDS with additional qualitative investigations (including some of the analyses undertaken at a later stage of the allocation methodology, i.e. during the qualitative adjustments) and anticipation capabilities regarding the potential future impact of the Global Fund investments based on trends and assumptions (demography, research & development and upcoming treatments or vaccines, etc.).

As regards the criteria used to decide on the GDS:

- ▶ **There is an urgent need to adjust the current GDS to better reflect the epidemiological situation and re-balance the distribution of funding across the 3 diseases to give more weight to TB.** Indeed WHO DALYs, IHME DALYs, WHO and HIME DALYs weighted by income and number of deaths all show that TB has a share of burden higher than 18%. Therefore, whatever the level of replenishment (higher or lower), re-balancing the distribution of funds would imply a proportionate redistribution of funds so as to reduce the gap between the share of funding allocated to each disease and the respective weight of each disease in the epidemiological landscape (what is suggested for TB could therefore apply to HIV or Malaria, depending on the epidemiological context).
- ▶ Ideally, the GDS shall be aligned with the scientific evidence on the relative needs of each disease and reflect as much as possible the result of a systematic approach similar as the one suggested under alternative 3. However, implementing such an approach cannot be envisaged in the short term as it would highly threaten the continuity of services in most countries and have a negative effect on lower-income countries. It is thus recommended **to revise the GDS incrementally over several allocation cycles to ensure it increasingly reflects the epidemiological landscape.**
- ▶ In this context and considering it is not realistic to expect that decision on GDS is fully aligned with scientific evidence without any political considerations, it is recommended to follow an approach following a similar logic than the one for alternative 2 (and/or the one that was applied during the 2023-2025 cycle), with a revised threshold aiming at a progressive alignment of the GDS with the epidemiological landscape.

4.3.2 Consequences of recommended changes

The **consequences** of recommended changes for the Global Fund's allocation methodology were identified and their effects in terms of **effectiveness, coherence, simplicity, efficiency, and sustainability** were analysed to highlight the main pros (and cons) they would bring. Recommendations would lead to following consequences:

- ▶ **They would have a mixed, yet overall positive effect on effectiveness**, with an increase in alignment with highest disease burden and a decrease in alignment with lowest economic capacity. Implementing the recommended changes would result in higher funding to TB above a certain replenishment amount. While this would increase the alignment with the highest disease burden, this would also deteriorate the alignment with economic capacity as TB is more prevalent in middle-income countries. This would also imply that more of this additional funding would be shifted from Africa to Asia.
- ▶ **Recommended changes would ensure a certain level of continuity of services**, as the funding below a certain level of replenishment remains unchanged. The predictability of this additional

amount would however not be guaranteed, as it would depend on the respective amount each disease would be allocated through the new split.

- ▶ **They would have little to no consequences in terms of simplicity and efficiency.** Recommended changes would neither be efficient nor simple as they would imply a differentiated GDS and therefore for Board Members to agree on two GDS. However, given that the Board already agreed on two GDS in GC7, it would not be more complicated compared to the status quo (though admittedly less simple than in GC6).

When it comes to trade-offs, as highlighted in the report, increasing TB's share at the GDS stage would drive more funding to **lower-middle income countries (LMICs)**, all else equal. While the aim of the allocation methodology is to align the Global Fund financing with highest disease burden and lowest economic capacity, it is important to note that increasing the share for TB would result in less alignment of Global Fund financing with lowest economic capacity.

4.3.3 Impact on overall timeline and steps in the process and possible challenges

It is recommended that the increase of TB is taken into consideration in the process of allocating Global Fund financing to recipient countries is taken into account at each cycle from cycle 2026-2028.

5. RSSH

Q3: How might a potentially separate allocation for RSSH be determined? What have been the implications on RSSH and the disease programs in not having a separate RSSH allocation? What would be the challenges and benefits in having a separate RSSH allocation including the consequences for allocations for the 3 diseases?

Methodological introduction

The Evaluation assessed the relevance of having an RSSH allocation to maximize impact. So far, such an RSSH allocation was not recommended, due to feasibility reasons (no “one-size-fits-all approach”), and because it was considered that its absence has not been an obstacle to an increase of direct RSSH activities. While the Board discussed a separate allocation for RSSH, the Board thus decided by majority to continue with not having a separate allocation for RSSH for the 2023-2025 period.

The answer to this evaluation question mainly relied on a qualitative approach based on inputs and perception from Board members, SC members, technical partners, and local stakeholders, as well on a simple quantitative approach based on available data on RSSH activities (budget, outcomes). Recommendations are aimed to add to recent reflections on the need for/ relevance of a separate RSSH allocation and provide foundations for establishing a consistent approach for defining the amount.

Summary of findings

Both Global Fund board members and CCM support a stronger investment in RSSH, which is considered crucial to contribute to the Global Fund’s strategic goals and maximize the impact of its resources. Yet views diverge regarding the relevance of introducing a separate RSSH allocation. Although investments in health systems have already been increasing over the last grant cycles, having a separate RSSH allocation would likely send a strong additional signal to stakeholders and contribute to further accelerating that increase. A separate RSSH allocation would incentivize countries and provide predictability, therefore allowing the emergence of a long-term strategy for RSSH funding at global and country level.

*However, **creating an upfront separate allocation for RSSH at global level is not recommended** as it would add rigidity by creating one more silo, thus going against the views of many board members who consider that the reinforcement of health systems should remain connected to the diseases. It would be faced with the challenge of determining the right trade-off balance between RSSH on the one side and disease programs on the other, which would add complexity to the initial steps of the methodology (CI and GDS). It would face other limitations such as the fact that there is no perfect set of metrics enabling the assessment of RSSH needs and allocating RSSH funding across countries. Lastly, a separate allocation for RSSH would decrease flexibility at the country level, which could lead to low absorption for countries who invested less in RSSH and decrease investments for countries who invested more in RSSH.*

*Considering these findings, **the evaluation recommends supporting the need to increase and improve RSSH investments by providing, in the allocation letters, an indicative range (minimal/target) of percentage of country allocations that would have to be dedicated to RSSH investment.** The share would have to be calculated based on ad hoc qualitative analyses outside of the allocation methodology process (yet to be undertaken prior to the issuance of allocation letters). Such an approach would consider the fact that the needs for stronger health systems vary significantly from one country to another, and that no “one-size-fits-all approach” is either possible or relevant.*

5.1. Findings

5.1.1. A separate allocation for RSSH could be relevant and meet some donors’ expectations of increasing RSSH effort

Most stakeholders support a stronger investment in RSSH activities

While the Global Fund’s primary objective is to end the three diseases, the organization has **increased its emphasis on RSSH in its 2023-2028 strategy**, with the mutually reinforcing contributory objective of

“Maximizing People-centered Integrated Systems for Health to Deliver Impact, Resilience and Sustainability”. Overall views are converging on the crucial role of RSSH activities to contribute to the Global Fund strategic goals overall, and **some of the advocates of higher RSSH investments are amongst donors that made the highest pledges for the 7th replenishment.**

This increasing focus from donors on building stronger health systems in developing countries is also accounted for by the conviction that a **stronger emphasis on RSSH would improve the cost-effectiveness of the Global Fund’s interventions and enhance their impact.** Indeed, although some raised the fact that the actual contribution of RSSH to fight the three diseases has not been well documented so far, several stakeholders interviewed at the Global Fund made the case that **building a RSSH at the country level would imply a more effective care for populations facing TB, HIV, or malaria risk of infection**⁵³. According to interviews, investments in RSSH would be instrumental in providing a more effective supply chain, competent and numerous health professionals, and accessible infrastructure, which are key in providing effective care for infected or at-risk of infection individuals.

RSSH activities have been increasing at country-level

Adequate funding should be made available for RSSH activities depending to country needs to improve the quantity and/or the quality of RSSH activities. So far RSSH investments have been increasing without an RSSH allocation communicated to countries - a more than proportionate increase relative to the overall increase in allocations. During the GC6 (2020-2022), US\$ 1,431M⁵⁴ have been invested in RSSH by countries, which amounts to 11% of the total country budget. This amount⁵⁵ was an increase of 13,8% from the Grant Cycle 5 (2017-2019). **Under the GC6 (2020-2022), 46% of countries have allocated more than 10% of their HTM allocations to RSSH activities** (including standalone RSSH activities and disease integrated RSSH investments), 12% of them went to the extent of allocating more than 20% to RSSH activities.

This positive trend reflects the strong interest of CCM members in RSSH activities and confirms that program split flexibility to shift some of the funding from disease-specific activities to RSSH activities is adequate and well used at country level. 91%⁵⁶ of CCM respondents to the survey judged that flexibility to revise the communicated allocation to increase investments in RSSH is important or very important as a key principle of the allocation methodology. The average results at country level show a positive or very positive opinions in 49 countries out of the 52 countries where respondents have answered the survey question.

In addition, when asked about their current satisfaction regarding their use of flexibility for RSSH, 65%⁵⁷ of the respondent consider it appropriate or very appropriate as shown in the graph below. The average results at country level show a positive or very positive opinions in 35 out of the 48 countries where respondents have answered the survey question.

⁵³ Source: Interviews.

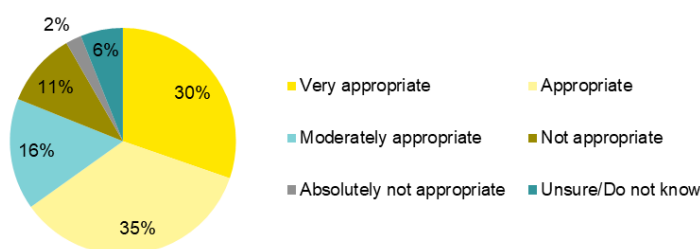
⁵⁴ Source: Global Fund data

⁵⁵ Source: “Communicated Allocation, Program Split, and Budgeted amounts by module” file communicated by the Global Fund

⁵⁶ Respectively 95% and 92% in Salvador and Madagascar vs. 91% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 49 countries, positive opinions are equal or above 50% of all responses. The 2 remaining countries are single-answers countries. 1 country did not agree nor disagree with the statement.

⁵⁷ Respectively 68% and 75% in Salvador and Madagascar vs. 66% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 48 countries, positive opinions are equal or above 50% of all responses. 5 countries disagreed with the statement and 6 countries neither agreed nor disagreed.

Figure 18: CCM respondents' satisfaction regarding the current Program Split Flexibility to shift some of the funding from disease-specific activities to activities that build RSSH



Source: CCM survey

Yet defining and communicating a separate RSSH allocation to countries would probably help preserve and enhance further RSSH investments at country-level

As confirmed through interviews, a separate RSSH allocation would send a strong signal to local stakeholders and foster them to further increase investments in Health Systems. Having a separate allocation dedicated to RSSH activities would present numerous advantages:

- ▶ It would incentivize countries to invest more in RSSH and a ripple effect would emerge, boosting the domestic spendings on RSSH.
- ▶ A separate RSSH allocation could contribute to solve some of the challenges faced by RSSH at country level. While the current bottom-up approach is more flexible and responsive to countries' needs, a more top-down approach would empower countries by giving more predictability. It would make grant preparation more efficient by clarifying funding expectations.
- ▶ In the absence of a separate RSSH allocation, RSSH investments depend entirely on negotiations at the CCM level, including during the program split process. The process of deciding on the program split and then developing the funding request can be resource intensive. A dedicated RSSH allocation would help reduce time in negotiations.

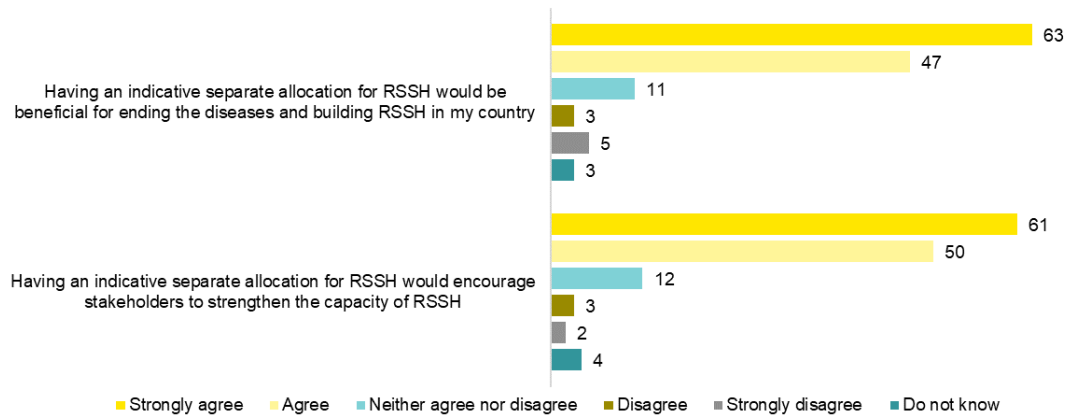
Considering these upsides, the CCM respondents are mostly in favor of a separate allocation dedicated to RSSH activities:

- ▶ 83%⁵⁸ of the respondents agree or strongly agree that having an indicative separate allocation for RSSH would be beneficial for ending the diseases and building RSSH in their country. The average result shows a positive or very positive opinions in 47 countries out of the 48 countries where respondents have answered the survey question (the 1 country left neither agreed nor disagreed with this statement).
- ▶ 84%⁵⁹ of the respondents think that having an indicative separate allocation for RSSH would encourage stakeholders to strengthen the capacity of RSSH in their country. The average result shows a positive or very positive opinions in 47 countries out of the 48 respondent countries where respondents have answered the survey question (the 1 country left neither agreed nor disagreed with this statement).

⁵⁸ Respectively 73% and 100% in Salvador and Madagascar vs. 83% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 47 countries, positive opinions are equal or above 50% of all responses.

⁵⁹ Respectively 59% and 100% in Salvador and Madagascar vs. 84% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 47 countries, positive opinions are equal or above 50% of all responses.

Figure 19: CCM respondents are mostly in favor of a 4th share dedicated to RSSH activities



Source: CCM Survey

5.1.2. However there is a lack of consensus on introducing a separate RSSH allocation

There is no consensus on the relevance of considering RSSH funding as a separate component.

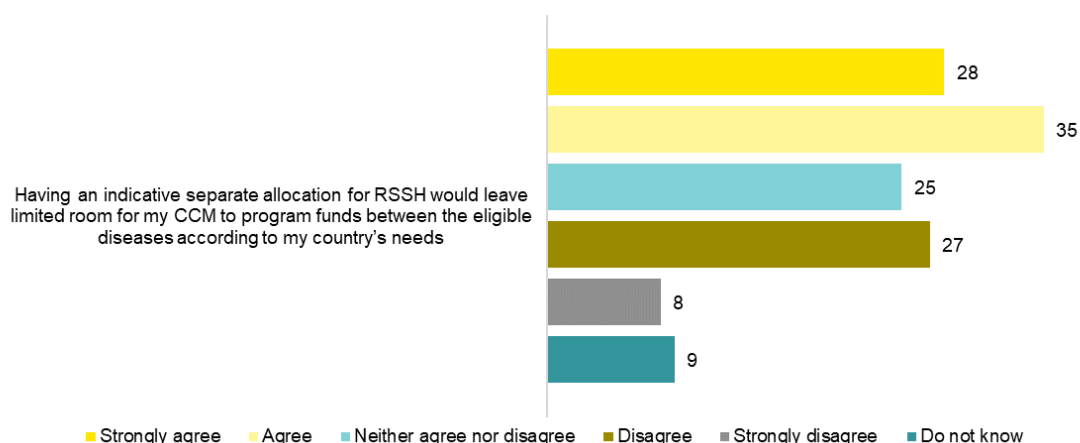
Although all Board and Strategy Committee members agreed on the need for a more substantial support for RSSH, there was no consensus on the relevance of having a separate share dedicated to RSSH funding. Some argued that having a separate allocation would secure a minimal funding towards RSSH. However, most of them disagreed, considering that RSSH funding should not be a separate component but should rather be integrated into diseases activities, in line with the strict acceptance of Global Fund’s mandate. This perception can however be nuanced, as areas such as disease surveillance, integrated laboratory, procurement functions and health system workforce have already been identified by the Global Fund as aligned with its strategies while being particularly impactful.

A dedicated share for RSSH would decrease the flexibility at the country level

As noted in interviews with several stakeholders ranging from Board Members to Members of CCMs, separate allocation would risk creating **one more silo** and **decreasing flexibility** at the country level. It would also **decrease the amount directly allocated to the three diseases** and would complexify the programming of funds at the country level. This opinion is also supported by the survey, as 48%⁶⁰ of the respondents admit that having a separate allocation for RSSH activities would leave limited room for the CCM to program funds between the eligible diseases according to their country’s needs. The average results at the country level show a positive or very positive opinions in 31 countries out of the 48 countries where respondents have answered the survey question.

⁶⁰ Respectively 68% and 58% in Salvador and Madagascar vs. 48% in average amongst all respondents. The situation in these 2 overrepresented countries does not change the overall statement. In these 27 countries, positive opinions are equal or above 50% of all responses. Overall, negative opinion was expressed by 16 respondents from 14 different countries. 7 countries did not express an opinion.

Figure 20: CCM respondents' emphasis that having a 4th share for RSSH would complexify the current programming of funds between the three diseases



Source: CCM Survey

In addition to the importance of flexibility, the interviews with benchmarked organisations, in particular with Gavi, also highlighted the critical need to protect **country ownership** when it comes to RSSH investments. Gavi's methodology to determine a "ceiling" for health system strengthening (HSS) grants relies on the principle of country ownership, which implies that the final allocation amount is always discussed with the country. Gavi's investment in health systems is indeed part of a more holistic approach which aims at strengthening health systems in a sustainable way without threatening countries' ownership.

The fact that there is no set of metrics enabling the assessment of RSSH needs across countries presents a major implementation challenge

First, determining an upfront fourth allocation would be faced with a methodological challenge as regard the amount of funding to be dedicated to RSSH vs. diseases at global level. Contrary to the GDS, which can rely on comparable metrics to distribute available resources across the three diseases, there would be no indicator to support the calculation of an amount to be taken out from the diseases' allocations to be allocated to RSSH only (decision on a potential upfront fourth share for RSSH would then face similar challenges as those faced by CI). Such challenge was raised by most stakeholders who are against having a separate allocation for RSSH, who at the same time highlighted that **trade-off decisions between diseases and RSSH can only be taken at country level**.

Second, a separate **allocation for RSSH should be allocated to countries based on reliable metrics**. However, whilst some indicators do exist there is no robust indicator that would allow a reliable allocation to countries, especially due to the variability of health systems:

- ▶ While several indicators can be used to assess the capacity, sustainability, and resilience of health systems, they often do not provide a full picture of the overall performance of health systems. The **number of active health workers per 10,000 inhabitants**, for instance, is a relevant indicator for the coverage and effectiveness of health services. However, it does not encapsulate the overall capacity and resilience of health systems, as they don't account for the skill mix of health workers, the quality of care provided, the affordability and accessibility of healthcare.
- ▶ **Composite health indicators** provide important insights into health systems. The **WHO UHC service coverage index** represents coverage of essential health services across the entire population in a country. It is based on the average score of 14 indicators selected from the following health areas: reproductive, newborn, maternal and child health; infectious diseases, noncommunicable diseases; service capacity and access. One of the main limits of this index is that it does not consider the quality of health services provided nor the financial support provided to patients.

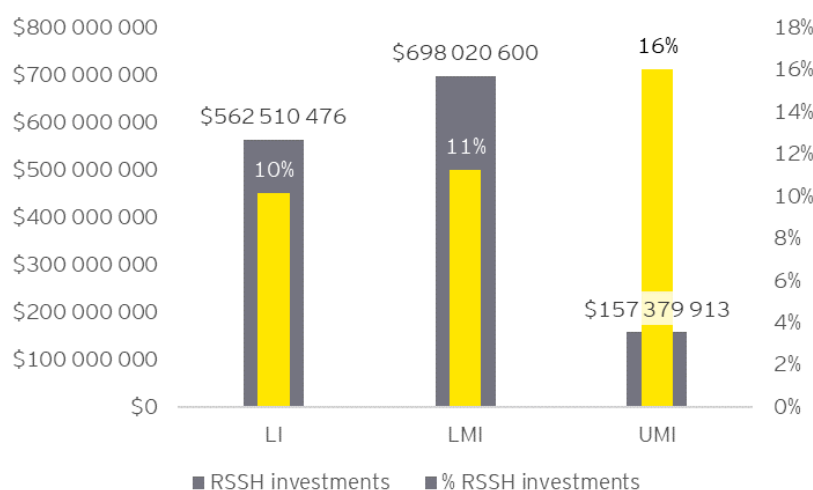
Most Interviewees confirm that RSSH characteristics can hardly be encapsulated in a single set of metrics and that there is no relevant indicator that would allow an optimal distribution of an RSSH envelope by countries. As health systems differ strongly from one recipient country to another, finding a reliable indicator which would enable the Global Fund to calculate the maturity of health systems remains a challenge. **Health systems are radically different** across the countries eligible to the Global Fund's allocation. This is due for instance to

different level of developments, different health strategies, political situations, etc. This makes creating a formula to assess the need for RSSH investments based on the model of disease burden formula a complicated endeavor. Furthermore, using flawed indicators could lead to erroneous evaluation. From the viewpoint of certain stakeholders, necessary RSSH investment in certain fragile countries or regions that need specific and dedicated support can be considered as part of catalytic investments which shall allow the distribution of additional funding where it is needed to achieve greater impact.

The strong variability of investments in RSSH, even within income groups, advocates against a one-size-fits-all approach

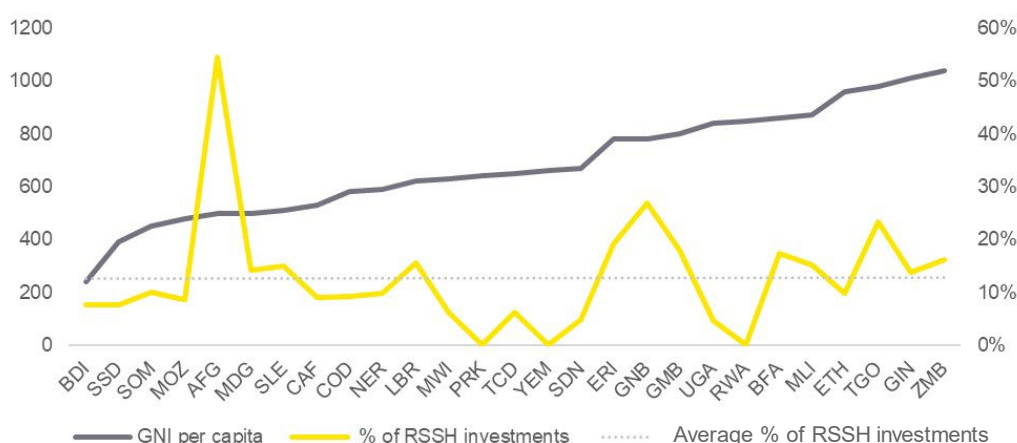
While there is a positive correlation⁶¹ between countries economic capacities and the share of RSSH Investments amongst their allocations, **this correlation is very weak. This reflects the fact that RSSH investments are significantly different even among countries belonging to the same income group.**

Figure 21: RSSH investments by income groups



Source: Global Fund data

Figure 22: 2021 GNI per capita and % of allocations dedicated to RSSH during the 6th GC for low-income countries



Source: Global Fund data

It is observed that as the GNI per capita increases, the share of the allocation invested in RSSH does not follow in the low-income countries presented in the graph. As a result, setting aside a share for RSSH investments at the expense of funding programs to fight HIV, TB, and Malaria for countries with low

⁶¹ The correlation coefficient is 0,0027.

investments in RSSH in the previous cycle might lead to a **low absorption**. In this context, a separate RSSH allocation may alone not be sufficient to fill in developmental gaps with regards to the performance of health systems at country level.

5.2. Potential alternatives

What alternatives were envisaged and why these alternatives?

Three alternatives have been identified to address the findings of the Evaluation with regards to RSSH, e.g. to support the Global Fund strategic objective of increasing the quantity and quality of RSSH activities and address some donors' expectations of raising the Global Fund's contribution to improving health systems to fight the three diseases. Although previous findings have highlighted challenges in terms of relevance and implementation, analyzing these alternatives aim to check further whether they might still bring more benefits than drawback despite their limitations.

The alternatives follow different approaches, as follows:

A first alternative (Alternative 1) would consist in determining a separate RSSH allocation at global level (to be taken from the disease allocations), before allocating it to countries. **It bases on following assumptions**

- ▶ **The upfront separate allocation for RSSH would amount to a certain percentage of total resources** (i.e. for instance 10%, a share in line with the historical amount allocated to RSSH by countries on average or another percentage that be defined, for instance based on replenishment scenarios).
- ▶ **The allocation of RSSH funding to countries could be based on countries economic capacities**, considering that lower-income countries generally allocate lower amounts to RSSH despite their greater needs for RSSH investments.

This alternative would address some donors' expectations who request for greater effort on RSSH vs. disease programmes and better consideration of RSSH needs in allocating resources.

A second alternative (Alternative 2) would consist in defining a separate allocation for RSSH as a certain percentage of country allocations communicated to countries. This alternative would not involve the determination of an upfront RSSH component, but instead the determination of revised indicative program splits communicated to countries to add a fourth share for RSSH. This alternative 2 would aim to further encourage countries' efforts to invest more on RSSH (vs. disease programs).

A third alternative (Alternative 3) would involve the determination of specific RSSH allocations to countries on a case-by-case basis. This alternative would change the final allocations to countries as part of the qualitative adjustment process in order to refine allocation amounts for specific RSSH country contexts. This alternative 3 would ensure additional funding is made available to countries with specific RSSH challenges and would respond to the finding that a one-size-fit-all approach that is detrimental to the effectiveness of the allocation.

5.2.1. Alternative 1: upfront separate allocation for RSSH distributed to countries based on countries' economic capacities

Presentation of the alternative:

Alternative 1 would imply that a fourth allocation dedicated to RSSH is created at global level, at the GDS stage. In the absence of a convincing set of metrics and comparable indicators that could define the amount dedicated to RSSH vs. disease programs, stakeholders supporting a full-fledged share of the fundings dedicated to RSSH recommend that such a **separate share for RSSH would base on a fixed percentage**. This percentage could represent at least 10% of total available resources for country allocations, regardless of the replenishment amount (lower, flat, or higher funding scenarios), and could be raised to a higher percentage depending on the Global Fund's willingness to provide a stronger support to RSSH. Another option would be to define a different percentage based on various replenishment scenarios, in respecting the principle of protecting disease allocations and re-directing any replenishment increase towards RSSH.

This option would also imply allocating the **RSSH funding to countries based on a specific metric, which could be the GNI per capita**. The amount allocated to RSSH would be higher for low-income countries. This would help address structural issues related to their weaker health systems and their average lower spending on RSSH (see *Figure 23*). In doing so, this approach aims at ultimately increasing the impact of programs fighting the three diseases.

Pros and cons:

This alternative 1 would present the following advantages:

- ▶ By defining a dedicated allocation for RSSH at global level, this alternative 1 would address some donors' expectations who request for greater effort on RSSH vs. disease programmes; It would provide **predictability and** allow managing the overall effort and investment of the Global Fund on RSSH. It would also provide more **visibility at a global level** on the Global Fund's overall investment on RSSH.
- ▶ It would ensure countries benefit from a guaranteed minimal amount for RSSH and ensure countries with the least ability to pay receive a highest amount of funding to accelerate on their investments for RSSH.

However several risks and drawbacks need to be considered.

- ▶ Taking aside a percentage of country allocations and dedicating it to RSSH would be **detrimental to HIV, TB, and Malaria programs** if the amount of the replenishment is similar to or lower than the previous one, which could threaten life-saving interventions. Furthermore, this alternative would involve major challenges with respect to the determination of a fourth allocation for RSSH globally. As previously noted, there is no approach that would allow an easy and appropriate trade-off decision between RSSH and disease-specific allocation, and setting a certain percentage, such as 10%, might not be accepted by all stakeholders, especially in case of a lower replenishment.
- ▶ This alternative would reinforce the siloed approach and would go against the views of most Board members who consider that RSSH should be primarily aimed at fighting one or more of the three diseases ('Global Fund is not for Global Health, it is for the three diseases').
- ▶ The RSSH allocation methodology would not rely on any RSSH-specific technical parameters. Economic capacity indicators such as GNI per capita, are reliable, transparent, available for all countries and updated on a regular basis. However they could not really **fit actual countries' needs in terms of RSSH investments**.
- ▶ The approach would likely lead to detrimental effect in terms of low absorption, especially in countries where RSSH investments were significantly lower during the last cycle. **As lower-income countries currently allocate less on average to RSSH, this option risks failing at increasing RSSH investments in these countries.**

Conclusion: This alternative would present some advantages that shall help shape a recommendation. However, due to the high risk of low absorption and to the threat it may cause on continuity in case of low funding scenarios, this alternative shall not be recommended *per se*.

5.2.2. Alternative 2: separate allocation for RSSH defined as a certain percentage of country allocations communicated to countries (for example 10%)

Presentation of the alternative:

This alternative would not involve the determination of an upfront RSSH component, **but instead the determination of a separate allocation for RSSH communicated as a share of each country allocation. This share could be for instance 10%**, a share in line with the historical amount allocated to RSSH by countries on average. This alternative would not change the final allocations to countries, but rather lead to revised indicative disease split communicated to countries to include a specific share for RSSH.

Pros and cons:

This approach would support a simple and predictable approach to RSSH in all countries. This option addresses several structural issues related to RSSH investments:

- ▶ The setting of a fixed RSSH allocation share to be included in all allocation letter through a top-down approach would provide **visibility and predictability at the country level**, as the percentage of RSSH investments would be determined upfront. This would decrease the time negotiating at country level.
- ▶ It also addresses the problem of the variability of RSSH investments across countries by creating an allocation with a fixed percentage dedicated to RSSH. In doing so, it **strongly incentivizes countries to allocate at least a minimal amount to RSSH**.
- ▶ It would address the concerns of some donors who consider that RSSH should be focused on the three disease and should not be considered as a separate component within the allocation methodology.

On the other hand, this approach presents several major issues, which prevent from recommending it:

- ▶ It would not be **fit to countries' needs**, as it does not consider the fact that the percentages of allocations invested in RSSH are highly variable: 13.6% of countries invest more than 20% of their allocation in RSSH. If the share determined in the allocation letter is lower, it could undermine the efforts in RSSH investment. It does not consider the previous share of fundings dedicated for RSSH at country level and does not measure the **real need of countries** regarding RSSH. As a result, it could lead to **low absorption** in countries where RSSH Investments were significantly lower during the last cycle, and to decreased investments in countries which had higher RSSH investments during the last cycle.
- ▶ Additionally, as for other alternatives, taking aside a percentage of country allocations and dedicating it to RSSH may threaten life-saving interventions in case of low funding scenarios, especially in countries which have the lowest ability to fight the diseases with their domestic resources, especially in case of low replenishment.

Conclusion: This alternative would allow for greater visibility and predictability for RSSH investments at global level. However, although simple and straightforward, it would show little benefits due to the limitations of such “one-size-fits-all approach”.

5.2.3. Alternative 3: separate allocation for RSSH determined as part of the qualitative adjustments process

Presentation of the alternative:

This alternative would consist in adjusting country allocations at the qualitative adjustments' stage of the allocation methodology to adjust funding levels upwards or downwards based in an RSSH parameters. Such approach would aim to consider countries situations as regards the maturity of their health systems to provide additional effort for countries in need of specific RSSH funding. It would go along with a separate allocation for RSSH communicated in the indicative program split as part of the allocation letters, based on an adjustment upwards or downwards of the RSSH target percentage of country allocations (starting from, for instance, an average of 10%, that would need to be adapted to each country).

Pros and cons:

This approach addresses some structural issues related to RSSH investments and limitations of the previous alternatives:

- ▶ Like previous alternatives, it could address the **lack of strong advocacy for RSSH investments** at the country level and decrease the time spent negotiating at country level while ensuring an amount for RSSH.
- ▶ Unlike alternative 2, it would **enable the Global Fund to have a tailored and holistic approach in terms of RSSH** and align its grants with the actual needs of countries. In case of low funding scenario, undertaking such adjustments at the QA stage would enable the Global Fund to prioritize certain countries (currently considered as RSSH priority countries) by reallocating funding where most needed. The impact would however depend on the sturdiness of the assessment of RSSH needs for each country, which would imply a time-consuming process.
- ▶ Lastly, this approach would be more flexible than alternative 1 and could make this option more acceptable to the Global Fund's stakeholders and help manage different expectations regarding RSSH.

However, this option presents several drawbacks:

- ▶ It would be detrimental to the simplicity of the process and to its efficiency, as it would **highly complexify the qualitative adjustment process**, which is already very dense. It would increase the workload dedicated to this stage as numerous relevant indicators are already being looked at under Stage 2 of QA (Key Contextual Factors). Furthermore it would also go against one of the principles of the QA process which is not intended to determine the focus of country investments.
- ▶ As for alternative 1, the approach and rationale for adjusting country allocations could hardly rely on any RSSH-specific technical parameters.
- ▶ This option could decrease the involvement of CCMs in the decision-making process, which would **weaken country ownership**. Additionally, this may not automatically provide visibility at the country level. Nonetheless, this process of determining RSSH investments could involve CCMs or governmental institutions.

Conclusion: This alternative would be highly relevant but too complex to be implemented at this stage. Yet the need to better align the approach with the actual RSSH needs shapes the final recommendation to a large extent.

5.3. Recommended changes and their consequences

5.3.1. Recommendation

What recommendation and why?

It is not recommended to define an upfront fourth share dedicated to RSSH (alternative 1). Such a fourth share would be more detrimental than beneficial:

- ▶ A separate allocation for RSSH could be detrimental to a more integrated approach between RSSH and the three diseases. Although all agree on the importance of enhancing RSSH, most Board members consider that RSSH should be linked with the three diseases, instead of being considered as a separate component.
- ▶ There is no appropriate approach that would allow determining an upfront amount for RSSH over disease programs that would fit under all replenishment scenarios, and any pre-determined percentage would cause a threat on continuity in case of low funding scenarios. Determining an upfront separate RSSH allocation could not be formula-based and would even more complexify the discussions occurring at the GDS step.
- ▶ Allocating RSSH funding to countries would be faced with a lack of relevant set of metrics that could be used by the Global Fund to calculate allocations, based on the needs for RSSH investments at country level or potential of maximizing the impact of RSSH investments.
- ▶ High variability of funds invested in RSSH among countries, even within countries income groups, would lead to low absorption or disincentivize RSSH investments. In addition, a joint financial domestic effort is necessary to achieve a critical level of RSSH funding, which depends on contextual needs and national priorities

It is not recommended, in the short term, to define a specific RSSH allocation amount as part of the qualitative adjustments (alternative 3) as it would complexify the allocation methodology.

It could be recommended instead to define a certain percentage of country allocations to be dedicated to RSSH, communicated together with the indicative disease split, yet based on a country-by-country adaptation (alternative 2, with different percentages). To incentivize tailored RSSH investments at country level, such target percentages, together with qualitative recommendations, would be tailored to country contexts recommendations based on the historical data and qualitative considerations and should be systematically added to the allocation letters. This would address the need of compensating for the lack of advocacy in favor of RSSH in certain countries, especially within CCMS.

Instead of a single fixed percentage, it could be preferable to determine **a range of percentage**, with a baseline (indicative minimal percentage to be dedicated to RSSH investments) and a target (preferable percentage to be reached). The benchmark with the Global Financing Facility (GFF) has indeed underlined the numerous advantages of **determining a range rather than a point estimate** for each country. It maximizes the fund's ability to be flexible, to incentivize financing from external and domestic resources and to respond to changing external circumstances.

The implication and directionality on the suggested percentage would be the following: countries with weaker health systems would be incentivized to dedicate a larger share to RSSH.

The determination of the range should be done for every country, based on a qualitative process including the following aspects:

- ▶ Country needs (health workforce, supply chain and health information)
- ▶ National priorities
- ▶ Historical levels and types of investments in RSSH
- ▶ Proportion of Global Fund financing invested in RSSH
- ▶ Other contextual factors

Such approach would ensure RSSH is prioritized at country level whilst ensuring that actual trade-offs decision between diseases and RSSH is taken at the right level.

Moreover, it is suggested to use, for every country, a more precise wording in the allocation letter to incentivize appropriately RSSH investments:

- ▶ Continue to give an overall judgment on the level of effort to be carried out: maintain / increase the financial effort dedicated to RSSH (in alignment to the range of percentage determined above)
- ▶ Include type of RSSH interventions to be implemented by level of priority and link to the three diseases. Whilst allocation letters for RSSH priority countries (for the 2023-2025 allocation period) already include suggested RSSH priority areas for investment based on country context, we suggest systematizing this approach and include bespoke suggested areas for RSSH for every country.

Figure 23: Illustrative example of the recommendation

Eligible disease component	Allocation (US\$)	Allocation Utilization Period
HIV	100,234,706	1 January 2024 to 31 December 2026
Tuberculosis	100,234,706	1 January 2024 to 31 December 2026
Malaria	100,234,706	1 January 2024 to 31 December 2026
RSSH	Between X% and Y% of the communicated amounts above	1 January 2024 to 31 December 2026
Total	100,234,706	

Source: Allocation letter received by the countries (the figures have been blurred voluntarily)

Although out of scope of the Evaluation, the need to further develop other levers that could support RSSH investments at country level was raised as a point of attention, underlined during the Interviews with Board and SC Members. In particular, possible solutions to be envisaged could include stronger support and assistance to CCMs by the Global Fund Secretariat and closer monitoring and capacity-building to ensure CCMs are well-equipped to invest effectively and efficiently in RSSH. Such levers would need further investigations that are not in the scope of the evaluation.

5.3.2. Consequences, including trade-offs implications and incidental or unintended consequences

The recommendation for RSSH detailed above would lead to many consequences regarding the Global Fund's allocation methodology:

- ▶ The efficiency of the whole process would necessarily be impacted as implementing a systematic qualitative approach – to ensure a tailored RSSH recommendation – would result to a heavier process and an increasing workload of the Global Fund in order to produce the Allocation letters to the recipient countries.
- ▶ The **effectiveness**, however, **would be reinforced** as the recommendation would be **tailored to the country needs** which would **mitigate the risk of a low absorption of funds**. This recommendation would be the opposite of a one-size-fits-all approach.
- ▶ Moreover, the **sustainability** of this approach would likely be ensured as it **respects the country ownership**. The countries are still the lead decision-makers as they can choose to use the **flexibility** to invest, or not, in RSSH regarding their specific needs. Also, the recommended approach can be refined at each grant cycle within the cyclical review process.
- ▶ However, there is **a risk for the Global Fund to be over-prescriptive** in the Allocation Letter but giving a **range of percentages** instead of a precise one and letting the countries adjust the funds regarding their needs thanks to the flexibility would mitigate this risk.

5.3.3. Impact on overall timeline and steps in the process and possible challenges

The changes required by this recommendation can be implemented during the cyclical review process leading to cycle 2026-2028 (GC8).

6. Technical parameters, scale-up/paced reduction and qualitative adjustments

Q4: Are steps 3, 4 and 5 of the allocation methodology, e.g. technical parameters, scale-up/paced reduction and qualitative adjustments, adequate for maximizing the impact of Global Fund investments whilst ensuring they are predictable, flexible, simple, and address the needs of the countries with highest disease burden and lowest economic capacity?

Methodology: Introduction

Steps 3, 4 and 5 of the allocation methodology form an overall consistent approach, with each step having its own rationale.

- ▶ *Technical parameters first aim to allocate funding to countries by disease, in line with the objective of the Global Fund resource allocation methodology*
- ▶ *Scale-up/paced reduction aims to ensure scale-up for components that previously received less than their Initial Calculated Amount (ICA) while preventing steep decreases in funding from the previous allocation period*
- ▶ *Qualitative adjustments aim to account for key epidemiological, programmatic, and other national context-related factors that cannot be formulaically accounted for or which are not fully represented in the allocation formula*

The Evaluation studied whether the current methodology could be adapted and/or enriched with additional parameters to better align with the objectives of the allocation methodology, and/or whether these objectives could be (i) better reflected or adjusted through alternative metrics, and/or (ii) new factors could be included in the qualitative adjustment step to complement the current methodology or replace some factors already considered. The relevance and effectiveness of integrating indicators related to vulnerability and performance were also assessed.

The revision of current disease burden indicators in the allocation methodology is not a focus of the Evaluation as these parameters are reviewed by technical partners, the Board and Strategy Committee in the cyclical review process.

The answer to this evaluation question relied mainly on stakeholders' perspectives, in-depth review of the current methodology, benchmarking, and quantitative analysis of potential alternatives.

6.1. Technical parameters

Summary of findings

Disease burdens and Country Economic Capacity (CEC) are aligned with the objectives of the Global Fund and support the effectiveness and feasibility of the methodology. GNI pc, the indicator used for economic capacity, has several limitations: it does not address inequalities within recipient countries and excludes parameters such as inflation. Nevertheless, it appears as the best primary indicator of economic capacity due to the drawbacks of other alternative indicators.

The GNI pc indicator could benefit from the addition of a complementary indicator on economic capacity which would allow for a clearer picture of countries' ability to mobilize resources to finance health policy. Public revenue per capita, adjusted for PPG debt interests, is a relevant proxy for measuring the breadth of public resources from which the government can draw in order to finance the health sector. It could therefore be used to increase the equity and effectiveness of the allocation methodology, by increasing its alignment on countries with the lowest economic capacity.

6.1.1 Findings on technical parameters

Disease burdens and Country Economic Capacity (CEC) are aligned with the objectives of the Global Fund and support the effectiveness and feasibility of the methodology

The combination of disease burden indicators and country economic capacity indicators favors the alignment of Global Fund financing with countries bearing the highest disease burden and lowest economic capacity. From a technical point of view, the indicators succeed at combining rigor and feasibility:

Disease burden indicators, which are reviewed at every cycle by the technical partners, are **recognized as robust and technically sound**.

GNI per capita, the proxy used for CEC, presents the advantage of being a reliable indicator, and available on a yearly basis. While it doesn't address inequalities within recipient countries and excludes parameters such as inflation, it **appears as the best option** due to the drawbacks presented by alternative indicators (CEPA, 2021):

- ▶ GNI per capita power parity purchase (PPP): This indicator would adjust for difference in price level. Data is available but there is debate regarding the methodology for estimating PPP and the difference in price levels is not annually updated. Its methodology is not as robust due to the use of different base years across countries to adjust for prices.
- ▶ GINI Coefficient: This indicator would account for inequalities within countries, but data availability tends to be poor. It could also discourage countries from addressing internal inequalities.

6.1.2 Potential alternative

What alternative was considered and why?

The alternative presented below proposes the addition of a complementary indicator on economic capacity. The Evaluation found that a **complementary indicator on economic capacity** would take better account of governments' capacity to finance health policy from public resources, which is not captured accurately by GNI pc according to the literature.

Incorporating an indicator for public revenue per capita would better account for a country's ability to mobilize its own resources to finance health policy

GNI per capita is a well-recognized proxy indicator for appropriately taking into consideration a country's economic capacity as an indicator of need in development aid allocation formulas, and as such is the primary indicator of need to consider⁶². However, **GNI per capita does not suitably capture a country's capacity to mobilize its own resources to finance its health policy** - as also highlighted by the 2021 CEPA report⁶³ - **in addition to Global Fund allocations**.

It is therefore **necessary for the Global Fund to consider not only GNI per capita, but also an indicator that would better reflect the government's ability to finance healthcare policy, in addition to the GNI pc**, which it is in no way intended to replace.

In the large majority of countries, to varying degrees but notably in low-income and lower-middle income countries, budgetary financing of health policy from domestic resources is strongly limited by difficulties in mobilizing additional tax resources⁶⁴. The CEPA report considers that the most suitable indicator is government revenue per capita, recommending that this indicator⁶⁵ be included in qualitative adjustments process, which is what was done last cycle.

But in a growing number of countries, healthcare financing is also severely inhibited by the pressure of public external debt on public spending⁶⁶. This issue echoes an approach in terms of fiscal space as defined in

⁶² CEPA, 2021

⁶³ "GNI p.c. does not accurately capture the real fiscal capacity of governments for health interventions" (Cepa, p. 5).

⁶⁴ IMF (2023). Regional Economic Outlook – Sub-Saharan Africa, The Big Funding Squeeze, April, Washington DC.

⁶⁵ "In summary, the key advantage of using general government revenue per capita is that it more accurately depicts the available fiscal space of governments when compared to GNI p.c." (Cepa, p. 10)

⁶⁶ Fan V. and Gupta S. (2023), What's rising debt got to do with health spending? Center for Global Development blog, January 13th.

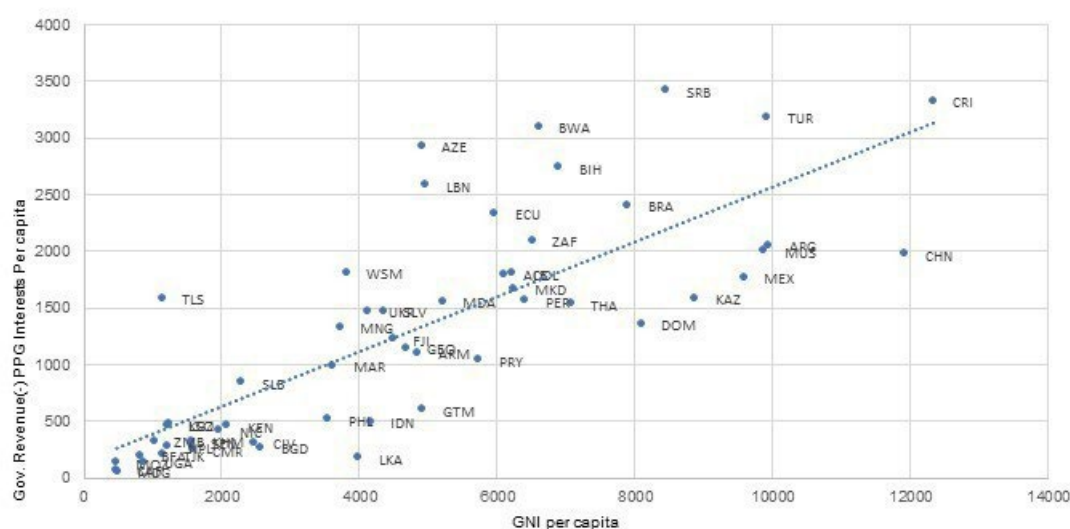
Heller's⁸⁷ as "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position".

We therefore propose considering public revenue within the government budget *minus* interests on external public or publicly guaranteed (PPG) debt: Revenue is cash receipts from taxes, social contributions, and other revenues such as fines, fees, rent, and income from property or sales. Repayment of principal is not taken into account because interest paid is included in the calculation of the fiscal balance, whereas on the one hand disbursements and amortization of capital are included in the financing of the overall balance (net lending/borrowing), and on the other hand the capital is most of the time at least rolled over.

- ▶ This "public revenue per capita adjusted for PPG debt interests" indicator is a **proxy for capturing the perimeter of public resources** from which the government can finance the health sector in implementing its policy choices.
- ▶ It is both an indicator of financing capacity and, in correlation, an indicator of need when calculated on a per capita basis as proposed.

Putting it into perspective with the GNI pc shows that for many countries in the sample for which data are available online (see *Figure below*), a wide range of the indicator levels is associated with an identical level of GNI per capita. The countries for which GNI per capita is comparatively a good predictor of their potential capacity to finance healthcare policy are those close to the regression line.

Figure 24: Total government revenues minus PPG debt interests available per capita and GNI per capita (Current US\$) - 2021



Source: World Bank data

For each country, calculating the gap between the value of the proposed indicator as observed and what it would be as estimated by a linear regression with GNI per capita, and expressing this gap as a percentage of the actual indicator as it stands, shows that **in more than a third of the sample, this public revenues adjusted for PPG debt interest per capita indicator is 50% or more below what is suggested by the corresponding GNI per capita** (the residual of the regression as % of the estimated value of the indicator). Note that the results are closely matched if the same calculations are carried out for public revenues excluding grants⁶⁹.

Considering the proposed indicator as a complement to GNI pc could **increase equity and effectiveness in Global Fund allocation** for two further reasons:

⁶⁷ Heller P. (2005), Understanding fiscal space - IMF PDP/05/4. Washington DC.

⁶⁸ Spearman's rank coefficient between the two indicators with and without grants calculated per capita is 0.984. But it's preferable to use revenue inclusive of grants, since a proportion of grants, which vary from country to country, is general budget support, and those allocated to a specific sector potentially free up resources that the government can allocate to spending in other sectors.

- ▶ Even in low-and middle-income countries that have opted for a national health insurance system, **budget financing for health is more substantial than insurance resources**⁶⁹;
- ▶ Sub-Saharan Africa is the only region in the world where the deficit in qualified health personnel is expected to increase by 2030⁷⁰, requiring a **significant financial effort to cushion** the consequential shock to come. For example, despite the staff shortage, in the ECOWAS (Economic Community of West African States) and ECCAS (Economic Community of Central African States), health and care staff remuneration accounts currently for 60% of government spending on health⁷¹.

The indicator is easy to calculate. The data currently available online and used in the above analysis is limited to 54 countries. But the data required for the calculation **can be available without major difficulties** for all countries eligible for Global Fund contributions. **Three- to five-year projections beyond the current years are readily available from the government authorities** (macroeconomic and budgetary projections) which update and use them each year for their mid-term public expenditure scenarios. They could be requested each year as needed.

The **potential counterproductive incentive of the proposed indicator (disincentivizing tax effort) is highly unlikely**. It is hard to imagine a Prime Minister and a finance minister deliberately deciding to relax the overall tax effort in order to benefit specifically from more GF subsidies or to borrow more in the expectation that an increase in Global Fund allocations would partly offset the cost of the new borrowing. The inclusion of performance indicators in the methodology, as recommended below, further reduces this eventuality if needed.

This been said, it shall be pointed out that the indicator does not distinguish between countries with poor or appropriate fiscal policies, and in this sense, taking it into consideration contributes to rewarding poor policies as well as good ones. But this point must not invalidate the interest that the indicator otherwise presents. Let's also note that the same applies to the GNI pc which depends in part on the quality of public policies, both in terms of long-term dynamics and short-term levels, and not only on exogenous factors (cf. for example Ayana 2023; Lee and Kim, 2009⁷²). That means that considering GNI pc in the allocation process also contributes, for some countries, to rewarding poor policies, which in no way detracts from its usefulness.

6.1.3 Recommended changes regarding economic capacity and their consequences

Recommendation and reasoning

It is recommended to complement the GNI pc with a public revenues pc indicator that better captures governments' ability to finance health policy from public resources.

GNI pc is a leading indicator of a country's economic capacity, but it does not capture adequately a government's capacity to finance health policy from public resources, as also pointed out in the Cepa report (2021). It is proposed to complement it with an **indicator of public revenue adjusted for interests on public and publicly guaranteed debt in relation to the population**, whose values are very different in many countries with the same level of GNI pc.

This indicator is a proxy for a country's capacity to dispose effectively of revenue that can potentially be used to finance health policy without any prejudice to the sustainability of the government's financial position. It refines the way in which economic capacity is taken into account in the allocation of Global Fund

⁶⁹ Cashin C., Dossou J-P (2021). Can National Health Insurance Pave the Way to Universal Health Coverage in Sub-Saharan Africa? *Health Systems & Reform*, 7:1.

⁷⁰ WHO (2021). *Health labour market analysis guidebook*. Geneva.

⁷¹ Toure, H., Aranguren Garcia, M., Bustamante Izquierdo, J. P., Coulibaly, S., Nganda, B., & Zurn, P. (2023). Health expenditure: How much is spent on health and care worker remuneration? An analysis of 33 low- and middle-income African countries. *Human Resources for Health*, 21(1),

⁷² Ayana I.D, Demissie W.M, Sore A.G (2023) Fiscal policy and economic growth in Sub-Saharan Africa: Do governance indicators matter? *PLoS ONE* 18(11). Lee K., B-Y. Kim (2009), Both Institutions and Policies Matter but Differently for Different Income Groups of Countries: Determinants of Long-Run Economic Growth Revisited, *World Development* Vol. 37, No. 3.

contributions. Its limitation - not differentiating between poor and good policies, rewarded in the same manner - also applies to the GNI pc, which is partly determined by policies, but it is outweighed by its advantages.

The indicator is simple to calculate. Its scope (revenue and PPG debt interest) is precisely defined (IMF, Government Finance Statistics Manual, 2014) which greatly reduces comparability problems. The necessary three-year forecast data are readily available from government authorities. Data are updated on an annual basis and present an acceptable level of reliability (the best currently available).

As the necessary data will be easy to mobilize, it is recommended that public revenue within the government budget minus interests on external public or publicly guaranteed (PPG) debt, per capita, be incorporated in qualitative adjustments in a first step and then into the formula. Therefore, the indicator would be taken into consideration in two stages.

In the next cycle (2026-2028):

- ▶ Integrate the public revenues per capita adjusted for PPG debt interests indicator into the qualitative adjustments.
- ▶ Calculate the indicator for eligible countries by requesting the necessary data for the coming years (public revenues, PPG debt interests) from the country's authorities via the CCM.
- ▶ Calculate rankings for GNI pc and the adjusted indicator.
- ▶ Consider an additional allocation for countries whose rank for the adjusted indicator will be much lower than that of the GNI pc.

For the following cycle:

- ▶ Integrate the adjusted indicator into the formula for calculating allocations in conjunction with the GNI pc and the vulnerability indicator(s) (see below), depending on the method and coefficients assigned to each. Integrating the proposed indicator into the allocation formula is ensuring equal or homogenous treatment for each country regarding this indicator, which is not the case if it is included within the qualitative adjustments, and therefore increases visibility and transparency in the methodology.

The two-stage suggested phasing will enable the Global Fund to have time to carry out the necessary simulations, to choose methodological options, trade-offs and the weight to be given to each element in the formula, identical or different (which cannot be done for the present exercise) and to measure the differences with the allocations resulting from the current process, in order to finalize the formula that will be retained for the next cycle.

Consequences of recommended changes

The indicator of public revenues adjusted for interests on public and publicly guaranteed debt in relation to the population **does not overlap with elements considered elsewhere** in the methodology and complements the GNI pc. as an indicator of needs.

Therefore, on one hand, it contributes to **improving vertical equity** in the Global Fund's support for recipient countries, and on the other hand, helps to **reduce the risk that the effectiveness of Fund-supported programs will be compromised** by governments' insufficient capacity to finance current health policy expenditure. It is not expected to have any impact on the cost-effectiveness of interventions or on the efficiency of Global Fund allocations.

The risk of encouraging the government (counterproductive incentive) to reduce its overall tax effort is low, as it is hard to imagine a government deciding to relax its overall tax effort or to borrow more to benefit specifically from more Global Fund subsidies.

Considering the proposed indicator adds a little complexity into the methodology, but without altering its transparency, as the scope of the indicator is clearly defined, and provided that the modalities for taking it into consideration are made explicit.

Integrating the proposed indicator into the allocation formula (second step in the proposed phasing) will ensure "equal or homogenous treatment" for each country regarding the indicators under consideration, which is not the case if they are included within the qualitative adjustments.

6.2. Integrating additional technical parameters: performance and vulnerability

Summary of findings

Performance indicators related to HIV, TB and malaria programs are currently limited to qualitative adjustments in a methodology primarily based on needs. Incorporating well-thought performance indicators directly into the formula could increase equity and provide beneficiaries incentives for results. The relevance of this approach is supported by the Evaluation finding that there is a correlation between the prevalence of the three diseases in a country and the country's low performance⁷³.

Integrating vulnerability indicators in the formula could increase equity and reinforce the current indicators of needs: a vulnerability indicator would capture country exposure to economic, political, or environmental shocks which can in turn impact its needs.

Incorporating performance and vulnerability indicators directly into the formula can, however, lead to significant changes in allocations across countries.

5.3.4. Findings on performance and vulnerability

A performance indicator could increase equity by providing beneficiaries well-thought incentives for results and maximize impact

Taking performance into account is an important dimension to integrate into resource allocation processes, as performance depends in part on the efforts made by beneficiaries to achieve predefined performance targets, in turn encouraging beneficiaries to strengthen the systems that deliver services and produce concrete results. Performance is currently considered only at the stage of qualitative adjustments through program performance, absorption, and coverage gaps.

Linking allocation to performance in relevant areas could help to:

- ▶ **Incentivize beneficiaries to increase their level of performance** by rewarding their merits, and to accentuate their efforts in dimensions that are important for program results;
- ▶ Ensure the best possible use of donor resources.

There could however be several challenges related to an indicator performance:

- ▶ The inclusion of performance in the formula does not allow for the consideration of the **root causes of poor performance**.
- ▶ Some key investments demonstrate **results over longer time horizons** (RSSH, equity/Human rights/gender, COEs), and the Global Fund noted in the 2023-2028 the need to create an enabling environment for such investments.

The choice of performance indicators is essential to ensure that the integration of this parameter meets its goals. Inappropriate indicators could induce counterproductive incentives, which would lead beneficiaries to adopt behaviors or measures that would:

- ▶ Ultimately prove detrimental to the achievement of program objectives
- ▶ Be based in part on largely exogenous factors, which governments cannot influence in the short or medium term.

Correlation analyses support to some extent the hypothesis of a link between country performance in governance and the prevalence of the reduction of prevalence of the three diseases

⁷³ The performance indicator used for this correlation analysis is IDA Country Performance Ratings. Performance in this context refers to overall performance and not specific performance related to health.

Countries that show **performant governance** as evaluated by The World Bank's IDA Resource Allocation Index (IRAI)⁷⁴ tends to see a **reduction of the prevalence of HIV, TB, and Malaria** between 2015 and 2021. As seen in the table below, correlation coefficients are weak but all negative, which means that good governance within countries is negatively correlated to the increase of prevalence of the three diseases.

Figure 25: Correlation between average CPR (IDA) by country from 2015 to 2021 / Evolution of prevalence by country between 2015 and 2021 (KPI1b)⁷⁵

Correlation coefficients	Methodology	HIV	TB	Malaria
	Pearson	-0,155	-0,133	-0,087

Source: WHO/UNAIDS and IDA data

This analysis is however insufficient to conclude on the link between performance and the prevalence of the diseases, considering the small country sample available and the weakness of the correlation (a perfect association is equal to 1), which prevents from deducing anything from it (it is rather informative).

Integrating performance and vulnerability indicators in the formula could increase equity and reinforce the current indicators of needs

A stronger integration of performance and vulnerability into the allocation methodology could help **support equity**, by giving priority to countries with the greatest needs on the one hand, and to the best-performing countries on the other hand.

As a result, **two main allocation models are often used**: one based on the needs of recipients, and one based on merit (or performance). While the Global Fund's model is mainly need-based, the interviews with the benchmarked organisations have underlined some interesting insights regarding performance-based models:

- ▶ **IDA's allocation is performance-based, as the country allocation depends on its CPR⁷⁶ (Country performance Rating) which enables IDA to assess a country's performance based on a wide range of criteria (CPIA)** (see the benchmark box below). IDA's Performance Based Allocation Formula is reviewed but not revised on a yearly basis: it is discussed with the Deputies and, based on the discussions, the matter is re-open (or not) and goes to the Board for approval. The indicators used by IDA are more global because of its scope. Nevertheless, the principle of performance indicators in itself is interesting and relevant for the Global Fund as incorporating a performance indicator and a vulnerability indicator directly into the formula could support a mixed model allowing for more cost-effectiveness and increased equity.
- ▶ **The GFF allocation model also takes performance into account (although in an indirect way)**, as trust fund resources are only allocated to countries that have demonstrated their commitment to RMNCAH (Reproductive, maternal, newborn, child, and adolescent health) by indicating their interest in utilizing IDA or IBRD resources for RMNCAH⁷⁷.

The principle of performance-based model and performance indicators appears relevant for the Global Fund as incorporating a performance indicator directly into the formula could support a mixed model allowing for more cost-effectiveness and increased equity. However, the Global Fund would have to come up with its own performance indicators in order to support its scope as the CPIA used by IDA are too broad (see the benchmark box below).

⁷⁴ This refers to (i) economic management (ii) structural policies (iii) policies for social inclusion and equity (iv) public sector management and institutions.

⁷⁵ Actual results in change in incidence rate from 2015 baseline to 2021 (using the latest published data from WHO/UNIADS - 2022 reports), A negative value indicates a reduction in prevalence rate, A positive value indicates an increase in incidence rate, 1=100%,

⁷⁶ Sources : [CPIA 2015 Criteria \(worldbank.org\)](https://www.worldbank.org/publications/cpiacriteria/), [CPIAFAQ2020.pdf \(worldbank.org\)](https://www.worldbank.org/publications/cpiafaq2020.pdf)

⁷⁷ Source: interview with the GFF



Country performance is the main determinant of IDA country allocations.

IDA resources are allocated thanks to the Performance-Based Allocation in per capita terms on the basis of a country's performance rating (CPR) and, to a limited extent, per capita gross national income (GNI). Use of the CPR ensures that good performers receive, in per capita terms, a higher IDA allocation —i.e., allocations are performance based.

The CPR is obtained by calculating a weighted average of the overall CPIA country rating, or IRAI, Clusters A-C average (24%), IRAI Cluster D average (68%) and the portfolio rating in the Bank's Annual Report on Portfolio Performance (ARPP) (8%). In other terms,

$$CPR = (0.24 \times CPIA_{A-C} + 0.68 \times CPIA_D + 0.08 \times PPR)$$

Where: $CPIA_{A-C}$ is the average of the ratings of CPIA clusters A to C; and $CPIA_D$ is the rating of CPIA cluster D. The PPR reflects the health of the IDA portfolio, as measured by the percentage of problem projects in each country.

IDA country allowance is then calculated using the formula below⁷⁸:

$$f = CPR^3 \times Population \times (GNI \text{ per capita})^{-0.125}$$



For more information on IDA's allocation, please refer to the **Annex 3.2** of the separate Annex document.

Sources : [CPIA 2015 Criteria \(worldbank.org\)](#), [CPIAFAQ2020.pdf \(worldbank.org\)](#)

The **interviews with the governance of the Global Fund revealed mixed opinions** on the integration of these two dimensions in the formula:

- ▶ **Regarding vulnerability**, several stakeholders considered that it was important to consider but were unsure whether this dimension could be encapsulated in an indicator which would respect the criterion of simplicity of the allocation methodology.
- ▶ **Regarding performance**, several stakeholders mentioned the need to incentivize performance more, while others were reluctant due to the fear that countries facing difficulties, such as insufficiently performant health systems, would be at a disadvantage.

Taking into account performance and vulnerability dimensions can however lead to significant changes in allocations across countries

Like other alternatives, these options present risks regarding the continuity of funding and the organization of current programs. Provision must be made for the gradual adjustment of Global Fund allocations to the countries that will be directly concerned, an essential transition phase to take into account the fact that

⁷⁸ [CPIA-FAQ-2020.pdf](#)

governments are often reluctant to anticipate and adjust to the contraction of external support, even if it has been announced⁷⁹. The implications for public finance management should not be underestimated.

5.3.5. Potential alternative on integrating performance parameters

What alternative was envisaged and why this alternative?

The alternative presented below consists in integrating a performance indicator into the formula. Based on the Evaluation findings, incorporating a performance indicator into the formula, in line with performance-based allocation methodologies and as supported by some stakeholders of the Global Fund⁸⁰, would increase equity by incentivizing and rewarding overall performance and health performance.

Two metrics would be appropriate to better account for countries overall and specific performance

Integrating performance indicators is part of the **current prevailing approach to aid allocation in both thinking and practice**.

The performance metrics currently incorporated in the qualitative adjustments contribute to accounting for this dimension, particularly the absorption rate indicator, implementation, and outputs indicators of the programs. However, it would be advisable to ensure that they are not highly correlated with each other or with other variables included into qualitative adjustments.

That said, the concept of performance *stricto sensu* refers to **the results obtained by a country in a specific field**, considering the initial situation and the external factors that influence these results alongside the policies implemented.

In addition to the elements of performance directly linked to Global Fund programs and included in the qualitative adjustments, two other dimensions of performance could be considered (cf. 3.4): one is a proxy for the overall quality of public policies, and the other is a specific indicator of the effort made by countries to finance health in parallel with Global Fund allocations.

The underlying rationale is that the results of programs supported by Global Fund are **not tightly insulated from their environment and that they do not depend solely on the effectiveness of government and health financing which directly concern the programs supported by the Global Fund or specifically concern the fight against the three target diseases**. HIV, TB, and malaria interventions are becoming less and less vertical, and more and more integrated into healthcare systems via what's going on in their building blocks⁸¹, whose influence they undergo to varying degrees. Health systems themselves are impacted by the features and implementation of most public policies.

From this standpoint, the above two indicators take into consideration two important dimensions that can have a significant impact on the achievement of the targeted goals of the Global Fund: the first at the macro level (quality of public policies), the second at the sectoral level (financial effort in favor of the healthcare sector). They are relatively unaffected by exogenous factors and **unlikely to induce counterproductive incentives**. Therefore, the Global Fund will **reward government achievements in areas that are important for program results although not specifically focused** on programs and on the fight against the three target pathologies.

Integrating a proxy for overall public policy quality through the Government Effectiveness indicator would incentivize country overall performance

⁷⁹ When the external partner withdraws on schedule, there are numerous examples of project or projects activities included in sectoral policies being halted for lack of resources, or because the authorities have not made the appropriate budgetary arbitrages in proper time.

⁸⁰ Source: Interviews.

⁸¹ Leadership and governance; service delivery; financing; workforce; products, vaccines, and technologies; health information system, (to use the WHO's nomenclature).

While an approach like Country Policy and Institutional Assessment (CPIA) would be appropriate, CPIA data are only available for a limited number of countries. In this context, it is therefore proposed to use the **Government Effectiveness indicator**⁸², calculated annually by the World Bank.

On top of the advantages mentioned above for incorporating performance, this indicator presents two specific advantages:

- ▶ The Global Fund funding tends to be carried out in countries which perform better in terms of control of corruption, government accountability, regulatory quality, and rule of law, but there is **no significant relationship between Global Fund financing and Government effectiveness**⁸³. This situation supports the suggestion to consider Government effectiveness clearly and effectively in Global Fund allocations to **encourage governments to improve governance as captured by the indicator**. In parallel, other potentially important elements to address certain country specificities can be considered if necessary in a qualitative adjustments type approach (e.g. including Challenging Operating Environments (COEs – particularly countries or regions that experience armed conflicts or civil unrest) with a view to contributing to maximizing health equity, gender equality and human rights in line with KPIs E1, E2, E3⁸⁴.
- ▶ Data are available online on the World Bank database and annually updated.

Box 6: Methodological note on government effectiveness indicator

Government Effectiveness "captures perceptions of:

- ▶ the quality of public services
- ▶ the quality of the civil service and the degree of its independence from political pressures
- ▶ the quality of policy formulation and implementation
- ▶ the credibility of the government's commitment to such policies.

Percentile rank indicates the country's rank among all countries covered by the aggregate indicator, with 0 corresponding to lowest rank, and 100 to highest rank. Percentile ranks have been adjusted to correct for changes over time in the composition of the countries covered by the World Governance Indicators 85".

Integrating an indicator of the effort made by the government to finance health policy would incentivize investments in the health sector

It is proposed to consider the evolution over three years of the **ratio of government health spending on domestic resources to discretionary spending**⁸⁶. This provides an indication of the government's health financing effort in a context where real domestic health expenditure is expected to plateau or contract until 2027 in most low-and middle-income countries (Kurowski *et al*, 2022)⁸⁷, and of fierce competition between health and other sectors, including the fight against global warming. This is an essential issue, as the intersectoral fungibility of health aid⁸⁸ is well established in the international literature (Mathonnat, 2022)⁸⁹, and

⁸² More specifically, it is suggested to use the percentile rank of countries for this indicator.

⁸³ Kavanagh and Chen (2019)

⁸⁴ Global Fund (2022), Key Performance Indicators (KPIs) Handbook for the 2023-2028 Strategy, October.

⁸⁵ World Bank definition from World Development Indicators database.

⁸⁶ In this context, discretionary spending would be measured by general government final consumption expenditure, thus excluding debt service.

⁸⁷ Kurowski C., Evans D., Tandon A., Eozenou P., Schmidt M., Irwin A., Cain J., Pambudi E., and I. Postolovska, (2022), From Double Shock to Double Recovery: Implications and Options for Health Financing in the Time of COVID-19. Technical Update 2: Old Scars, New Wounds. Washington, DC: World Bank.

⁸⁸ Fungibility refers to the possibility that aid is used in ways not intended by donors when disbursing the funds aid intended for crucial social and economic sectors may substitute for spending that recipient governments would have undertaken anyway.

⁸⁹ Mathonnat J. (2022), Fungibility and additionality of health aid: issues and implications for health and public policies, Policy Brief, European Union, Macro Helpdesk INTPA, Nov.

the WHO (2021)⁹⁰ has shown that the **budgetary priority given to health decreases in LICs when health aid increases**. Incorporating this indicator would help address this unintended consequence.

Data are available for countries eligible for Global Fund support (World Bank and WHO database) and are annually updated.

Integrating a composite index from health output indicators and impact indicators has also been considered

A composite index from health output indicators (ex: number of people put on antiretroviral drugs, number of workers in health sector), outcome indicators (rate of antiretroviral coverage), and impact indicators (change in disease prevalence), could also be considered, but their correlation with the variables included in the qualitative adjustments would have to be carefully examined beforehand. It is therefore not proposed to retain an index of this type, all the more so as crucial elements are adequately captured by KPIs P1, P2 and P3 addressing the issue "Contribute to Pandemic Preparedness and Response".

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The Global Financing Facility for Women, Children and Adolescents (GFF) established a tailored composite indicator to fulfil its mission.

Need combines following indicators and birth registration in an unweighted manner to form a **composite need score for each country** using the methodology from UNDP's Human Development Index:

- ▶ Maternal mortality ratio (deaths per 100,000 live births).
- ▶ Under-five child mortality (deaths per 1,000 live births).
- ▶ Percentage of children under five years of age whose height-for-age is below minus two standard deviations from the median of the WHO Child Growth Standards.
- ▶ Proportion of women aged 15–49 years who are married or in union and who have met their need for family planning.
- ▶ Percentage of HIV-positive pregnant women receiving antiretrovirals for prevention of mother-to-child transmission of HIV.
- ▶ Percentage of live births attended by skilled health personnel.
- ▶ Percentage of infants aged 12–23 months who received three doses of diphtheria/pertussis/tetanus vaccine).

In all cases, data were taken from international sources (the World Bank, WHO, UNICEF, and UNDESA).

The approach used to allocate IDA resources was built on and adapted to the GFF context, with need replacing the "Country Performance Rating" in IDA and the weighting of need and population adjusted. The resulting equation is:

$$f = \text{Need}^2 \times \text{Population}^{0.5} \times \text{Income}^{-0.125}$$

The GFF came up with a tailored indicator in order to fulfill its mission. The Global Fund could learn from this methodology in order to integrate a vulnerability and/or performance component to its allocation formula. This composite indicator would be tailored to the Global Fund's mission.

For more information on Gavi's allocation, please refer to **Annex 3.1** of the separate Annex document.

Source : Annex 8 - [untitled \(globalfinancingfacility.org\)](#)

5.3.6. Recommended changes regarding performance and their consequences

Recommendation and reasoning

It is recommended to better take performance into consideration by integrating two specific indicators into the allocation process.

⁹⁰ WHO (2021), Global expenditure on health: public spending on the rise? Geneva.

While the Global Fund's allocation methodology is currently mainly need-based, several organizations incorporate performance-based components, such as IDA, the concessional branch of the World Bank in their allocation formula. It is recommended that the following two indicators be taken into consideration:

- ▶ Government Effectiveness (three-year average) reflecting the quality of public policies (see Box 5 above)⁹¹
- ▶ The **evolution over three years of the percentage of discretionary public expenditure** that the government allocates to health, as a proxy for the financial effort made by the government in support of the health sector, so-called "merit" criteria supplementing need criteria.

The proposal here addresses several shortcomings in the current Global Fund's allocation process. The underlying rationale is that the achievements of programs supported by Global Funds are **not tightly insulated from their environment**. In order to take into consideration two important dimensions that can have a significant impact on the achievement of the targeted goals of the Global Fund supported programs, the two proposed indicators incorporate a **different, complementary** (and therefore non-duplicative) approach compared to what is captured by the current qualitative adjustments.

The data are available, and updated every year, their scope is clearly defined, they present an acceptable level of robustness, reflecting, in the case of health expenditure, the major efforts made by the WHO in recent years to improve data quality and comparability.

This recommendation cannot be acted on immediately and will require thorough additional analyses over the next cycle to be fully integrated. As for the recommendation related to economic capacity, the two-stage phasing (first, by including them in the qualitative adjustments, then in the formula) will enable the Global Fund to have time to carry out the necessary simulations, arbitrages, to choose the weight to be given to each element in the formula, identical or different (which cannot be done for the present exercise) and to measure the differences with the allocations resulting from the current process, in order to finalize the formula that will be retained for the next cycle.

Consequences of recommended changes regarding performance

The current allocation process includes qualitative adjustments that adequately take account of program performance dimensions. Adding a performance component incorporating a government effectiveness indicator and a government financial effort indicator for the health sector, within the qualitative adjustments first, and then in the allocation formula, aims at incentivizing countries to lead good governance in public policies and alleviate underfunding in the healthcare sector. This would favor the fight against HIV, TB, and malaria. This will have several consequences on the effectiveness, simplicity, efficiency, and sustainability of the allocation methodology.

Regarding effectiveness, adding a performance component will **increase the cost-effectiveness of the Global Fund's investments but not necessarily improve its focus** on countries with higher disease burdens or lowest economic capacity:

- ▶ Adding a performance component in the methodology **doesn't imply that funds will go to countries with higher disease burdens**. Indeed, if a country has a high disease burden but a government displaying poor public policies, the country would be disadvantaged by the performance component.
- ▶ Adding a performance component may **have an impact on the alignment with lowest economic capacity** but further analysis would be needed to assess this impact.
- ▶ This recommendation will allow a **better cost-effectiveness** of the Global Fund's investments as better performing countries will be awarded more funding.
- ▶ This recommendation decreases the simplicity of the methodology, as it takes into account additional important dimensions **increasing the complexity and preparation costs** of the review process.
- ▶ It does not impact the sustainability of investments except for the **continuity of services**.

Impact on overall timeline and steps in the process and possible challenges

⁹¹ If CPIA clusters cannot be made available for all countries eligible for GF support.

It is recommended that the two proposed indicators be taken into consideration in the process of allocating Global Fund financing to recipient countries in *two different stages*, for the *current and next cycle*.

In the next Grant Cycle (2026-2028):

- ▶ Integrate the two proposed indicators into qualitative adjustments, assessing their level of correlation with other existing variables.
- ▶ Carry out the necessary analyses with a view to integrating the two indicators into the allocation formula in the next cycle. This implies having made choices regarding the weightings to be given to each indicator and selecting a method for combining these merit elements in a global approach integrating capacity and vulnerability (needs) indicators.

For the following Grant Cycle:

- ▶ Integrate the proposed indicators into the allocation formula, thus ensuring "equal or homogenous treatment" for each country regarding the indicators under consideration, which is not the case if they are included within the qualitative adjustments. Including them in the formula therefore increases visibility and transparency and provides a signaling effect that encourages governments to take steps that will directly and indirectly enhance the effectiveness of Global Fund supported programs.
- ▶ Estimate their impact on the volume of allocations benefiting each country.
- ▶ Set up a transitional mechanism if the magnitude of the impact makes it necessary, in particular to avoid disruptions in funding that would undermine the continuity and coherence of the Fund's supported programs.

5.3.7. Potential alternative on integrating a vulnerability indicator

What alternative was envisaged and why this alternative?

The alternative presented below consists in integrating a vulnerability indicator into the formula. Based on the Evaluation findings, integrating a vulnerability indicator would increase equity by better accounting for countries' needs and respond to the demand of several stakeholders of the Global Fund for increased consideration of vulnerability⁹². Additionally, the selected indicators for vulnerability presented in this section respond to several quality criteria: minimizing moral hazard, avoiding the generation of bureaucratic costs, broad data availability, simplicity, and transparency.

A vulnerability indicator could reinforce the indicators of needs which are already considered in the current methodology but don't fully capture country economic capacity

Vulnerability can be defined as the risk that a country's health system will be permanently affected by exogenous shocks. It is currently considered at the qualitative adjustments stage by adjusting for **higher costs in challenging operating environments, as well as under "other considerations" of QA Stage 2**. Beyond the allocation methodology, the Global Fund also has an Emergency Fund which is included in catalytic investments. In light of the ongoing debates, it would be recommended that Global Fund also explore the need or possibility of considering a vulnerability index in its allocation formula. Reflections could be initiated on the form such an index would take, and simulations carried out to determine the likely impact of such a change. Some entities or institutions are already considering vulnerability in their allocation models:

- ▶ In 2014, for example, the European Commission adopted an allocation formula for the **European Development Fund** that included the vulnerability index used by the United Nations Committee for Development Policy for the identification and graduation of least developed countries (LDCs). A similar formula has been adopted for 2019-2020, supplemented by an environmental vulnerability index, to allocate resources for the new financial cooperation instrument for all countries identified on both a geographical and political basis.

⁹² Interviews

- ▶ Among the multilateral development banks, the **Caribbean Development Bank** has introduced a vulnerability criterion into its concessional credit allocation formula. The **Asian Development Bank**, as part of its ADF 13 resource allocation framework, grants economic vulnerability bonuses to SIDS eligible for ADF grants.

This increase in interest is related to the realization that indicators such as **GNI per capita are not sufficient to capture countries' economic capacity or ability to pay**, as it does not consider the risk of seeing this capacity collapse or of countries being caught in a poverty trap. It does not reflect the socio-economic challenges and characteristics inherent to vulnerable countries. Vulnerable countries are often faced with short-term contractions in national wealth due to economic and environmental shocks, particularly natural hazards. With the increasing frequency and severity of these shocks, such countries are becoming more exposed to long-term economic setbacks, requiring a broader, long-term allocation of resources to maintain or increase their economic capacity and thus meet their financial needs.

The aim of this additional indicator is **to strengthen needs indicators, by addressing the limitations of GNI per capita**. Adding a **vulnerability index to the GNI per capita would better reflect the needs of countries with low economic capacity**. Some countries with a relatively high level of income (due to distortions in the structure of their economy) are permanently under the influence of external environmental and economic shocks. Failure to take account of a country's vulnerabilities alongside per capita income as a factor of need can therefore compromise the long-term economic stability of these countries, with the possibility of a reversal of development gains. Thus, vulnerability as a need factor could be aimed at preventing the various structural risks to which countries are subject.

The interviews with the benchmarked organizations highlighted the implementation, at Gavi, of a special policy to address different types of vulnerability via **the Fragility, Conflict and Violence envelope** (see *benchmark box below*). The main advantages of this envelope are that it enables Gavi to seize opportunities and respond with greater agility to the dynamic needs of countries facing fragility, conflict, and violence.

The Fragility, Emergency and Displaced Populations Policy enables Gavi to adopt a tailored and practical support aimed at countries facing vulnerability in its various shapes.

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Additional Health System Strengthening funds may be provided under the Fragility, Emergency and Displaced Populations Policy⁹³. These funds are additional to the HSS ceiling amounts, and they represent 10% of the total HSS envelop. The funds are taken from the underspent resources and are not set aside from the start.

Those 10% are allocated to countries which are recognized as either facing chronic fragility, under an exceptional emergency or having to deal with a high burden of displaced population.

- ▶ **Chronic Fragility:** Set out prioritization criteria to determine which countries can benefit from a flexible, tailored approach to maintain and strengthen immunization coverage. Through differentiated support, countries experiencing chronic fragility challenges can systematically identify and reach zero dose children and missed communities with the full course of vaccines, as a critical step towards integrated Primary Health Care (PHC) and other essential services.
- ▶ **Acute Emergencies:** Provide timebound, flexible and timely support to protect lives in acute time-limited emergencies by sustaining routine immunization services and preventing increase in vaccine preventable diseases and outbreaks.
- ▶ **Displaced Populations:** Ensures the provision and suitability of Gavi's support to reaching displaced populations.

The Gavi's Fragility, Emergency and Displaced Populations Policy can be compared to the Global Fund's own fund directed towards vulnerable countries as it consists in setting aside funding dedicated to specific situations/contexts.

*For more information on Gavi's allocation, please refer to **Annex 3.1** in the separate Annex document.*

Source : Interview with Gavi, [Board Document Template \(gavi.org\)](https://www.gavi.org/documents/default.aspx?documentid=10244)

Several indices could be integrated to better account for vulnerability

⁹³ [Fragility, emergencies, and displaced populations policy \(gavi.org\)](https://www.gavi.org/documents/default.aspx?documentid=10244)

A number of principles or considerations need to be taken into account when developing and selecting the vulnerability index to be used in an allocation formula:

- ▶ The index should **minimize moral hazard and "counterproductive incentives"** by focusing on structural vulnerabilities, exposures to unavoidable risks and shocks, rather than policy-induced vulnerabilities;
- ▶ The index should be a composite index that builds on existing externally sourced indices to **avoid generating significant new bureaucratic costs** for the Global Fund;
- ▶ The index must contain indicators for which data are available for all countries eligible for Global Fund resources;
- ▶ All the components included in the index must be based on a foundation that is in line with the allocation methodology established. In addition, it should be adapted to the kind of resources allocated;
- ▶ The index must be established based on a consensus that integrates countries' points of view on the different sources of vulnerability;
- ▶ The index must be simple, understandable, and transparent.

With the growing prominence of vulnerability in international financing debates, several measures of vulnerability have been developed for use in resource allocation, in line with the principles outlined above. These include the UN's Economic and Environmental Vulnerability Index, the Caribbean Development Bank's Multidimensional Vulnerability Index, the Commonwealth's Universal Vulnerability Index, and the UN's Multidimensional Vulnerability Index (MVI).

The vulnerability indices used to allocate resources may vary from one entity to another, but must meet a certain number of common principles, such as those defined above. This is also the case for performance indicators, which may differ from one institution to another, even though they are very close.

Very few vulnerability indices possess the properties required for their use as resource allocation criteria. They can be used as such in their entirety or reconstituted to best suit the objectives of the Global Funds. Candidate indicators include:

- ▶ **The United Nations Economic and Environmental Vulnerability Index.** This is a simple index used alongside the GNI per capita and the Human Assets Index (HAI) to identify and graduate LDCs. Data are available for a large number of developing countries (142), with conceptual and technical reviews carried out by the UN Committee for Development Policy every three years. The index is already used by some entities in their resource allocation. The United Nations General Assembly invited development partners to consider the index as one of the criteria for allocating their resources⁹⁴. The European Commission has adopted it in its European Development Fund resource allocation formula. The Asian Development Bank, as part of its ADF 13 resource allocation framework, grants bonuses to eligible SIDS on the basis of the economic and environmental vulnerability index.
- ▶ **Both the United Nations Multidimensional Vulnerability Index (MVI) and the Commonwealth Universal Vulnerability Index (UVI)** cover a large sample of developing countries (142 and 138 countries respectively). Both are composite indices made up of relevant indicators with very good properties for use in an allocation formula. However, the large number of indicators does not facilitate their use for specific allocations.
- ▶ The Global Fund, based on a consensus with the countries, could nevertheless draw on or select a few indicators that could be used to allocate its resources. Specialized agencies such as IFAD consider in their allocation formula a multidimensional vulnerability index (with a significant weighting) that incorporates the dimensions of climate change, food security, nutrition, and inequality to ensure that vulnerable countries receive higher allocations. As a performance index, IFAD uses a weighted average of two indices: Portfolio rating (PORT) and Rural Sector Performance rating on policies and institutions for rural development (RSP), with greater weight given to the PORT.

⁹⁴ Resolution A/C.2/67/L.53 of December 4, 2012

5.3.8. Recommended changes regarding vulnerability and their consequences

Recommendation and reasoning

It is recommended to integrate a vulnerability index in the methodology.

Integrating a vulnerability index in the methodology addresses several shortcomings while being relatively acceptable:

- ▶ Adding a vulnerability component would allow to complement the economic capacity indicator and address some of its shortcomings; namely, that it does not consider the exposure of countries to economic, political, epidemiological, and climatic risks.
- ▶ While some Global Fund's stakeholders were in favor of the inclusion of a vulnerability component, others discarded it as too complex.
- ▶ Adding a vulnerability component would improve equity considerations, as it would allow to account for the exposure of countries to risk.
- ▶ Taking vulnerability into account directly in an allocation formula, through a simple and understandable index, would be beneficial in reinforcing the transparency that is one of the hallmarks of good resource allocation.

The growing debate on vulnerability as a criterion for eligibility and resource allocation should not be overshadowed by Global Fund. While more and more voices are being raised in favor of including a vulnerability index in allocation, there is less consensus when it comes to using any particular index. That's why, given the importance but complexity of the concept, it's important for Global Fund to conduct such an exercise smoothly; starting, for example, by first establishing the principles as well as the theoretical and conceptual foundations of the index; then proceeding to the choice of variables (reliable and available) which are in line with the pre-defined framework. The whole process should be transparent and inclusive to ensure its acceptance.

The inclusion of vulnerability in the Global Fund allocation formula is not expected to happen any time soon. Global Fund might, on the other hand, embark on a long reflection on the relevance of such a recommendation, as well as on the characteristics and methodology of the index construction. Given that any change in an allocation formula implies winners and losers, this exercise could be complemented by an analysis of the potential impact of the chosen (or constructed) index on the distribution of allocated resources.

Consequences of recommended changes regarding vulnerability

Including an index of structural vulnerability in an allocation formula has several positive consequences:

- ▶ It ensures **greater equity** in opportunities, by factoring in countries' structural handicaps.
- ▶ It would act as a stabilizer by **strengthening prevention and structural resilience**, which would be more effective than ex-post shock compensation.
- ▶ Finally, the inclusion of a vulnerability index directly in the allocation formula **avoids multiple discretionary exceptions**, windows and special ex-post adjustments that have been considered by interviewees to have limited impact

The impact of including a vulnerability index to address the limitations of the GNI per capita in addressing country needs should **depend primarily on the way in which the two factors are combined**. The method of calculating the average (geometric or arithmetic) between these two variables is important, and involves a political choice by the Global Funds between two solutions:

- ▶ Whether the impact of vulnerability on the measurement of needs should decrease as the GNI per capita increases, so as to guarantee a certain allocation to poor countries, many of which are also highly vulnerable (geometric average).
- ▶ Whether the two variables should be perfectly substitutable (arithmetic average)

If vulnerability is well combined with GNI per capita (with a respective weight for each parameter to be determined), it will **not be at the expense of low-income countries**, especially if the modeling exercise shows that the lower the GNI per capita, the greater the marginal impact of vulnerability. Nevertheless, given the

heterogeneity within different groups of countries or incomes, it's worth keeping a more attentive eye on the allocation or change in allocation at country level.

The impact of taking vulnerability into account in the allocation will also depend on the Global Fund's priorities, which will be reflected in the allocation formula in the weights given to needs factors and performance factors. This can be determined through simulations if data for all countries is available. For example, a study⁹⁵ on the impact of the inclusion of vulnerability on the allocation of the African Development Fund showed that, given a constant envelope and by suitably adjusting the parameters, it was possible to **allocate more resources to the most vulnerable countries without giving less to the best-performing countries**; the adjustment being made in particular by a reallocation between the best-performing but vulnerable countries and the best-performing but less vulnerable countries.

Incorporating a structural vulnerability dimension into the allocation process necessarily **increases complexity, but is not detrimental to transparency**, as long as the methods for taking into account the construction of the index and its inclusion in the formula are clearly explained. Moreover, incorporating vulnerability in the formula rather than in the qualitative adjustments has the advantage of allowing it to be taken into account in a uniform manner in each country.

Impact on overall timeline and steps in the process and possible challenges (Q9)

It is recommended that the indicator be taken into consideration in the process of allocating Global Fund financing to recipient countries in *two different stages*, for the *current and next cycle*.

For the next Grant Cycle (2026-2028):

- ▶ Decide on the composition of the vulnerability index, the coefficients to be assigned to each component and the method of calculation according to the Global Fund's priorities and carry out scenarios estimating their impact on the amount of country allocations.
- ▶ Estimate different ways of combining the chosen index with the other elements of the allocation formula.

For the following Grant Cycle:

- ▶ Introduce the index and the combination methods selected into the calculation formula. Set up a transitional mechanism if the magnitude of the impact makes it necessary, in particular to avoid disruptions in funding that would undermine the continuity and coherence of the Fund's supported programs.

6.3. Scale-up/paced reduction mechanism

The scale-up/paced reduction mechanism supports the principle of continuity which has been endorsed by all the stakeholders interviewed. It meets practical implementation needs. This step was updated in 2022, with a refinement of two parameters:

- ▶ The **movement of funds**, which was set at 7.5% of the total funding available for country allocation (from US\$800 million limit previously)⁹⁶
- ▶ The **paced reduction components**, which was set to a maximum of 90% of previous funding levels (from 75% previously)⁹⁷

Why is no alternative suggested?

While there is no alternative that aims at reviewing the scale-up/paced reduction mechanism itself, a renewed use of the scale-up/paced reduction mechanism has been integrated in the GDS recommendations.

These modifications allow for more accurate implementation of the intention of this step in all funding scenarios. The step is currently recognized for its role in the implementation of the principle of continuity which is endorsed by all the stakeholders interviewed.

⁹⁵ Guillaumont, P., Jeanneney, S. G., & Wagner, L. (2020). Measuring vulnerabilities to improve aid allocation, especially in Africa. FERDI, 155p.

⁹⁶ Source: Global Fund.

⁹⁷ Source: Global Fund.

6.4. Qualitative adjustments

Summary of findings

Qualitative adjustments are an important step which is instrumental in ensuring the flexibility of the methodology.

Stage 1 ensures more equity in HIV allocations by considering key populations. It is effective at counterbalancing the limitations of the disease burden formula used for HIV, which does not accurately reflect the needs of countries with small populations, nor of countries with limited prevalence due to successful programs. Due to the lower quality of the data used and the complexity of the analysis, it is justified for this analysis be included in qualitative adjustments only.

Stage 2 refines the analysis of the needs of recipient countries by allowing a more detailed analysis for needs at country level, for instance by considering vulnerability, human rights, and gender. It also incentivizes performance by conserving program performance and absorption; in doing to, it supports the effectiveness of the Global Fund's interventions.

Qualitative adjustments play an important role in ensuring the flexibility of the methodology and refining the analysis of needs while accounting for the effectiveness of interventions.

An important qualitative step which is instrumental at ensuring the flexibility of the methodology

The last step of the methodology, the qualitative adjustments represent the **only part of the methodology, which is not considered formulaically**, with catalytic funding scenarios. As such, they represent the most discussed step with catalytic funding scenarios and the Qualitative Adjustments stages have often been considered as a “black box” according to several stakeholders interviewed. By balancing the mathematical and rigid nature of the formula with additional detailed country-level information, they provide a **necessary complement to the formula and bring flexibility and accuracy to the methodology**.

The drawback of this approach is that this step is not as **objective and transparent** as other steps included in the formula. The following steps are taken to ensure an adequate level of transparency:

- ▶ The Strategy Committee approves the process for the Qualitative Adjustments
- ▶ All adjustments and rationales are reported to the Strategy Committee

While key and vulnerable populations are already considered through disease burden indicators as part of the general population, qualitative adjustments allow the Global Fund to advantage countries with large key populations and/or key populations with high HIV prevalence, in line with the second objective of the Global Fund's allocation methodology. This qualitative adjustment ensures that certain limitation factors (stigma, criminalization, and discrimination) are taken into account to facilitate access to health services.

Qualitative adjustments are made in two stages:

- ▶ Stage 1 aims to refine epidemiological contexts as needed
- ▶ Stage 2 aims to provide a comprehensive adjustment, considering key epidemiological, programmatic, and other relevant contextual factors

Stage 1 ensures more equity in HIV allocations by considering key populations

The first stage of the Qualitative Adjustments is actually a formulaic adjustment, informed and based on data. According to interviewees, there are two main reasons why this first stage is formula-based:

- ▶ In 2017, some constituencies expressed concerns on the key populations' adjustment, as the HIV burden metric (PLHIV) is known to under-represent the burden of HIV in key populations in concentrated and mixed epidemic settings. It was therefore decided to add them into the qualitative adjustments.
- ▶ While this stage is formulaic, the data is of comparatively lower quality than the data used for the disease burden indicators.

The separation of the disease burden analysis between technical parameters and qualitative adjustments is useful to increase the clarity and transparency of the first part of the methodology while allowing for refinements at the qualitative adjustment stage.

For HIV, it effectively counterbalances the limitations of the disease burden, which is based exclusively on the number of persons living with HIV. As a result, the disease burden indicator for HIV included in technical parameters may not reflect the needs for several situations, in particular the following:

- ▶ **Countries with small populations**, where key populations may be disproportionately affected;
- ▶ Countries which limit prevalence due to **successful prevention programs**.

In order **not to disincentivize prevention and account for key populations**, Stage 1 adjusts the allocation depending on the proportion, and size estimate of two largest key population groups⁹⁸. New infections estimates among key populations are also considered although this indicator is given a smaller weight, to account for expanding incidence among key populations.

Stage 1 adjustments are **directly based on recommendations made by technical partners in the cyclical review process**. These adjustments are not relevant for all diseases. For the 2023-2025 cycle, this stage **focused on HIV only** for several reasons:

- ▶ **With regards to TB, there is, at this stage, little subset of population to be considered** for key populations (others than prisoners and incarcerated populations, people living with HIV, migrants, refugees, miners, and people who work in poorly ventilated conditions, and indigenous populations). The TB community still needs to agree upon a list of populations they define as key and which they want to consider, based on data. However, the data is limited and not regularly collected.
- ▶ For Malaria, **technical partners did not recommend a qualitative adjustment to refine the epidemiological context** as they did not find it relevant. An adjustment was included for malaria for the 2017-2019 cycle⁹⁹, but was removed for the 2020-2022 cycle as analysis showed that it may have led to excessively steep reductions for countries with low endemicity of malaria¹⁰⁰.

A second stage which refines the analysis of the needs of recipient countries and accounts for the effectiveness of interventions

Some contextual factors **refine elements which are to some extent already considered formulaically**, by allowing **a more detailed analysis for needs at country level**: economic capacity, incidence, and mortality¹⁰¹ (disaggregated by sub-population and sub-national levels where possible), and coverage gaps (which is considered only at the global level through the GDS in the formula). Other contextual factors account for **performance** (through program performance, absorption), and to some extent **vulnerability** (through indicators related to challenging operating environments).

The **integration of Human Rights and Gender** considerations is a good example of the refinement of the analysis of countries' needs through the Qualitative Adjustments. This demonstrates the Global Fund's willingness to recognize that the Human Rights environment and gender norms may influence the level of impact of its intervention. The objective is indeed to focus on scaling up programs to remove the impact of barriers, by including in the eligible programming a range of interventions specific to Human Rights. In this context, the Qualitative adjustments represent an effective answer to navigate this ethical space and incentive countries showing positive signs in terms of gender of Human Rights based on metrics (indices on Human Rights environments).

⁹⁸ Key populations groups may be sex workers, people who Inject drugs, men who have sex with men, transgender people. Source: Global Fund data.

⁹⁹ The stage 1 adjustment for malaria consisted in the application of a cap of \$6 per person at risk for countries with population at risk of less than 1 million, to account for settings with low endemicity of malaria.

¹⁰⁰ Source: Global Fund, Interviews with Technical partners.

¹⁰¹ For HIV, these factors are not considered formulaically.

Why is no alternative suggested?

No alternative is suggested as there is no evidence that qualitative adjustments need to be modified. However, it shall be noted that the Qualitative Adjustments have oftentimes been considered as a "black box", as explained under the next section on the overall cyclical review process.

7. Cyclical review process

Q10: To what extent are the quality assurance mechanisms built into the overall allocation methodology process, effective in ensuring that high-level decisions on resource allocation are informed by robust and rigorous technical parameters, metrics, and inputs (including the latest epidemiological data)? How, if necessary, can quality assurance mechanisms be strengthened in advance of the next and subsequent allocation periods?

Methodological introduction

The answer to this question mainly relied on interviews, a thorough documentary review, as well as process mapping and analysis. Benchmarking was also enlightening and useful to collect best practices and suggest recommendations to improve the effectiveness and efficiency of the process. More specifically, the following was assessed:

- ▶ *The quality and exhaustivity of the documentation and communication regarding the review process shared with stakeholders (documents, policies, procedures, historical performance data, and feedback from other stakeholders);*
- ▶ *The understanding of the entire process and of each key steps by the stakeholders (clear and comprehensive material allowing for informed decision making, Q&A sessions);*
- ▶ *The timelines for consultations, discussions, and decisions;*
- ▶ *The perceived strengths, inefficiencies, pain points, and bottlenecks of the current review process;*
- ▶ *The clear definition of roles & responsibilities, engagement and collect system of opinions of the stakeholders.*

Summary of findings

Several quality assurance mechanisms contribute to the overall approval of the allocation methodology process, such as the intervention of technical partners, the important degree of formalization and documentation of the process, the transparency of allocation criteria, the high level of preparation of the Secretariat, and positive interactions with the Board and the SC. Criticisms have nonetheless been expressed regarding the opacity of the Qualitative Adjustments (QA) stages, which are often considered as a “black box” according to Technical Partners. Additionally, due to the length of the process and its division between various steps, Board and SC Members may lack the ability to consider the methodology holistically. Opportunities to deep dive and consider important modifications could also contribute to increase the ability of the process to address the shortcomings of the allocation methodology.

Several quality assurance mechanisms contribute to the overall good acceptance of the allocation methodology process

Overarchingly, the vast majority of interviewees has considered the overall cyclical review process as a rigorous, well-communicated and transparent process (even in comparison to other international organisations, according to some technical partners). Several quality assurance mechanisms contribute to this overall good acceptance of the allocation methodology process:

- ▶ **The legitimacy of the technical partners** and the nature of the tools and processes used contribute to a transparent data gathering and effective use of independent expertise. The intervention of technical partners at key points of the process, namely for disease burden indicators and qualitative adjustments, **guarantees the inputs are technically sound and can be trusted by Board and SC Members**, even for disease and key points they don't specialize in. As such, the inputs of technical partners help create a common ground which can be trusted by all stakeholders.
- ▶ **The degree of process formalization and documentation** enable a clear view of the different steps of the methodology, of its timeline, and of the distribution of roles and responsibilities between

stakeholders. The interviews conducted throughout the Evaluation have shown a good understanding of the process of the allocation methodology.

- ▶ **The high level of preparation of the Secretariat supports the robustness of the process:** The Secretariat thoroughly prepares documentation to ensure that Board and SC Members have access to the necessary information. The **amount, level of detail and timeliness of information provided to Board and SC Members is adequate** and allows key stakeholders to make relevant decisions.
- ▶ **Good quality of interaction with the Board and the SC.** During the interviews, the Board and Strategy Committee members praised the quality of the debates occurring during the cyclical review process. They reassessed their trust towards the Secretariat concerning the quality and level of available documentation and regarding the relevance of it.
- ▶ More specifically, the allocation methodology is based on **transparent allocation criteria** that are known and well-accepted by stakeholders. Transparency is one of the Global Fund's key principles and has been recognized by stakeholders as one of the main advantages of the allocation methodology. The transparency of the allocation criteria however does not exclude an undoubtable level of complexity, that can ultimately limit the readability and comprehensibility of the resource allocation methodology.

It is important to note that decisions on investment do not end solely at the end of the Allocation Methodology as **there are other levers used by the Global Fund during Grant Implementation to ensure flexibilities and response to unexpected events and changes:** for example, thanks to grant flexibilities, countries were allowed to meet immediate COVID-19 response demands (either by using up to 5% of their grant value where there were savings, and/or reprogramming up to 5% of the value of a grant).

■ **The functioning of Qualitative Adjustments supports the efficiency of the process at the expense of its transparency**

Within this process however, the Qualitative Adjustments stages have often been considered as a “black box” according to Technical Partners. For instance, while UNAIDS is engaged into Stage 1 of the Qualitative Adjustments by providing data on population estimates, other stakeholders regret only seeing the “end result” of those qualitative adjustments. Very single change made in QA is reported to the SC (of which the technical partners are members), and all changes over 5m and 15% are reported to the entire Board along with their rationales. Despite noticeable effort from the Secretariat to provide partners with more transparency, the opacity of the Qualitative Adjustment stages has been brought up by most of the interviewees, especially since this step of the methodology provides the opportunity to take into account donors' priorities and agendas. The confidentiality of the qualitative adjustment process and its concentration on a few days however support the efficiency of the methodology.

■ **While the process is timely, having a holistic view of the allocation methodology remains challenging for Board and SC Members**

Due to the **important amount of information and the length of the process**, it may be difficult to connect the different items to be discussed and analyze the background of the methodology thoroughly. Board and SC Members have additional needs regarding the review process:

- ▶ **A need for a more holistic approach.** Due to the length of the process and its division into separate recommendations and decisions depending on the step of the methodology considered, Board and SC Members may lack the ability to consider the methodology holistically.
- ▶ **A need for opportunities to deep dive and consider important modifications.** The timing may make it challenging for some Board Members to deep dive on specific methodological issues and consider implementing important modifications.



IDA's review of the process depends on the content of discussions.

IDA's Performance-Based Allocation formula is discussed with the Deputies and then go to the Board for approval, even though a review of the methodology occurs each cycle, some parts of the methodology do not re-open systematically.

In fact, the core components of the formula are reviewed only when the Board or the Deputies show a big appetite in re-opening those subjects.

Thus, the review only occurs when needed and this ensures:

- ▶ A stronger predictability at the country level of the allocated amounts as the formula does not necessarily changes from a cycle to another.
- ▶ A certain efficiency of the process as is reviewed only what is needed to be reviewed.

The review process of the Global Fund's allocation methodology, which takes place on a 3-year basis, is more thorough than the IDA's one as it is systematic. While it allows the Global Fund to adapt and adjust its methodology, it is very time consuming.

Source: Interview with IDA

8. Final conclusion and recommendations

The objective of this independent Evaluation was to assess the adequacy of the Global Fund's current resource allocation methodology and challenge the robustness of its different steps and processes, in order to identify alternatives and propose recommendations that may result in greater impact of the Global Fund's investments and more effective delivery of its Strategy.

To do so, the Evaluation Team has answered **retrospective questions** that aimed at dissecting the different steps and processes of the resource allocation methodology and evaluate their adequacy to meet the Global Fund's objectives. This assessment was supported by the collection of stakeholders' viewpoints and by sound data analyses. It found that the evolution of the Global Fund's resource allocation methodology has demonstrated over the past cycles a **constant willingness to review, challenge, evolve and search for improvements** to update the resource allocation methodology and reinforce its contribution to the Global Fund's principles and objectives. Each step of the allocation methodology (whether it concerns the catalytic investments, the Global Diseases Split, the Qualitative Adjustments) have proven relevant to support the organisation's strategic vision but also pragmatically accomplish and deliver its mission at country level. For instance, as a global institution, the challenge is to **balance local and specific expectations and overarching principles (including transparency, predictability, among others)**. The allocation approach is not immune to the effects of that exercise, and the Evaluation found that Global Fund's allocation methodology overall relevantly aims at supporting its strategic vision at global level and accomplishing its missions at country level.

With regards to the effectiveness of the current resource allocation methodology, areas of improvement have however been identified and **a set of recommendations** has been elaborated. The recommendations detailed throughout the report and summarized below have been built on the main findings of this Evaluation and are the result of an exhaustive triangulation process (based on the different data collection tools deployed throughout the Evaluation). The benchmarks with other international organisations (*as seen in **Annex 3** of the separate Annex document*) have also enabled a comparative approach that helped identify the best practices and shaped pragmatic and realistic recommendations. It is important to note that these recommendations are the sole responsibility of the Evaluation Team.

In accordance with the Global Fund's guidelines¹⁰² when it comes to formulating recommendations, recommendations have been categorized into three different types, as summarized below:

- ▶ **Critical Recommendations**, when the implementation of the recommendation is essential and necessary to achieve the Global Fund's Strategic Objectives;
- ▶ **Important Recommendations**, when the recommendation needs to be prioritized for the Global Fund to enhance the delivery of its Strategy;
- ▶ **Possible Considerations**, when the recommendation should be anticipated by the Global Fund when changes are likely to be required in the near future.

¹⁰² A Guidance document has been provided to the Evaluation Team under the title "Formulating Recommendations in Global Fund Independent Evaluations Guidance for Evaluators."

Table 4: Overview of recommendations

Step	Findings	Timeline
GDS	<p><u>As regards keeping or not a GDS:</u></p> <p>► Recommendation 1: It is recommended to keep an upfront GDS as the second step of the allocation methodology to divide funding between the three diseases, as the evaluation found it brings more benefits than drawbacks. Its relevance and utility were confirmed to facilitate the strategic management of expectations from donors and better take account of global health landscape which has some disease-specific features. An alternative methodology with no GDS (Alternative 1) would threaten the continuity of services and decrease transparency for donors and countries. It would increase the complexity of the methodology, as it would require the definition of an alternative disease burden indicator uniting the three diseases under common metrics, which might lead to an implied GDS. Finally, alternative methods without a GDS would not guarantee the alignment of the methodology on its objectives to fight the three diseases and align on the highest disease burden, considering the shortcomings associated with the available indicators allowing comparison across the three diseases.</p>	<p>Critical Recommendation</p> <p>This recommendation is short-term and applies to all future allocation cycles</p>
	<p><u>As regards the approach for deciding on the GDS:</u></p> <p>► Recommendation 2: It is recommended to ensure decision made on the GDS for each allocation cycle is systematically informed by technical and scientific evidence on the relative needs of each disease. Although the final decision on GDS might not be aligned with the result of such analysis, it is recommended to ensure the Board is systematically provided with updated analyses on trends and that the GDS is updated to avoid any growing gap with the evolution of the epidemiological landscape.</p> <p>Ideally, it is recommended the technical and scientific evidence is provided by the Secretariat supported by external technical partners which could be those involved in the determination of 2013 initial split (IHME, HEARD and Imperial College). Alternatively, it is recommended to run, as a minimum, the approach proposed under alternative 3.</p>	<p>Critical Recommendation</p> <p>This recommendation is short-term and applies to all future allocation cycles</p>
	<p>► Recommendation 3: It is also recommended to explore new types of evidence that could feed into debates on the best GDS and make a stronger use of prospective analytical capacities to take account of future and longer-terms needs. Several board members have recommended to make the GDS relies on more investigation and anticipation capacities (and includes some of the analyses considered only at a later stage of the allocation methodology, i.e., during the qualitative adjustments.</p>	<p>Potential consideration</p> <p>This recommendation is medium-term</p>
	<p><u>As regards the criteria used to decide on the GDS:</u></p> <p>► Recommendation 4: There is an urgent need to adjust the current GDS to better reflect the epidemiological situation and re-balance the distribution of funding across the 3 diseases to give more weight to TB. Indeed, WHO DALYs, IHME DALYs, WHO and HIME DALYs weighted by income and</p>	<p>Critical Recommendation</p> <p>This recommendation is</p>

Step	Findings	Timeline
	<p>number of deaths all show that TB has a share of burden higher than 18%. Therefore, whatever the level of replenishment (higher or lower), re-balancing the distribution of funds would imply a proportionate redistribution of funds so as to reduce the gap between the share of funding allocated to each disease and the respective weight of each disease in the epidemiological landscape (what is suggested for TB could therefore apply to HIV or Malaria, depending on the epidemiological context).</p>	<p>short-term and applies to the next allocation cycle</p>
	<p>► Recommendation 5: Ideally, the GDS shall be aligned with the scientific evidence on the relative needs of each disease and reflect as much as possible the result of a systematic approach similar as the one suggested under alternative 3. However, implementing such an approach cannot be envisaged in the short term as it would highly threaten the continuity of services in most countries and have a negative effect on lower-income countries. It is thus recommended to revise the GDS incrementally over several allocation cycles to ensure it increasingly reflects the epidemiological landscape.</p> <p>In this context and also considering it is not realistic to expect that decision on GDS is not influenced by any political considerations, it is recommended to follow an approach similar to alternative 2 (and/or the one that was applied during the 2023-2025 allocation cycle with a revised threshold), with a particular attention to be paid to the need to ensure a stronger alignment of the GDS with the epidemiological landscape cycle after cycle.</p>	<p>Important Recommendation</p> <p>This recommendation is short-term and applies to all future allocation cycles</p>
RSSH	<p>► Recommendation 6: It is recommended to define a certain percentage of country allocations to be dedicated to RSSH, communicated together with the indicative disease split, yet based on a country-by-country adaptation. To incentivize tailored RSSH investments at country level, such target percentages, together with qualitative recommendations, would be tailored to country contexts recommendations based on the historical data and qualitative considerations and should be systematically added to the allocation letters. This would address the need of compensating for the lack of advocacy in favor of RSSH in certain countries, especially within CCMs.</p> <p>Instead of a single fixed percentage, it could be preferable to determine a range of percentage, with a baseline (indicative minimal percentage to be dedicated to RSSH investments) and a target (preferable percentage to be reached). The benchmark with the Global Financing Facility (GFF) has indeed underlined the numerous advantages of determining a range rather than a point estimate for each country. It maximizes the fund's ability to be flexible, to incentivize financing from external and domestic resources and to respond to changing external circumstances.</p> <p>The implication and directionality on the suggested percentage would be the following: countries with weaker health systems would be incentivized to dedicate a larger share to RSSH.</p> <p>The determination of the range should be done for every country, based on a qualitative process including the following aspects:</p>	<p>Important Recommendation</p> <p>This recommendation is short-term and applies to all future allocation cycles</p>

Step	Findings	Timeline
	<ul style="list-style-type: none"> Country needs (health workforce, supply chain and health information) National priorities Historical levels and types of investments in RSSH Proportion of Global Fund financing invested in RSSH Other contextual factors <p>Such approach would ensure RSSH is prioritized at country level whilst ensuring that actual trade-offs decision between diseases and RSSH is taken at the right level</p>	
	<p>► Recommendation 7: Moreover, it is recommended to use, for every country, a more precise wording in the allocation letter to incentivize appropriately RSSH investments:</p> <ul style="list-style-type: none"> Continue to give an overall judgment on the level of effort to be carried out: maintain / increase the financial effort dedicated to RSSH (in alignment to the range of percentage determined above) Include type of RSSH interventions to be implemented by level of priority and link to the three diseases. Whilst allocation letters for RSSH priority countries (for the 2023-2025 allocation period) already include suggested RSSH priority areas for investment based on country context, we suggest systematizing this approach and include bespoke suggested areas for RSSH for every country. 	<p>Important Recommendation</p> <p>This recommendation is short-term and applies to all future allocation cycles</p>
Technical Parameters	<p><u>As regards complementing GNI pc with a public revenues pc indicator that better captures governments ability to finance health policy from public resources (public revenues within the government budget minus interests on PPG deb, per capita)</u></p> <p>► Recommendation 8: It is proposed to complement it with an indicator of public revenues within the government budget minus interests on external public or publicly guaranteed (PPG) debt, per capita, incorporated into the technical parameters. This indicator is a proxy for a country's capacity to dispose effectively of revenues that can potentially be used to finance health policy without any prejudice to the sustainability of the government's financial position. It refines the way in which economic capacity is taken into account in the allocation of Global Fund investments.</p> <p>The indicator is simple to calculate. The necessary three-year forecast data are not currently available online for all countries eligible for Global Fund support but they are readily available from government authorities. Data are updated on an annual basis and present an acceptable level of reliability (the best currently available).</p> <p>The indicator would be taken into consideration in two stages, different for the current cycle and the next one :</p>	<p>Potential Consideration</p> <p>This consideration recommendation is short and medium-term</p>

Step	Findings	Timeline
	<p><i>In the next cycle (2026-2028):</i></p> <ul style="list-style-type: none"> ● Integrate the public revenues per capita adjusted for PPG debt interests indicator into the qualitative adjustments. ● Calculate the indicator for eligible countries by requesting the necessary data for the coming years (public revenues, PPG debt interests) from the country's authorities via the CCM. ● Calculate rankings for GNI pc and the adjusted indicator. ● Consider an additional allocation for countries whose rank for the adjusted indicator will be much lower than that of the GNI pc. <p><i>In the following cycle (2029-2031):</i> Integrate the adjusted indicator into the formula for calculating allocations in conjunction with the GNI pc and the vulnerability indicator(s) (see below), depending on the method and coefficients assigned to each. Integrating the proposed indicator into the allocation formula is ensuring equal or homogenous treatment for each country regarding this indicator, which is not the case if it is included within the qualitative adjustments, and therefore increases visibility and transparency in the methodology.</p> <p>The proposed two-stage phasing (first in the qualitative adjustments for the next cycle, then in the formula) will enable the Global Fund to have time to carry out the necessary simulations, to choose the weight to be given to each element in the formula, identical or different (which cannot be done for the present exercise) and to measure the differences with the allocations resulting from the current process, in order to finalize the formula that will be retained.</p> <p><u>As regards integrating a performance indicator:</u></p> <ul style="list-style-type: none"> ▶ Recommendation 9: In addition to the current program-focused performance indicators included in the Qualitative Adjustments, the Evaluation recommends incorporating into the allocation process two indicators capturing performance in two important dimensions in which Global Fund-supported programs operate and which are likely to have an impact on program results. While the Global Fund's allocation methodology is currently mainly need-based, several organizations incorporate performance-based components, such as IDA, the concessional branch of the World Bank in their allocation formula, because programs are not insulated from the environment in which they operate. The proposal here, in line with an approach based on so-called "merit" criteria supplementing need criteria, addresses two shortcomings in the current Global Fund's allocation process. <p>It is recommended that the following two indicators be taken into consideration the two following criteria as they capture performance in two important dimensions in which Global Fund-supported programs operate and which are likely to have an impact on program results. Their consideration (as an incentive for action)</p>	<p>Potential Consideration</p> <p>This recommendation is short and medium-term</p>

Step	Findings	Timeline
	<p>is intended to encourage countries to move forward in these two dimensions, which are important for the programs supported by the Global Fund:</p> <ul style="list-style-type: none"> ● Government Effectiveness (Quality and implementation of public policies); three-year average. ● The evolution over three years of the percentage of discretionary public expenditure that the government allocates to health, as a proxy for the financial effort made by the government in support of the health sector, so-called “merit” criteria supplementing need criteria. <p>The required data are easily available, their scope is clearly defined, they present a fair degree of quality and robustness and are updated every year.</p> <p>As for the recommendation related to economic capacity, the two-stage phasing will enable the Global Fund to have time to carry out the necessary simulations, to choose the weight to be given to each element in the formula, identical or different (which cannot be done for the present exercise) and to measure the differences with the allocations resulting from the current process, in order to finalize the formula that will be retained for the next cycle.</p>	
	<p><u>As regards integrating a vulnerability index:</u></p> <ul style="list-style-type: none"> ▶ Recommendation 10: It is recommended that a vulnerability index be taken into consideration in the process of allocating Global Fund financing to recipient countries. The composition of the vulnerability index will require further analysis during the next cycle. ● Adding a vulnerability component would allow to complement the economic capacity indicator and address some of its shortcomings; namely, that it does not consider the exposure of countries to economic, political, epidemiological, and climatic risks. ● Adding a vulnerability component would improve equity considerations, as it would allow to account for the exposure of countries to risk. ● Taking vulnerability into account directly in an allocation formula, through a simple and understandable index, would be beneficial in reinforcing the transparency that is one of the hallmarks of good resource allocation. 	<p>Potential Consideration</p> <p>This recommendation is long-term</p>

