Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Twenty-First Board Meeting
Geneva, 28-30 April 2010

GF/B21/11
Decision

PRIORITIZATION FOR ROUND 10

OUTLINE:

1. This report summarizes the recommendations of the Policy and Strategy Committee (PSC) on revisions to the existing prioritization principles for Round 10 approved proposals.

PART 1: INTRODUCTION

1.1 The Global Fund prioritization principles (which are described in the Comprehensive Funding Policy[1]) establish the "queueing" mechanism for approved proposals in the event that there are insufficient resources available to fund all proposals.

1.2 At its Twentieth meeting, the Board requested the prioritization principles be reviewed in advance of Round 10[2] and that any revisions should consider the work already undertaken by 'Tension Working Group'[3]. In response, following the Twentieth Board Meeting, an Interagency Expert Working Group was established to review the existing disease burden criteria and provide input on other related technical parameters.

1.3 Following the Board Retreat on 1-3 February 2010, the Board Chair and Vice Chair requested that the Policy and Strategy Committee (PSC) consider this issue and present recommendations for Round 10 prioritization to the Board at its Twenty-First Board Meeting. In response to this, the PSC established an ad-hoc Working Group, chaired by the Vice-Chair of the PSC, Todd Summers, to review options for Round 10 prioritization and develop recommendations for PSC review and subsequent Board consideration. The Working Group met on 13 April 2010 and presented its recommendations to the PSC on 19 April 2010 during a full PSC teleconference.

1.4 This paper presents for Board consideration a revised prioritization model which will apply for Round 10 only.

PART 2: RECOMMENDATIONS FOR ROUND 10

2.1 The PSC recommends that existing prioritization principles be revised by applying an expanded composite index that includes the following parameters:

i. Incorportating the TRP recommendation category within this composite index (instead of using it as a filter as is currently the case);

ii. Revising the existing disease burden parameters and scoring within the composite index; and

iii. Retaining the current poverty parameter and scoring within the composite index.

TRP Recommendation Category

2.2 Currently the TRP recommendation category is the primary filter for prioritization and therefore proposals are funded first by recommendation category and then within that category, if required, assigned a composite index that determines the order in which proposals are funded. The PSC notes that when assigning recommendation categories the TRP does not make a value judgement on which proposals should be prioritized for funding, except for its acknowledgment that Category 2B proposals are a somewhat weaker sub-set of recommended Category 2 proposals.

2.3 The PSC recommends that the TRP recommendation category not be used as the primary filter for prioritization and that instead it be integrated into the composite index and scored as follows:

Category 1 and 2 = 4; Category 2B =3

[1] http://www.theglobalfund.org/documents/comprehensive_funding_policy.pdf

[2] GF/B20/DP30

[3] The Working Group on Managing the Tension between Demand and Supply in a Resources Constrained Environment (GF/B19/DP26)

2.4 The PSC recommends that the feasibility of an expanded classification system for use in the future by the TRP for recommending proposals for funding be explored by the relevant Board committee.

Disease Burden

2.5 The PSC acknowledges that the existing disease burden indicators and scoring currently used for prioritization are blunt and should be improved. The Interagency Expert Working Group has recommended revised disease burden indicators, values and scoring for the three diseases. The PSC agrees that that the revised indicators and scoring presented by the Interagency Working Group were an improvement and accepted the proposed changes for malaria and tuberculosis.

2.6 For HIV/AIDS, the PSC discussed a revision to ensure that countries with high prevalence among Most-At-Risk-Persons (concentrated epidemics) not be disadvantaged. This modification had been endorsed by the PSC Prioritization Working Group, subject to review by the Interagency Expert Working Group. This review was done, and resulted in a recommendation back to the PSC and to the Board that the original recommendation made to the PSC at its 13th Meeting be maintained (see Annex 2). Notwithstanding, the PSC is recommending the modification put forth by the PSC Prioritization Working Group.

2.7 The revised disease burden indicators, values and scores are described in Annex 1.

Poverty

2.8 Poverty is part of the existing prioritization composite index and is measured by World Bank income level classification. While acknowledging that there is merit in revisiting the existing indicators and scoring, the PSC does not recommend any change to this parameter for Round 10 and instead recommends that this be included as part of the planned review of eligibility criteria. Some Committee members expressed concern that 'lower-middle' and 'upper-middle' income countries are disadvantaged by the compounding of prioritization and eligibility rules.

Other parameters

2.9 The PSC considered the merits of including 'continuation' and 'funding history' as additional parameters for prioritization.

Funding History

2.10 With respect to funding history the PSC does not recommend that this be included as a parameter for Round 10 in order to ensure that countries which request funding in discrete progressive tranches with repeat (but smaller) applications are not disadvantaged. Instead, the PSC requests that the ***TRP review unspent funds and/or evidence of significant 'under-spending' in existing grants as part of its review of Round 10 proposals based on data to be provided by the Secretariat***. The PSC requests that the TRP includes this review as part of its formal recommendation process.

2.11 The PSC also recommends that the Secretariat identify and take appropriate action where grants have an excess allocation of grant funds over what they can reasonably be expected to utilize due to slower than anticipated progress in implementation.

Continuation

2.12 The PSC acknowledges that 'protecting the gains' of existing investments is important. The inclusion of 'continuation' as a parameter for prioritization was discussed both by the ad-hoc PSC Prioritization Working Group and the Interagency Working Group. However, both groups acknowledged the difficulty in defining what constitutes 'continuation' and therefore the difficulty in including it as a prioritization parameter.

2.13 Instead, the PSC recommends that the Portfolio and Implementation Committee (PIC) examine the possibility of establishing an ***exceptional bridge funding mechanism*** for consideration at the Twenty-Second Board Meeting as a safeguard for Global Fund programs that might fail to secure continuation funding through Round 10. Should it decide to recommend this mechanism for Board approval, that should be done in time for consideration by the Board at the same time as approval of Round 10 proposals.

Decision Point: Prioritization for Round 10 Proposals

1. The Board decides that, for Round 10 only, the prioritization provisions of the Comprehensive Funding Policy described in Article 8 will be replaced with the provisions set out in Annex 1 to the Round 10 Prioritization document (GF/B21/11, Annex 1).

2. The Board request that, at the time of issuing the call for Round 10 proposals, the Secretariat communicate clearly to applicants the new prioritization mechanism that will apply for Round 10.

3. The Board requests (1) the Portfolio and Implementation Committee consider an exceptional bridge funding mechanism as proposed by the PSC for possible approval at its Twenty-Second meeting; and (2) the TRP to review data on significant under-spending on existing grants as part of its formal recommendation process (such data to be provided by the Secretariat).

This decision does not have material budgetary implications.

PART 3: RESOURCE ALLOCATIONS FOR THE 2011-2013 REPLENISHMENT PERIOD

3.1 The Working Group considered the amount of potential resources available for Round 10 under the three scenarios described in the document "Resource Scenarios 2011-2013" and updated the PSC on these discussions.

3.2 The PSC notes that several Committee members representing the Donor block have emphasized the need to balance resources evenly across the Replenishment period rather than committing them disproportionately in the first year of the replenishment period.

3.3 Implementing constituency members have expressed the view that any policy to limit or "cap" resources was inconsistent with the demand-driven basis of the Global Fund and was otherwise not in their purview as representatives of implementers or even within the mandate of the PSC to consider.

3.4 The PSC can therefore make no recommendation in relation to resources for Round 10 but acknowledges the need for the Board to address this matter.

PART 4: MEDIUM AND LONG TERM ISSUES FOR CONSIDERATION

4.1 The PSC notes that the ad-hoc PSC Prioritization Working Group identified several issues that should be considered in the medium term and long term by the Secretariat and relevant committee. These issues include:

- Disease burden criteria, indicators and values should continue to be reviewed both for prioritization for future rounds and as part of the upcoming eligibility and cost-sharing review;
- Future work around prioritization should include analysis on different factors that could influence prioritization, such as "unmet need" and disease incidence; and
- Particular attention should be paid to cost-sharing and domestic contributions during the eligibility and cost-sharing review. Any revisions to the existing policies should ensure that cost-sharing is 'auditable' and monitored throughout the grant lifetime. In addition, graduation and exit strategies for 'lower-middle' and 'upper-middle' income countries should be considered, including allowing cost-sharing to be averaged over the life of a grant such that Global Fund support tapers down as a percentage of overall funding.

This document is part of an internal deliberative process of the Fund and as such cannot be made public. Please refer to the Global Fund's documents policy for further guidance.

Annex 1

Prioritization for funding amongst proposals Round 10 TRP-recommended proposals

8. The system for prioritizing among Round 10 TRP-recommended proposals, in the event that there are insufficient resources available to approve all TRP-recommended proposals, is as follows:

a. The Secretariat is responsible for assigning a score to all TRP-recommended components of proposals in accordance with the composite index described in paragraph (b) below and is to present the Board with these scores at the time of the Board's consideration of the TRP's recommendations. They are then financed in descending order (with the highest scoring proposals receiving priority).

b. A composite index, based on three criteria, is used to assign scores to each TRP-recommended component of a proposal as described below.

Criteria	Indicator	Value	Score
TRP Recommendation	TRP Recommendation Category	Category 1 Category 2 Category 2B	4 4 3
Disease Burden	Specific disease burden criteria set forth in paragraph c below		4 3 2 1
Poverty	World Bank Classification	Low Income Lower-Middle Income Upper-Middle Income	4 2 0

c. The specific disease burden indicators, values and scores which will be used to assign scores for disease burden are:

i. For HIV/AIDS:

Indicator	Value	Score
HIV prevalence in the general population and/or in vulnerable populations*	HIV national prevalence ≥ 2% OR MARP[1] prevalence ≥10%	4
	HIV national prevalence ≥ 1% and <2% OR MARP prevalence ≥5% and <10%	3
	HIV national prevalence ≥ 0.5% and <1%	2
	HIV national prevalence < 0.5% and MARPS <5% OR no data	1

*Source of data: WHO and UNAIDS

[1] MARP: Most at risk populations

ii. For Tuberculosis

Indicator	Value	Score
Combination of tuberculosis notification rate per 100,000 population (all forms including relapses); and WHO list of high burden countries (TB, TB/HIV or MDR-TB) **	TB Notification rate per 100,000 population ≥ 146) **OR** TB Notification rate per 100,000 population ≥83 and <146 and high TB burden, high TB/HIV burden, or high MDR-TB burden country	4
	TB Notification rate per 100,000 population ≥83 and <146 **OR** TB Notification rate per 100,000 population ≥38 and <83 and high TB burden, high TB/HIV burden, or high MDR-TB burden country	3
	TB Notification rate per 100,000 population ≥38 and <83 **OR** TB Notification rate per 100,000 population < 38 and high TB burden, high TB/HIV burden, or high MDR-TB burden country	2
	TB Notification rate per 100,000 population < 38	1

** Source of data: WHO

iii. For Malaria[2]

Indicator	Value	Score
Combination of mortality rate per 1,000 persons at risk of malaria; morbidity rate per 1,000 persons at risk of malaria; and contribution to global deaths attributable to malaria***	Mortality rate ≥ 0.75 and morbidity rate ≥ 10 **OR** Contribution to global deaths ≥ 1%	4
	Mortality rate ≥ 0.75 and morbidity rate <10 **OR** Mortality rate ≥ 0.1 and <0.75 regardless of morbidity rate **OR** Contribution to global deaths ≥ 0.25% and <1%	3
	Mortality rate <0.1 and morbidity rate ≥1 **OR** Contribution to global deaths ≥ 0.01% and < 0.25%	2
	Mortality rate <0.1 and morbidity rate <1 **OR** Contribution to global deaths < 0.01%	1

*** Source of data: WHO

[2] (i) It is recommended to use burden estimates for earlier years (2000) in order not to penalize countries that have demonstrated progress; and
(ii) In the case that a proposal is submitted from a sub-national Applicant it will be scored according to incidence and mortality rates for those specific areas (and the contribution of those areas to the global burden).

Annex 2

Interagency Working Group recommended HIV/AIDS indicator, values and scores

i. For HIV/AIDS:

Indicator	Value	Score
HIV prevalence in the general population and/or in vulnerable populations*	HIV national prevalence ≥ 2%	4
	HIV national prevalence ≥ 1% and <2% OR MARP[3] prevalence ≥10%	3
	HIV national prevalence ≥ 0.5% and <1% OR MARP prevalence ≥5% and <10%	2
	HIV national prevalence < 0.5% and MARPS <5% OR no data	1

* Source of data: WHO and UNAIDS

[3] MARP: Most at risk populations