GF/B30/6

Board Decision

Revision 1

NEW FUNDING MODEL: ELIGIBILITY, COUNTERPART FINANCING AND PRIORITIZATION POLICY REVISION.

Purpose:

This paper presents the proposed revisions to the current Eligibility, Counterpart Financing and Prioritization Policy in order to incorporate previous Board decisions, align with the new funding model and address issues raised at the 8th and 9th meetings of the Strategy, Investment and Impact Committee (SIIC).

This paper includes a revised policy (Attachment 1), which reflects amendments agreed by the SIIC, for Board adoption.

PART 1. BACKGROUND

1.1 The "Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund" (Policy) was approved by the Board at its Twenty-Third Meeting in May 2011,[1] and included as Attachment 2 to this paper, based on an extended review by the Joint Working Group of the Policy and Strategy Committee (PSC) and the Portfolio Implementation Committee (PIC).[2]

1.2 Under the new funding model, the main tenets of the Policy remain valid. However, several provisions of the Policy are no longer relevant, or are otherwise addressed, as a consequence of the changes resulting from the new funding model.

1.3 Furthermore, decisions from the Twenty-Fifth Board Meeting[3] and the subsequent exercise of delegated authority by the Board Chair on eligibility[4] also need to be reflected in the Policy.

1.4 The proposed revisions do not change the fundamental principles for determining eligibility (e.g., income-level classifications by the World Bank and disease-burden indicators from key partners) or the counterpart financing requirements.

1.5 The Strategy, Investment and Impact Committee (SIIC) discussed revisions to the Policy at its 8th and 9th Meetings in July 2013 and October 2013, respectively. Following deliberations, the SIIC endorsed the revisions, which are explained and set forth in Attachment 1 to this paper.

1.6 In order to allocate resources for the 2014-2016 Replenishment period, the revised Policy (Attachment 1) is presented to the Board for approval.

PART 2. REVISIONS TO THE POLICY

Incorporating Recent Board Decisions

2.1 At its 8th Meeting in July 2013, the SIIC noted the need to incorporate in the Policy previous Board decisions from the Twenty-Fifth Board Meeting and subsequent decisions by the Chair of the Board under delegated authority. These include:

i. Upper-middle income (UMI) countries that are members of the Group of 20 (G-20) countries would no longer be eligible for financial support from the Global Fund unless they have an 'extreme' disease burden (the "G-20 rule");

ii. The one-year Grace Period provision for changes in country income classification was rescinded for both new requests for funding and continued funding requests (Renewals);

iii. Notwithstanding the G-20 rule, countries covered under the NGO Rule would remain eligible to apply for HIV/AIDS funding; and

[1] GF/B23/DP23 and set forth in GF/B23/14 - Attachment 1.
[2] The Joint PSC-PIC Report on the Review of the Global Fund's Eligibility, Cost Sharing and Prioritization Policies and Recommendation for a New Integrated Policy, GF/B23/14
[3] GF/B25/DP16: Modification of Grant Renewals and Transition to New Funding
[4] Electronic Report to the Board B25/ER/05

iv. Application of certain provisions, such as counterpart financing, focus of applications, and the G-20 rule, to Renewals.

2.2 Following agreement by the SIIC at its 9th Meeting in October 2013, the Policy has therefore been updated to reflect these decisions.

2.3 In addition, the SIIC has endorsed the Secretariat's recommendation to include in the revised Policy a previous decision point[5] on the ineligibility of members of the OECD's Development Assistance Committee (DAC)[6] as a matter of consistency with previous Board decisions on eligibility. The inclusion of this provision would not affect the eligibility of currently funded countries.

Alignment with the new funding model

2.4 A number of existing provisions in the Policy are specific to a Rounds-based system which included competition for available resources. The new funding model[7] is primarily based on an allocation approach, although there remains a competitive element for incentive funding. This renders certain existing provisions of the Policy redundant or requiring revision.

General and Targeted Funding Pools

2.5 Currently, eligible UMI countries with 'high' disease burden, and UMI 'small island economies' with 'low' or 'moderate' disease burden are limited to a pre-defined maximum amount of funding under the 'Targeted Funding Pool'. The concept of eligibility for a pre-defined maximum amount of funding for these UMI countries has been incorporated into the revised Policy in paragraph 9. Other references to 'General' and 'Targeted' pools have been removed.

Recent Funding and Prioritization

2.6 Having adopted a funding model which is based primarily on an allocation approach, the following provisions are no longer relevant and have been removed from the current Policy:

i. Paragraphs 19 to 22 relating to recent funding;[8] and

ii. Part 5, paragraphs 37-46 which describe prioritization criteria to be used in the event of there being insufficient resources immediately available to approve all TRP-recommended proposals.

[5] GF/B2/4c.
[6] OECD-DAC Members: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, European Union (institutions, not countries), Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, The Netherlands, United Kingdom and United States.
[7] Decision Point: GF/B28/DP4
[8] GF/B23/14 – Attachment 1

Counterpart Financing

2.7 Currently, the Policy states that the Technical Review Panel (TRP) must review and assess compliance with counterpart financing as a material part of the review of applications. The TRP noted in its Report on the Transitional Funding Mechanism (TFM)[9] the challenges for it to assess compliance (and in particular the veracity of the data provided) in the absence of robust supporting documentation as part of its application review processes. The TRP also stressed the importance of robust assessment and tracking of counterpart financing commitments.

2.8 Counterpart financing continues to remain an important principle in the new funding model and, in line with the TRP recommendation, will be reviewed at the time of requesting new funding (both during country dialogue and with the submission of concept note(s)). In addition, counterpart financing will be continuously monitored and assessed throughout grant implementation and corrective actions taken in cases of non-compliance or changing government commitments. The revised Policy, based on the recommendations of the Secretariat and the TRP, reflect that compliance decisions will be made by the Secretariat, noting that the TRP, as part of its review of concept notes, will receive information related to counterpart financing and can raise issues related to government commitment and sustainability.

Eligibility of countries certified as malaria-free or in which malaria never existed or has disappeared

2.9 Under the current Policy all low income countries, lower-middle income (LMI) countries, and UMI countries designated under the 'small island economy' exception[10] are eligible to apply for funding from the Global Fund, for the three diseases and/or cross-cutting Health Systems Strengthening.

2.10 The current list of the eligible countries for 2013 includes 25 eligible LMI and UMI small island economy countries, all of which have a 'low' burden of malaria.[11]

2.11 Of these 25 countries, 21 are either certified as 'malaria-free' by WHO (seven countries) or are on the WHO Supplementary List of countries where malaria never existed or disappeared (14 countries).[12] None have ever received Global Fund funding for malaria.[13] Unless there is a change to the existing Policy, these countries would, *prima facie*, receive a malaria allocation potentially of the order of USD 60 million[14] (based on a scenario with USD 12 billion available for allocation). The list of countries is in Annex 1 to this paper.

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[9] GF/B26/ER 07

[10] Exception to the International Development Association lending eligibility requirements.

[11] According to the current policy, a 'low' disease burden score for malaria is given if a country's mortality rate is < 0.1 and morbidity rate < 1, or contribution is < 0.01%. Importantly, if a country has no disease burden data available, a 'low' disease burden score is also given.

[12] Three countries are classified as in the prevention of the re-introduction stage (Egypt, Iraq and Syrian Arab Republic) and one country is classified as in the pre-elimination stage (El Salvador)

[13] Only Armenia has ever applied for malaria funding in Rounds 5 and 6, and was not recommended for funding for malaria.

[14] Scenario assumptions: calculation is based on the parameters for allocation (including floor funding/ Band 4 methodology), external financing adjustment, Minimum Required Level (MRL) calculations taken as 20% reductions on 2010-12 disbursements, and 2013 eligibility as used for the Transition to the new funding model. They do not take into account any of the SIIC recommendations to the Board arising from the 8th SIIC meeting or subsequent decisions by the Board or SIIC. All amounts are subject to revision in relation to associated changes adopted for the full implementation of the new funding model.

2.12 'Malaria-free' certification is a country-driven process in which countries can request WHO to certify its malaria-free status when it has zero locally acquired malaria cases for at least three consecutive years. Certification of malaria elimination is based on an assessment of the current situation and the likelihood that malaria-free status can be maintained. The official register of certified malaria-free countries is updated every time a new country is certified, and published in the annual World Malaria Report. Countries remain listed as having achieved malaria elimination even if they subsequently suffer a temporary occurrence of local transmission and to date there is no process for decertification. The WHO Supplementary List includes countries that have: i) never had malaria transmission; or ii) been malaria-free for over a decade.[15]

2.13 Given the above and recognizing that none of these countries have received Global Fund funding, the SIIC endorsed the Secretariat's recommendation to make countries certified as 'malaria-free' by WHO or on the WHO Supplementary List ineligible for malaria funding. In making its recommendation to the SIIC, the Secretariat noted that WHO, in discussion, concurred with this proposal.

2.14 In any event, 'malaria-free' countries are expected to continue reporting on an annual basis to WHO. The Secretariat, in consultation with WHO, will evaluate the need to provide some funding to these countries should there be a substantial change in their reported malaria status during an allocation period.

Funding newly ineligible countries or components

2.15 At its 8th Meeting the SIIC discussed, in the context of the World Bank income classifications that will be used to determine eligibility for 2014, the need for transition plans for newly ineligible countries/components. The SIIC also noted that additional consideration should be given in order to ensure civil society continues to have access to funding in cases where policy decisions have been taken to maintain funding for non-governmental organizations (NGOs).

2.16 In its presentation of revisions to the Policy, the Secretariat noted the following Board decisions that were relevant to the discussion on continuing funding for countries/components that would otherwise be ineligible in 2014:

i. Since 2003, Board decisions and related policies have explicitly made 'high' income countries ineligible to receive funding as single country applicants;[16]

ii. In 2009 the Board rescinded the grace-period for those countries that moved up from UMI to 'high' income[17] reaffirming its position on not funding 'high' income countries; and

iii. The 'NGO Rule' for HIV/AIDS,[18] applicable to certain UMI countries, was included into the current Policy to allow for the funding of targeted services for

[15] Source: WHO website (updated on 6 March 2013). Countries included in the WHO Supplementary List do not need to request (and are not eligible for) 'malaria-free' certification.
[16] GF/B4/7; GF/B6/9; GF/B16/7, Attachment 1, Revision 1
[17] GF/B19/DP14
[18] Paragraph 11 of GF/B23/14 – Attachment 1 states: UMICs not listed on the OECD's DAC list of ODA recipients are ineligible to apply for funding for HIV and AIDS proposals except if the application is submitted by a non-governmental organization (NGO) within the country in which activities would be implemented, and for which the government of such country shall not receive any funding. This could be in the form of a non-CCM application or other valid application. Such funding requests shall demonstrate that they target key services, as supported by evidence and the country's epidemiology. Confirmation shall also be provided by applicants that the targeted services are not being provided due to political barriers.

civil society and NGOs in cases where there are political barriers to providing these services.

Proposed transitional funding for newly ineligible/countries components

2.17 Each year a number of countries become eligible for one or more components, and others become ineligible due to changes in their World Bank income classification and/or a change in disease burden data.[19] With the grace period having been rescinded in 2011, the impact of a change to income classification is immediate with respect to eligibility status and potential funding amounts. This immediate application of changes to income classification can be more pronounced for countries moving from LMI to UMI because such countries often do not have a 'high', 'severe' or 'extreme' disease burden which is needed to maintain eligibility.

2.18 As such, the revised Policy includes a transition measure whereby certain newly ineligible countries/components funded under an existing grant could remain eligible to receive funding for up to one allocation period immediately following their change in eligibility. The Secretariat, based on country context and existing portfolio considerations, would determine the appropriate amount and period of funding, and could take into consideration, but not be limited to, the following:

i. Whether or not there is sufficient time left on the existing grant (e.g., more than 12 months from becoming ineligible) to allow for a clear transition to other sources of funding (national or otherwise);

ii. The scope of the funding (e.g., limited only to essential—recognizing the given epidemiological context—prevention, care and treatment activities); and

iii. Appropriate and measureable time-bound actions for eventual and complete transition to national and/or other resources.

2.19 Paragraph 13 of the revised Policy contains this provision.

Inclusion of a grace period for countries currently funded under the 'NGO Rule'

2.20 To address concerns with respect to maintaining funding for civil society for key services not being provided by governments, the revised Policy permits existing HIV grants funded under the 'NGO-Rule' to receive a grace-period of one allocation period after they become ineligible due to changes in their income-level classifications.

2.21 The 'NGO Rule' for HIV/AIDS was introduced in May 2011 when the current Policy was approved by the Board. Previously, unless a UMI country was on the OECD-DAC List of ODA Recipients,[20] UMI countries were ineligible for funding for HIV/AIDS. Since its adoption, two NGO applications from the Russian Federation benefitted from this rule under the TFM.

[19] For example, Albania, Fiji, and Belize experienced changes in eligibility status between 2007 and 2013 due to fluctuations in income-level classification.

[20] The Development Assistance Committee (DAC) of the Organisation of Economic Co-Operation and Development publishes a list of countries eligible for Official Development Assistance (ODA) which is revised every three years. Countries that exceed the 'high' income threshold for three consecutive years at the time of the review are removed and G-8, European Union (EU) members and countries with a firm EU ascension date are not included.

2.22 According to the 2013 Eligibility List, five UMI countries (i.e., Bulgaria, Latvia, Lithuania, Romania and Russian Federation) were technically eligible[21] to apply for funding in 2013 under this 'NGO Rule'. Of these countries, only Bulgaria (through a government Principal Recipient) and the Russian Federation (through two NGOs) currently receive funding for HIV.

2.23 In 2013, the Russian Federation moved from UMI to 'high' income and therefore under the current Policy it is ineligible for funding in 2014. Based on the revised Policy, the Russian Federation would be eligible for an allocation for the 2014-2016 period, noting that should they continue to remain 'high' income they would not receive an allocation for the 2017-2019 allocation period. With this inclusion, Bulgaria and Romania would continue to be eligible (and receive an allocation)[22] if they continue to demonstrate a 'high', 'severe' or 'extreme' disease burden; however they would only be able to access the funding if they can demonstrate that there are political barriers to providing key services. Latvia and Lithuania would no longer be eligible as they are now classified as 'high' income and do not currently receive funding for HIV.

2.24 Paragraph 14 of the revised Policy contains this provision.

Eligibility of Regional and Multi-Country Applicants

2.25 The current Policy states that for a regional applicant to be eligible for funding, the majority (at least 51 percent) of countries included in the application must be eligible to submit a request for funding for the same disease as a single-country applicant. This does not preclude the inclusion of 'high' income countries to receive direct funding support within a regional/multi-country application. Since Round 8, four eligible regional applications have included 'high' income countries.[23]

2.26 Regional, multi-country and non-CCM applicants, according to the current Policy, do not have to comply with counterpart financing requirements; however, they do need to meet the focus of application requirements.[24]

2.27 For regional and multi-country applicants, the Secretariat will, in line with previous TRP recommendations, explicitly describe the links between the regional/multi-country application and all other Global Fund support. In the event that the regional application foresees a significant portion of the funds to directly support national disease programs, the Secretariat will factor this into its assessment of counterpart financing assessment of constituent single country future applications.

2.28 In relation to small islands or other small countries with total populations of less than one million and/or countries who will receive a pre-defined indicative funding ceiling, the Secretariat may require applications from a common geographical, economic grouping with similar epidemiology in order to facilitate more effective program management.

[21] They are not on the OECD DAC List and have a 'high' disease burden, as defined by the current Policy. The Secretariat cannot determine whether or not the targeted services being requested are not provided due to political barriers at the time of determining eligibility and this is only determined at the time of submission of a funding request.

[22] Bulgaria and Romania remain eligible as the current 'NGO Rule' remains unchanged.

[23] RCM PANCAP-CARICOM (Round 9, recommended) – Antigua and Barbuda, Bahamas, Barbados, Trinidad and Tobago; MENHARA (Round 9, not recommended) – Kuwait; RCM OECS (Round 10, not recommended) – Antigua and Barbuda; and MENHARA (Round 10, recommended) – Bahrain, Oman

[24] Applications from 'lower-middle' income countries must be focused at least 50 percent of the interventions on Special Groups/Interventions. This requirement is 100 percent if the applicant is an 'upper-middle' income country. Paragraphs 16 and 17 of the revised Policy set forth these requirements.

Timing of the updates to the Eligibility List

2.29 Eligibility determinations are currently made on an annual basis following the annual publication of the World Bank (Atlas Method) Income Classifications and receipt of the most recent disease burden data provided by WHO and UNAIDS. The determinations are effective for new funding in the following calendar year (1 January to 31 December). The eligibility list will be used to determine which countries will be eligible to receive an allocation (and for which disease components) and identify the counterpart financing requirements and any other restrictions.

2.30 With a move to three-year allocations, the Secretariat has considered, and discussed with the SIIC, the implications of maintaining the eligibility list either on an annual basis or once every allocation period. While aligning the timing of the eligibility list to the allocation period is a simpler option it ignores the potential impact of constantly changing income level and disease burden information.

2.31 Undertaking eligibility updates on an annual basis would require a clear operational policy to manage those countries that become eligible/ineligible during an allocation period. Noting that a number of countries over the course of the last seven years have experienced fluctuations in income level, thus making them ineligible one year and eligible the next, the revised Policy contains the following:

i. A country (for the relevant components which meet the criteria) is only deemed newly eligible once it has maintained its eligibility criteria (as regards income level and disease burden) for two consecutive eligibility determinations;

ii. Where there is a need to allocate funding during an allocation period to newly eligible countries/components, the Secretariat will seek to fund these within their respective Bands, subject to available funding. The Secretariat notes that for the most part these will be Band 4 countries and that any funding will only be for a limited term (e.g., one year) and be modest in amount; and

iii. For countries/components that have become ineligible during an allocation period and have not accessed their indicative amounts, that they continue to be eligible for funding. However the country dialogue would address what is considered an appropriate level of funding and establish clear time-bound actions for the eventual and sustainable transition to other sources of funding.

PART 3. COMPARISON OF EXISTING AND REVISED POLICY

3.1 The explanatory note in Attachment 1 to this paper further summarizes the revisions to the Policy and the rationale for such revisions. Additionally, the note lists relevant paragraph references in the existing and revised Policy to demonstrate how topics or provisions have been amended, reorganized or deleted.

3.2 Attachment 1 to this paper also contains the revised Policy that is presented to the Board for adoption. For reference and comparison, the existing Policy is contained in Attachment 2 to this paper.

PART 4. DECISION POINT

4.1 Based on the Strategy, Investment and Impact Committee's recommendation of the revisions presented in this paper, and set forth in the revised Policy contained in Attachment 1 to this paper, the following decision point is proposed for Board adoption:

GF/B30/DP5: Revision of the Policy on Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund

1. ***The Board approves the amended policy on "Eligibility Criteria, Counterpart Financing Requirements and Prioritization of Proposals for Funding from the Global Fund"[1] as set out in GF/B30/6 – Revision 1, Attachment 1 (the "Amended Policy"). The Amended Policy, "The Global Fund Eligibility and Counterpart Financing Policy," is effective upon the date of this decision and applies to all subsequent eligibility determinations.***

2. ***The Board requests the Strategy, Investment and Impact Committee and the Secretariat to initiate a process that by the end of 2014 will provide options and recommendations to the Board to refine the Global Fund's approach to transitioning countries. This approach shall include consideration of appropriate public health indicators to measure progress in sustaining and enhancing gains against the three diseases.***

[1] Previously adopted under Decision Point GF/B23/DP23, and set forth in GF/B23/14, Attachment 1.

Annex 1

Table 1. Countries with "low"[1] malaria disease burden certified as malaria-free

Country	Income Level 2013 Eligibility List
Armenia*	Lower Middle Income
Dominica	Upper Middle Income *(Small Island Economy)*
Grenada	Upper Middle Income *(Small Island Economy)*
Kosovo[2]	Lower Middle Income
Morocco	Lower Middle Income
St. Lucia	Upper Middle Income *(Small Island Economy)*
West Bank and Gaza[3]	Lower Middle Income

* Previously applied to the Global Fund but were not recommended for funding.

Table 2. Countries with "low" malaria disease burden added to the WHO Supplementary List of countries where malaria never existed or disappeared without specific measures

Country	Income Level 2013 Eligibility List
Albania	Lower Middle Income
Fiji	Lower Middle Income
Kiribati	Lower Middle Income *(Small Island Economy)*
Lesotho	Lower Middle Income
Maldives	Upper Middle Income *(Small Island Economy)*
Marshall Islands	Lower Middle Income *(Small Island Economy)*
Micronesia	Lower Middle Income *(Small Island Economy)*
Mongolia	Lower Middle Income
Republic of Moldova	Lower Middle Income
Samoa	Lower Middle Income *(Small Island Economy)*
St. Vincent & Grenadines	Upper Middle Income *(Small Island Economy)*
Tonga	Lower Middle Income *(Small Island Economy)*
Tuvalu	Upper Middle Income *(Small Island Economy)*
Ukraine	Lower Middle Income

[1] According to the current policy, a "low" disease burden score for malaria is given if a country's mortality rate is < 0.1 and morbidity rate < 1, or contribution is < 0.01%. Importantly, if a country has no disease burden data available, a "low" disease burden score is also given.

[2] There is no WHO data for Kosovo. In consultation with WHO, data from Serbia's classification has been used for Kosovo, which is certified as malaria-free.

[3] There is no WHO data for West Bank and Gaza. In consultation with WHO, West Bank and Gaza has been classified as malaria-free.

Attachment 1

GF/B30/6 – Revision 1

Explanatory Note – Revisions to the Eligibility, Counterpart Financing and Prioritization (ECFP) Policy

Purpose:

1. This document provides the Board with additional explanation on the SIIC recommended revisions to the ECFP policy.
2. The table below highlights areas where significant changes have been made. Minor changes to language for consistency and alignment with the new funding model are not highlighted. Re-ordering of existing paragraphs is also not highlighted unless relevant to the rationale for revision.

Topic addressed	Current policy reference and change	Rationale for revision	Revised policy reference
General and Targeted Funding Pools	(*Part 2, Paragraphs 4-6):* Has been removed.	An allocation formula makes the general and targeted funding pools redundant as countries will receive allocations that take into account ability to pay (GNI) and disease burden.	Not applicable
Eligibility: Timing provisions	*(Part 3, paragraph 9):* The timing provision has been separated from the income level section in the current policy.	This has been revised to reflect an annual eligibility determination that takes into account the most recent income-level classifications and disease-burden information. Includes provisions on what happens when a country or component becomes eligible or ineligible during an allocation period. Includes parameters where a country or component that becomes newly eligible during the allocation period may receive an allocation. Also provides guidelines for a country or component that becomes newly ineligible prior to accessing its allocation funding during the allocation period.	Part 2, paragraph 6, a and b.
Eligibility: Income-level provisions	*(Part 3, paragraph 9):* Updated	The income level section has been revised to include Board decisions from the 25th Board Meeting (GF/B25/DP16) and subsequent decisions of the Chair of the Board under delegated authority (B25/ER/05) referenced in Sections 2.1 and 2.2 of the paper. In addition, the section also: • Includes the UMI small island economy exception clause	Part 2, paragraph 7a-7g

		that is currently in Paragraph 15 of the current Policy. • Includes provision to make OECD DAC members ineligible as per GF/B2/4c	
Eligibility: Grace period rule for countries	*(Part 3, paragraph 10):* Removed	This has been removed as per GF/B25/DP16	Not applicable
Pre-defined maximum funding	Not part of the current policy	This has been revised to establish that although there is no longer a 'Targeted Pool,' countries that would have only been eligible for this Pool, will be subject to pre-defined maximum levels of funding.	Part 2, paragraph 9
Ineligibility of 'Malaria-free' and 'Supplementary List' countries	Not part of the current policy	As per the SIIC recommendation, this has been added so that 'lower-middle' income and 'upper-middle' income small island economies that are either certified as 'Malaria-free' by the WHO or are on the WHO's 'Supplementary List' of countries which never had malaria or where malaria disappeared without specific measures are **not eligible** for funding.	Part 2, paragraph 10
Regional/multi-country applicants	*(Part 3, paragraphs 12 and 13):* Paragraph 13 in the current policy has been removed as it is no longer relevant with the new funding model.	The remaining provision with respect to regional/multi-country applicants has been revised for clarity.	Part 2, paragraph 11
Eligibility: NGO Rule for HIV/AIDS	*(Part 3, paragraph 11):* restructured for clarity	The NGO rule has been restructured for clarity. In provision (12c), the condition has been amended so that governments eligible under the NGO rule cannot directly receive funding as opposed to not receiving funding at all. This amendment notes that in some cases the health service providers may be 'government entities' due to the service delivery structure in-country.	Part 2, paragraph 12
Transition Funding	Not part of the current policy	Per SIIC recommendation a provision to allow for countries or components funded under an **existing grant** that become ineligible to receive up to one additional allocation period immediately following their change in eligibility and	Part 2, paragraphs 13 and 14

		allows for the Secretariat, based on country context and existing portfolio considerations, to determine the appropriate period and amount of funding. As per the SIIC recommendation, a 'grace'-period for one allocation period has been made available to existing HIV grants that have been funded under the NGO rule, but become ineligible due to changes in income classification.	
Recent Funding	*(Part 3, paragraphs 19 -22):* Removed	This has been removed as it is no longer relevant with an allocation methodology.	Not applicable
Counterpart Financing	(Part 4, paragraphs 30-33): the role of the TRP in determining compliance for Counterpart Financing has been removed	Reference to the TRP determining compliance of Counterpart Financing has been removed. The Secretariat's role in determining compliance has been added. Accordingly, paragraph 31 regarding the TRP's decisions on Counterpart Financing has also been deleted. Reference to the Periodic Review in paragraph 33 has been removed.	Part 3, paragraphs 25 and 26
Prioritization	*(Part 5, paragraphs 37-46)*: Removed	This has been removed as it is no longer relevant with an allocation methodology.	Not applicable
Annexes	Annex A: Resource Allocations for the General Funding Pool and Targeted Funding Pool	This has been removed as it is no longer relevant with an allocation methodology.	Not applicable
	Annex C: Flow Chart showing the Eligibility Criteria and required Focus of Proposals for the General and Targeted Funding Pools	This has been updated to remove reference to the 'General' and 'Targeted' Funding Pools, and to include the G-20 Membership.	Annex B
	Annex E: General Funding Pool Composite Index for Prioritization	This has been removed as it is no longer relevant.	Not applicable

THE GLOBAL FUND ELIGIBILITY AND COUNTERPART FINANCING POLICY

PART 1: OVERVIEW

1. As outlined in the Framework Document[1], the Global Fund's criteria for eligibility for funding should take into account a number of factors such as disease burden, political commitment, the involvement of an inclusive Country Coordinating Mechanism and the poverty situation[2] of the country[3] in which activities will be implemented.
2. This document sets out an integrated Eligibility and Counterpart Financing[4] policy (the "Policy"). It is designed to ensure that available resources are allocated to countries and regions with the highest disease burden and least ability to bring financial resources to address these health problems, while giving due priority to communities and subpopulations at high risk of disease.
3. This Policy applies to all funding opportunities and establishes criteria to identify components eligible to receive funding allocations,[5] and sets requirements and restrictions on how funds may be accessed.

PART 2: ELIGIBILITY

4. Eligibility criteria are established to identify which countries may qualify to apply for funding from the Global Fund, and under which conditions. Eligibility determinations will be based on compliance with Country Coordinating Mechanism (CCM) minimum eligibility requirements and such other eligibility requirements as described in this Policy. Applications must also demonstrate compliance with Counterpart Financing requirements (Part 3 of this Policy).
5. **CCM Minimum Eligibility Requirements:** All applicants must comply with the CCM minimum eligibility requirements approved by the Board and as amended from time to time[6].
6. **Timing:** Eligibility determinations will be made on a yearly basis following the publication of income level classifications (see Paragraph 7 of this policy) and provision of official disease burden data by key partners[7]. These determinations will be effective from 1 January to 31 December of the following calendar year subject to the following provisions:
    a. Countries or components that become eligible during an allocation period may receive an allocation, subject to the availability of funding, only after being newly eligible for two consecutive eligibility determinations.
    b. Countries or components that become ineligible during an allocation period before accessing their funding will not forfeit their allocation. However, the Secretariat may adjust the level of funding and require specific time-bound actions for transitioning to other sources of financing.
7. **Income Level:** The income level eligibility of a country submitting an application shall be based on a country's income classification as determined by the Global Fund. The Secretariat will make the determination of income classification following the publication

[1] The Framework Document of the Global Fund (January 2002)
[2] Income level measured by appropriate economic indicators, such as the World Bank, Atlas Method.
[3] References in this document to "country" refer to "economy" as classified by the World Bank.
[4] Formerly referred to as 'cost-sharing' criteria in previous Board decisions.
[5] Under the funding model adopted at the Twenty-Eighth Board Meeting (GF/B28/DP4), all eligible country components are calculated three-year indicative funding amounts for each allocation period, based on an allocation methodology that utilizes indicators approved by the Strategy, Investment, and Impact Committee.
[6] GF/B16/DP19, GF/B20/DP12 and as amended by GF/SIIC08/DP4.
[7] Disease burden data is the latest available official data provided by the headquarters of the following key partners per disease: HIV and AIDS: UNAIDS and WHO; Tuberculosis: WHO; Malaria: WHO.

of the World Bank (Atlas Method) Income Classifications in July of each year (or following the month of publication if different from July). With respect to income classification, eligibility shall be determined considering the following:

a. Low income countries (LICs) shall be eligible without specific restriction.

b. Lower middle income countries (LMICs) shall be split into two income groups using as a cut-off the midpoint[8] of the range of GNI per capita for LMICs as reported by the World Bank. Countries at the midpoint or below the midpoint shall, for the purposes of this Policy, be described as "Lower LMICs" and those above the midpoint as "Upper LMICs". All LMICs must comply with requirements regarding the focus of applications (see Paragraph 16 of this Policy).

c. Upper middle income countries (UMICs) will be evaluated for eligibility based upon their respective disease burden (see Paragraph 8 of this Policy). In addition, all UMICs must comply with the requirements regarding the focus of applications (see Paragraph 17 of this Policy).

d. UMICs designated under the 'small island economy' exception to the International Development Association lending requirements, are eligible to apply for funding from the Global Fund, regardless of national disease burden.

e. UMICs that are members of the Group of 20 (G-20) countries are not eligible for new or renewal of existing funding unless they have an 'extreme' disease burden. However, countries excluded from applying for funding under this provision may be eligible to apply for HIV/AIDS funding if they meet the criteria described in Paragraph 12 of this Policy (i.e., the NGO Rule).

f. High income countries (HICs) shall be ineligible to apply for funding through a single country application.

g. Members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) are ineligible to apply for funding.

8. **Disease Burden:** All LICs and LMICs shall be eligible to apply for funding for HIV and AIDS, tuberculosis, malaria[9], and/or Cross-cutting Health Systems Strengthening. Subject to Paragraph 7.d. of this Policy, UMICs shall only be eligible to apply for funding for the disease(s) in which their reported disease burden[10] is measured as 'High', 'Severe' or 'Extreme' as reported in the matrix included in Annex C to this Policy, and as may be amended from time to time. UMICs which are eligible to apply for funding on account of having a 'Severe' or 'Extreme' disease burden, but not those with 'High' disease burden, shall be eligible to apply separately for Cross-cutting HSS funding.

9. Recognizing the diversity of country situations, eligible UMICs with a 'high' disease burden and eligible 'Small Island Economy' exception countries to the International Development Association lending eligibility requirements[11] with a 'low' or 'moderate' disease burden will only be eligible to receive a pre-defined maximum amount of funding[12].

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[8] The 'midpoint' is defined as the average between the lower and the upper bound GNI per capita of the LMIC category.

[9] Countries certified as malaria-free by WHO or on the WHO's Supplementary List of Countries are not eligible for funding (as per paragraph 10 of this policy).

[10] As reported by official data provided by the headquarters of the following partners: UNAIDS and WHO for HIV and AIDS, and WHO for tuberculosis and malaria.

[11] As found at the International Development Association website.

[12] These maximum amounts will be defined prior to the commencement of each allocation period as part of the allocation methodology assessed by the Strategy, Investment and Impact Committee.

10. Notwithstanding Paragraphs 7.a. through 7.g. above, countries that are certified as 'malaria-free' by WHO or are on the WHO's 'Supplementary List' of countries where malaria never existed or disappeared, regardless of their income level, are not eligible to apply for malaria funding.

11. A Regional or multi-country application shall only be eligible for funding where the majority (at least 51 percent) of countries included in the application would be eligible to submit their own request for funding for that same disease through a single-country application. Furthermore, a regional or multi-country application must meet the specific requirements for submitting a regional application.

12. **NGO Rule for HIV/AIDS:** UMICs not listed on the OECD's DAC list of ODA recipients[13] are eligible to apply for HIV and AIDS funding only if the following conditions are met:

    a. Such country has a reported disease burden of 'High', 'Severe' or 'Extreme';

    b. The application is submitted and the program will be managed by a non-governmental organization (NGO) within the country in which activities would be implemented;

    c. The government of such country shall not directly receive any funding;

    d. Requests are submitted as a non-CCM or other valid application;

    e. Such funding requests must meet the focus of application requirements set forth in Paragraph 17 of this Policy and must demonstrate that they target key services, as supported by evidence and the country's epidemiology; and

    f. Applicants must provide confirmation that the services requested in the application are not being provided due to political barriers.

13. **Eligibility Transitions:** Subject to paragraph 7 e. through g., countries or components funded under an existing grant that become ineligible may receive funding for up to one additional allocation period immediately following their change in eligibility (Transition Funding). The Secretariat, based on country context and existing portfolio considerations, will determine the appropriate period and amount of funding.

14. Notwithstanding paragraph 7 e. through g., a grace-period of one allocation period will be provided to those countries with an existing HIV grant that meet the criteria in paragraph 12 and become ineligible due to changes in income level.

15. **LIC Application Focus:** All LICs may submit applications for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS deemed appropriate to the populations being served, without restriction on the scope of the application, but subject to Technical Review Panel (TRP) review.

16. **LMIC Application Focus:** All Lower and Upper LMICs may submit applications for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS but must focus at least 50 percent of the interventions on Special Groups and/or Interventions[14]. Compliance with this criterion will be determined at the time of the TRP review.

17. **UMIC Application Focus:** If eligible, according to disease burden as set out in Paragraph 8 above, UMICs must focus 100 percent of the interventions on Special Groups and/or Interventions. Compliance with this criterion will be determined at the time of the TRP review.

[13] The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development publishes a list of countries eligible for Official Development Assistance (ODA).

[14] Special Groups and/or Interventions are 'underserved and most-at-risk populations' and/or 'highest impact interventions within a defined epidemiological context' as further defined in Annex A.

PART3: COUNTERPART FINANCING

18. Counterpart Financing requirements will apply to all countries applying for funding to the Global Fund.

19. Regional, multi-country and non-CCM proposals are not required to meet the Counterpart Financing requirements described in this Policy.

20. **Minimum Threshold:** Applicants must demonstrate compliance of the national government of the country which is the subject of an application with the minimum threshold for Counterpart Financing. Counterpart Financing threshold is defined as the minimum level of the government's contribution[15] to the national disease program, as a share of total government and Global Fund financing[16] for that disease. To comply with this requirement, the applicant must either demonstrate that its respective national government has met the minimum threshold at the application stage, or, if the country's share is below the minimum threshold for Counterpart Financing, it must provide a justification and present an action plan as to how it intends to move towards it as part of the proposal application (see Paragraph 25 of this Policy).

21. The minimum threshold for Counterpart Financing shall be 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs[17]. UMICs will be encouraged to increase their Counterpart Financing contribution to above 90 percent during the duration of grant implementation to facilitate graduation out of Global Fund financing.

22. **Increased Government Contribution:** Over the course of implementation of grants funded by the Global Fund within any given country, the government of that country must increase the absolute value of their contribution to the national disease program and health sector each year. In monitoring compliance (see Paragraphs 25 and 26 of this Policy), extenuating circumstances can be submitted by the applicant for consideration along with clear action plans to meet Counterpart Financing requirements.

23. **Expenditure Data:** Applicants will be required to report government expenditure to key partners[18] using existing measurement mechanisms each year. The numbers, once validated, will be used to assess progress.

24. An applicant should include provision for up to US$ 50,000 (per disease) to support costing studies if needed and/or requested by the Global Fund and/or the TRP. The Global Fund will invest through partners on an annual basis[19] using existing measurement mechanisms to make the health and disease expenditure data publicly available for proposal development.

25. **Compliance:** At the time of application submission, applicants will be required to report on Counterpart Financing percentages and trends of their respective national governments. A justification and action plan must be provided as part of the application

[15] The measure for a government's contribution is the annual average of that government's spending in the past two years and current government budget for the relevant disease program. Government expenditure is ideally measured as all government spending on the disease program, excluding external assistance other than loans.
[16] The measure for Global Fund financing is the annual average of all categories of financing requested and provided through other existing Global Fund grants for that disease, for the implementation period of the new application.
[17] The minimum Counterpart Financing threshold for Cross-cutting HSS proposals shall be set at the same levels as for disease proposals and is measured in the same way. Counterpart Financing in the context of Cross-cutting HSS proposals is the total of the government's contribution to all national disease programs (HIV and AIDS, tuberculosis and/or malaria as applicable to a country) which either have existing Global Fund support or a funding request under consideration. Global Fund financing is the total of existing and requested funding for the applicable diseases and HSS.
[18] Key partners include WHO and UNAIDS, among others.
[19] Amount should be based on an annual estimate from partners for the provision of disease and health expenditure data.

submission if Counterpart Financing is below the minimum threshold (see Paragraph 20 of this Policy).

26. Review of the state of compliance with Counterpart Financing requirements will be a material part of all funding requests and conducted by the Secretariat.

27. **Transitions in Income Category:** If a country transitions from one income category to another during a grant period, its minimum threshold will not be reassessed until it applies for funding again.

28. Countries nearing income level category transition will be encouraged to increase their Counterpart Financing contribution with the aim of reaching the next Counterpart Financing threshold in time for their next application for funding.

29. An Early Warning system will be developed and implemented by the Secretariat to identify countries likely to be transitioning to another income level category in the next three years.

Definitions of 'Underserved and Most-At-Risk Populations' and 'Highest-Impact Interventions within a Defined Epidemiological Context'

Underserved and most-at-risk populations:

Subpopulations, within a defined and recognized epidemiological context:

1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population.

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

Highest impact interventions within a defined epidemiological context:

Evidence-based interventions that:

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

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

Cross-cutting HSS interventions addressing needs of underserved populations:

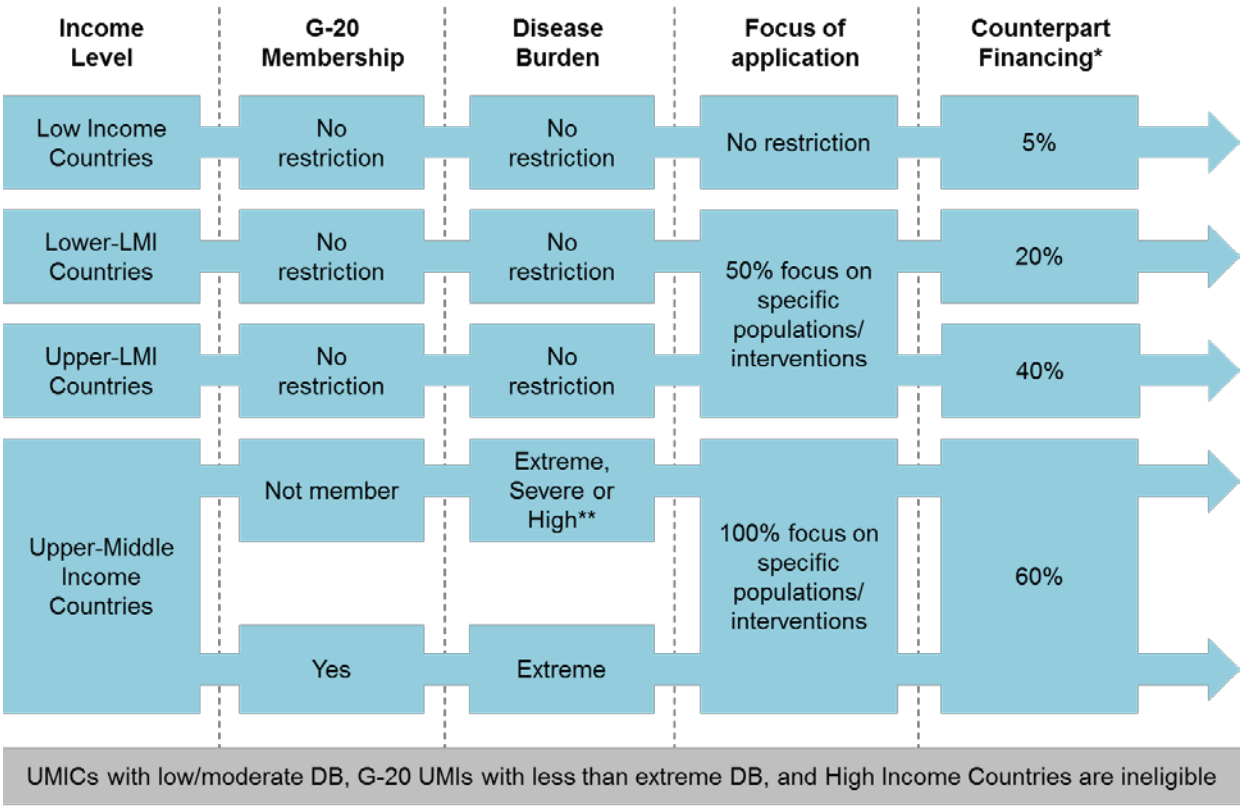
Health systems and community systems strengthening interventions that, within the country context, improve program outcomes for underserved populations in two or more of the diseases by:

1) Improving equitable coverage and uptake addressing any, and preferably all, of:
    - Availability of services
    - Access to services
    - Utilization of services
    - Quality of services

AND

2) Are not funded adequately

Flow chart showing the Eligibility Criteria and required application focus



** Minimum threshold: this is the minimum government contribution to the national disease program, as a share of the total of the government and Global Fund financing for that disease.*
*** Small Island Economies are eligible if they have a low or moderate disease burden.*

Annex C

Disease Burden Indicators

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

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

† MARP: Most-at-risk population

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

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

CURRENT POLICY ON ELIGIBILITY CRITERIA, COUNTERPART FINANCING REQUIREMENTS, AND PRIORITIZATION OF PROPOSALS FOR FUNDING FROM THE GLOBAL FUND

(as approved at the Twenty-Third Board Meeting)

Twenty-Third Board Meeting
Geneva, Switzerland, 11-12 May 2011

GF/B23/14
Attachment 1

POLICY ON ELIGIBILITY CRITERIA, COUNTERPART FINANCING REQUIREMENTS, AND PRIORITIZATION OF PROPOSALS FOR FUNDING FROM THE GLOBAL FUND

PURPOSE:

This attachment provides the full text of the new integrated policy on Eligibility, Counterpart Financing and Prioritization for discussion and approval by the Board.

POLICY ON ELIGIBILITY CRITERIA, COUNTERPART FINANCING REQUIREMENTS, AND PRIORITIZATION OF PROPOSALS FOR FUNDING FROM THE GLOBAL FUND

PART 1: OVERVIEW

1. As outlined in the Framework Document[1], the Global Fund's criteria for eligibility for funding should take into account a number of factors such as disease burden, political commitment, the involvement of an inclusive Country Coordinating Mechanism and the poverty situation[2] of the country[3] in which activities will be implemented.

2. This document sets out an integrated Eligibility, Counterpart Financing[4] and Prioritization policy (the "Policy"). It is designed to ensure that available resources are allocated to countries and regions with the highest disease burden and least ability to bring financial resources to address these health problems, while giving due priority to communities and subpopulations at high risk of disease.

3. This Policy is intended to apply to all Rounds-based and National Strategy Application Funding Channels as well as any other Funding Channels as the Board shall determine. The Policy will apply when the Board has approved the launch of such funding channels, having given due consideration to the resources that are expected to be available to meet demand.

PART 2: GENERAL FUNDING POOL AND TARGETED FUNDING POOL

4. Recognizing the diversity of country situations, the Global Fund will allow funding applications through two distinct funding pools, the General Funding Pool and the Targeted Funding Pool. The choice of pool to which an applicant may apply will be at the discretion of the applicant, however an upper middle income country with a disease burden designated as "high" may only apply for eligible diseases to the Targeted Funding Pool. An applicant may not apply for funding for the same disease to both pools at any given time. The proportion of the resources available to fund proposals within a Call for Proposals which shall be allocated to the General Funding Pool and those allocated to the Targeted Funding Pool is defined in Annex A of this Policy.

5. The *General Funding Pool:* Individual applications to the General Funding Pool shall not be required to restrict the maximum amount of grant funds requested through their proposal. Applications from lower middle income countries and upper middle income countries must comply with requirements relating to focus of proposals (as described in Paragraphs 16-19 of this Policy).

6. The *Targeted Funding Pool:* The Targeted Funding Pool is intended to provide funding for eligible proposals which must comply with the requirements relating to focus of proposals (as described in Paragraphs 16 -18 of this Policy). Proposals for cross-cutting Health Systems Strengthening ("Cross-cutting HSS") shall not be eligible for funding under the Targeted Funding Pool.

[1] The Framework Document of the Global Fund (January 2002)
[2] Income level measured by appropriate economic indicators, such as the World Bank, Atlas Method.
[3] References in this document to "country" refer to "economy" as classified by the World Bank.
[4] Formerly referred to as 'cost-sharing' criteria in previous Board decisions.

PART 3: ELIGIBILITY

7. Eligibility criteria are established to identify which countries may qualify to apply for funding from the Global Fund, and under which conditions. Eligibility determinations will be based on compliance with Country Coordinating Mechanism (CCM) minimum eligibility requirements and such other eligibility requirements as described in this Policy. Applications must also demonstrate compliance with Counterpart Financing requirements (Part 4 of this Policy).

8. **CCM Minimum Eligibility Requirements:** All applicants must comply with the CCM minimum eligibility requirements approved by the Board and as amended from time to time[5].

9. **Income Level:** The income level eligibility of a country submitting a proposal shall be based on a country's income classification as determined by the Global Fund. The Secretariat will make the determination of income classification following the publication of the World Bank (Atlas Method) Income Classifications in July of each year (or following the month of publication if different from July), and in conjunction with the disease burden data provided by key partners[6]. These determinations will be effective for new applications to the Global Fund from 1 January to 31 December of the following calendar year. The income classification groups shall be determined by five distinct categories as follows:

    a. Low income countries (LICs) shall be eligible without specific restriction.

    b. Lower middle income countries (LMICs) shall be split into two income groups using as a cut-off the midpoint[7] of the range of GNI per capita for LMICs as reported by the World Bank. Countries at the midpoint or below the midpoint shall, for the purposes of this Policy, be described as "Lower LMICs" and those above the midpoint as "Upper LMICs". All LMICs must comply with requirements regarding the focus of proposals (see Paragraph 17 of this Policy).

    c. Upper middle income countries (UMICs) will be evaluated for eligibility based upon their respective disease burden (see Paragraph 14 of this Policy). In addition, all UMICs must comply with the requirements regarding the focus of proposals (see Paragraph 18 of this Policy).

    d. High income countries (HICs) shall be ineligible to apply for funding through a single country application.

10. In cases where a country moves up from one income level to the next[8], a one-year grace period will apply such that for the purpose of applications submitted in the next calendar year, the determination of income level eligibility will be based on the income level classification of the previous year. For applications within that year the earlier income level classification will apply. The one-year grace period shall not apply to countries moving from UMIC to HIC.

[5] GF/B16/DP19

[6] Disease burden data is the official data provided by the headquarters of the following key partners per disease: HIV and AIDS: UNAIDS and WHO; Tuberculosis: WHO; Malaria: WHO.

[7] The 'midpoint' is defined as the average between the lower and the upper bound GNI per capita of the LMIC category.

[8] Referred to as 'transitioning'

11. UMICs not listed on the OECD's DAC list of ODA recipients[9] are ineligible to apply for funding for HIV and AIDS proposals except if the application is submitted by a non-governmental organization (NGO) within the country in which activities would be implemented, and for which the government of such country shall not receive any funding. This could be in the form of a non-CCM application or other valid application. Such funding requests[10] shall demonstrate that they target key services, as supported by evidence and the country's epidemiology. Confirmation shall also be provided by applicants that the targeted services are not being provided due to political barriers.

12. A Regional Proposal shall only be eligible for funding where the majority of countries included in the proposal would be eligible to submit their own request for funding for that same disease through a single-country application.

13. Further, a Regional Proposal shall only be eligible to request funding under the General Funding Pool if the majority of countries included in the proposal would be eligible to submit their own request for funding under the General Funding Pool for that same disease through a single-country application.

14. **Disease Burden:** Regardless of disease burden, all LICs and LMICs shall be eligible to apply for funding for HIV and AIDS, tuberculosis, malaria, and/or Cross-cutting Health Systems Strengthening. UMICs shall only be eligible to apply for funding for the disease(s) in which their reported disease burden[11] is measured as 'High', 'Severe' or 'Extreme' as reported in the matrix included in Annex D to this Policy, and as may be amended from time to time. However, UMICs with a 'High' disease burden may only apply to the Targeted Funding Pool. UMICs which are eligible to apply for funding on account of having a 'Severe' or 'Extreme' disease burden, but not those with 'High' disease burden, shall be eligible to apply for Cross-cutting HSS funding from the General Funding Pool.

15. Proposals from UMICs designated under the 'small island economy' exception to the International Development Association lending eligibility requirements[12], are eligible to apply for funding from the Global Fund regardless of national disease burden. Those UMICs designated under the 'small island economy' exception and which have an 'Extreme' or 'Severe' disease burden may apply to either the General Funding Pool or the Targeted Funding Pool, while those with a 'High', 'Medium', or 'Low' or unreported disease burden may only apply to the Targeted Funding Pool.

16. **Proposal Focus:** All LICs may submit proposals for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS deemed appropriate to the populations being served, without restriction on the scope of the proposal, but subject to Technical Review Panel (TRP) review.

[9] The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development publishes a list of countries eligible for Official Development Assistance (ODA)
[10] These extraordinary funding requests will, in the same manner as other funding requests, be reviewed for technical soundness by the TRP and approved by the Board.
[11] As reported by official data provided by the headquarters of the following partners: UNAIDS and WHO for HIV and AIDS, and WHO for tuberculosis and malaria.
[12] As found at the International Development Association website.

17. All Lower and Upper LMICs may submit proposals for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS but must focus at least 50 percent of the proposal's budget on Special Groups and/or Interventions[13] for applications to the General Funding Pool and 100 percent on Special Groups and/or Interventions for applications to the Targeted Funding Pool. Compliance with this criterion will be determined at the time of the TRP review.

18. If eligible, according to disease burden as set out in Paragraph 14 above, UMICs must focus 100 percent of the proposal's budget on Special Groups and/or Interventions, regardless of whether the application is to the General Funding Pool or the Targeted Funding Pool. Compliance with this criterion will be determined at the time of the TRP review.

19. **Recent Funding**: Irrespective of which income classification group an application falls within, an applicant shall be ineligible to apply for funding for HIV and AIDS, tuberculosis, malaria, and/or Cross-cutting HSS if the applicant has received Board-approved funding[14] for the same component (HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS) and has completed less than 12 months of implementation of that funding (the "Implementation Window"). The Implementation Window shall apply from the program start date or Implementation Period starting date (as applicable and as set out in the grant agreement with the Principal Recipient) to the closing date for submission of proposals.

20. Exceptions to the Implementation Window shall be limited to instances where (i) the proposal includes geographic coverage different from the most recent proposal approved by the Board; or where (ii) the proposal intends to implement new technical guidance requiring significant investment.

21. Prior to submitting a proposal, an applicant with a history of Recent Funding (as set out in Paragraph 19 above) must demonstrate all of the following:

    a. The proposal corresponds to one of the specific circumstances described in Paragraph 20 of this Policy;
    b. The need addressed in the proposal cannot be addressed through reprogramming of existing funding; and
    c. There is adequate absorptive capacity and ability to roll-out the proposed new interventions.

22. Applicants with a history of Recent Funding intending to submit an application must present a brief summary of the planned scope of the proposal prior to full proposal development (a "Proposal Concept"). The TRP, with support from the Secretariat, will determine whether or not the Proposal Concept meets the exceptions described and the additional requirements described in Paragraphs 19-21 of this Policy. The results of the review will be communicated to the applicant in a timely manner. Should the Proposal Concept be determined to meet the exceptions noted above, the application will be accepted as receivable. However, final determination of compliance with the exceptions described above will be made by the TRP at the time of proposal review.

[13] Special Groups and/or Interventions are 'underserved and most-at-risk populations' and/or 'highest impact interventions within a defined epidemiological context' as further defined in Annex B.

[14] Reference to 'Board-approved funding' shall include those instances from Rounds 8, 9 and 10 where an applicant received funding for Cross-cutting HSS via section 4B/5B of the disease proposal form, irrespective of whether this funding was signed into a separate and new grant agreement with the Principal Recipient or consolidated into an existing grant agreement.

PART4: COUNTERPART FINANCING

23. Counterpart Financing requirements will apply to all countries applying for funding to the Global Fund.

24. Regional and non-CCM proposals are not required to meet the Counterpart Financing requirements described in this Policy.

25. **Minimum Threshold:** Applicants must demonstrate compliance of the national government of the country which is the subject of a proposal with the minimum threshold for Counterpart Financing. Counterpart Financing threshold is defined as the minimum level of the government's contribution[15] to the national disease program, as a share of total government and Global Fund financing[16] for that disease. To comply with this requirement, the applicant must either demonstrate that its respective national government has met the minimum threshold at the proposal stage, or, if the country's share is below the minimum threshold for Counterpart Financing, it must provide a justification and present an action plan as to how it intends to move towards it as part of the proposal submission (see Paragraph 30 of this Policy).

26. The minimum threshold for Counterpart Financing shall be 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs[17]. UMICs will be encouraged to increase their Counterpart Financing contribution to above 90 percent during the duration of proposal implementation to facilitate graduation out of Global Fund financing.

27. **Increased Government Contribution:** Over the course of implementation of grants funded by the Global Fund within any given country, the government of that country must increase the absolute value of their contribution to the national disease program and health sector each year. In monitoring compliance (see Paragraphs 30-33 of this Policy), extenuating circumstances can be submitted by the applicant for consideration along with clear action plans to meet Counterpart Financing requirements.

28. **Expenditure Data:** Applicants will be required to report government expenditure to key partners[18] using existing measurement mechanisms each year. The numbers, once validated, will be used to assess progress.

29. An applicant should include provision for up to US$ 50,000 (per disease) to support costing studies if needed and/or requested by the TRP. The Global Fund will invest through partners on an annual basis[19] using existing measurement mechanisms to make the health and disease expenditure data publicly available for proposal development.

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[15] The measure for a government's contribution is the annual average of that government's spending in the past two years (for example, in Round 11: 2009 and 2010) and current government budget (for example, in Round 11: 2011) for the relevant disease program. Government expenditure is ideally measured as all government spending on the disease program, excluding external assistance other than loans.

[16] The measure for Global Fund financing is the annual average of financing requested and other existing Global Fund grants for that disease, for the first implementation period of the new proposal.

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

[18] Key partners include WHO and UNAIDS, among others.

[19] Amount should be based on an annual estimate from partners for the provision of disease and health expenditure data.

30. **Compliance:** At the time of proposal submission, applicants will be required to report on Counterpart Financing percentages and trends of their respective national governments. A justification and action plan must be provided for review by the TRP if Counterpart Financing is below the minimum threshold (see Paragraph 25 of this Policy).

31. The TRP will review compliance with Counterpart Financing requirements as a material part of their overall review of the proposal. In doing so, the TRP can make one of three decisions:
    a. Accept the Counterpart Financing arrangements as stated by the applicant in their proposal;
    b. Insert conditionality to acceptance of the Counterpart Financing arrangements as stated by the applicant in their proposal; or
    c. Reject the Counterpart Financing arrangements as stated by the applicant in their proposal.

32. If data is unclear, or the justification for non-compliance with the minimum thresholds is found unsatisfactory, the TRP may request further information.

33. Review of the state of compliance with Counterpart Financing requirements will also be a material part of the Periodic Review.

34. **Transitions in Income Category:** If a country transitions from one income category to another during a grant period, its minimum threshold will not be reassessed until it applies for funding again.

35. Countries nearing income level category transition will be encouraged to increase their Counterpart Financing contribution with the aim of reaching the next Counterpart Financing threshold in time for their next application for funding.

36. An Early Warning system will be developed and implemented by the Secretariat to identify countries likely to be transitioning to another income level category in the next three years.

PART 5: PRIORITIZATION

37. Prioritization criteria shall apply to all applications in the event that sufficient resources are not immediately available to approve all TRP-recommended proposals by the Global Fund Board. The criteria applied for prioritization of applications shall be dependent on whether a particular application is to the General Funding Pool or the Targeted Funding Pool.

38. **General Funding Pool:** Proposals within the General Funding Pool shall be prioritized based on a three-part Composite Index comprised of income level, disease burden and TRP recommendation category. The Secretariat is responsible for assigning scores to proposals and to present the Board with these scores at the time of the Board's consideration of the TRP's recommendation for funding.

39. Disease Burden indicators as set out in Annex D of this Policy shall apply to all proposals within the General Funding Pool except where they are revised by the Global Fund Board from time to time. An indicator for Cross-cutting HSS proposals shall be used in place of a disease burden indicator and shall be comprised of an average of the respective disease burden scores for the diseases benefiting from the Cross-cutting HSS proposal.

40. Proposals under the General Funding Pool shall be assigned a score in accordance with the table in Annex E of this Policy and shall be funded in accordance with this scoring in descending order, with the highest scoring proposals receiving priority over lower scored proposals.

41. If there are insufficient resources to fully fund all proposals in a particular score, the proposals shall be sub-prioritized by the Secretariat according to their GNI per capita, whereby the proposals with the lowest GNI per capita will receive priority over those proposals from countries with a higher GNI per capita.

42. **Targeted Funding Pool:** All proposals will be subject to a budget ceiling, and the maximum size of the Targeted Funding Pool will be pre-set as defined in Annex A of this Policy. Proposals within the Targeted Funding Pool shall be prioritized based on the agreed methodology for ranking developed by the TRP.

43. The TRP shall prioritize proposals recommended for funding in the Targeted Funding Pool via a two-step process. First, the TRP shall review the proposals to determine whether they should be recommended for funding. As with other proposals, they will be assigned a recommendation category (1, 2, 2B, 3, or 4). Second, all proposals recommended for funding (1, 2, or 2B) will then be assigned an additional score, based on an agreed methodology, to enable prioritization. The TRP review process will incorporate measures to ensure consistency of approach.

44. **Surplus of assets in either the General Funding Pool or Targeted Funding Pool:** In the event that available funding for either the General Funding Pool or the Targeted Funding Pool exceeds TRP-recommended demand in that pool, then any surplus assets would be available to meet unmet demand, if any, in the other pool.

45. **Regional Proposals:** The prioritization model for regional proposals shall reflect which pool the application is submitted to. If submitted to the General Funding Pool, the income level and disease burden scores shall be derived, respectively, from an average of the individual scores of each country included in the regional proposal.

46. **UMIC Allocation:** Funding for UMICs in the General Funding Pool shall not exceed 10 percent of the proposal value (lifetime incremental) of the particular funding window. However, such 10 percent limit in funding shall not apply to funds allocated to UMICs in the Targeted Funding Pool.

Resource Allocations for the General Funding Pool and Targeted Funding Pool

The *General Funding Pool:* A majority of Global Fund resources available to fund proposals will be assigned to applications made to the General Funding Pool. The proportion of funds available shall be set at a minimum of 90 percent of the total resources available within a particular funding window. Individual applications to this pool are not subjected to limits as to the maximum proposal amount.

The *Targeted Funding Pool:* The proportion of Global Fund resources available for the Targeted Funding Pool shall be 10 percent of available financial resources for a particular funding window or a maximum of US$ 150 million for the first two years of grant life (and a maximum of US$ 350 million over five years). An application to the Targeted Funding Pool must have a pre-defined budget ceiling of not more than US$ 5 million for the first two years and not more than US$12.5 million for a five year proposal, both ceilings relating to incremental funding in the case of a consolidated proposal.

Surplus of assets in either the General Funding Pool or Targeted Funding Pool: In the event that available funding for either the General Funding Pool or the Targeted Funding Pool exceeds TRP-recommended demand in that pool, then any surplus assets would be available to meet unmet demand, if any, in the other pool.

Definitions of 'Underserved and Most-At-Risk Populations' and 'Highest-Impact Interventions within a Defined Epidemiological Context'

Underserved and most-at-risk populations:

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

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

Highest impact interventions within a defined epidemiological context:

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

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

Cross-cutting HSS interventions addressing needs of underserved populations:

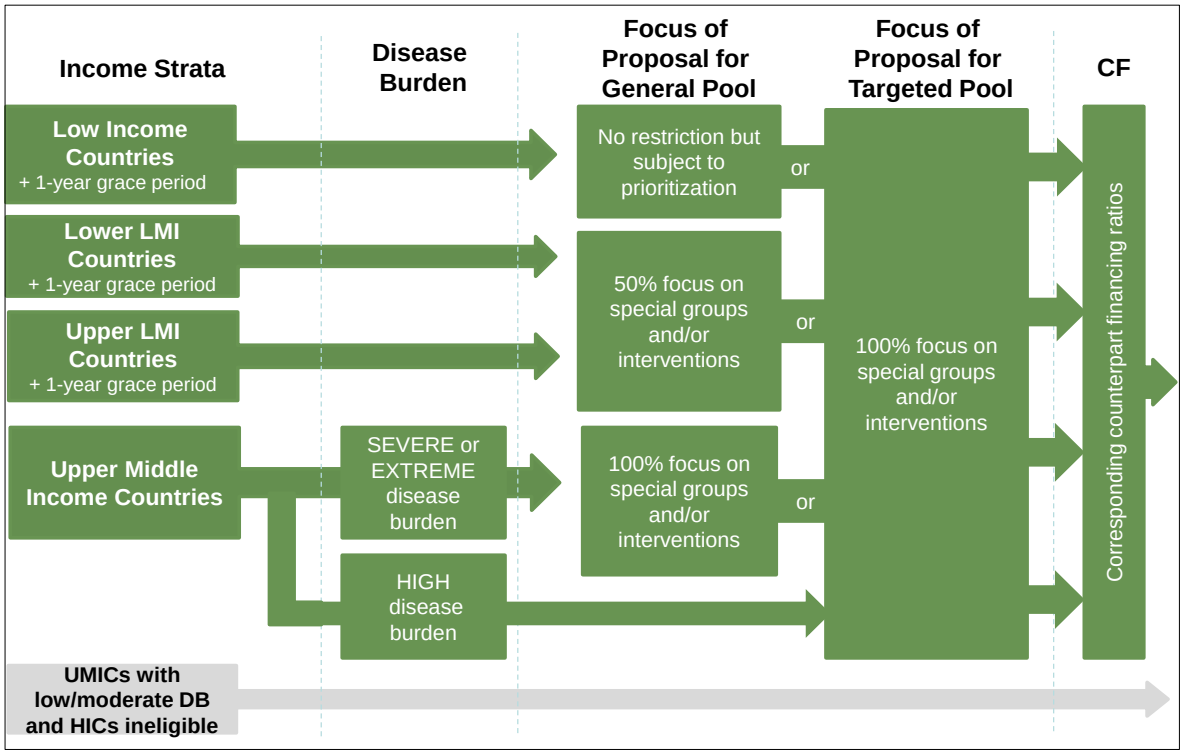
Health systems and community systems strengthening interventions that, within the country context, improve program outcomes for underserved populations in two or more of the diseases by:
1) Improving equitable coverage and uptake addressing any, and preferably all, of:
    - Availability of services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

AND

2) Are not funded adequately

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

Flow chart showing the Eligibility Criteria and required Focus of Proposals for the General and Targeted Funding Pools



* CF refers to Counterpart Financing

Annex D

Disease Burden Indicators and Scores

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

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

† MARP: Most-at-risk population

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

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

General Funding Pool Composite Index for Prioritization

Countries with the greatest need (by reference to disease burden and income) will typically access the General Pool. The prioritization model in the General Pool builds on a three-part Composite Index for Prioritization comprising: country income level, disease burden as follows:

i. Income Tiers/Scores: use of the four-tiered income stratification, described in Paragraph 9 of the Policy, and narrowing the score differential between LIC and UMIC categories (see table below);

ii. Disease Burden: application of a weight (score) to "Extreme" disease burden = 8, "Severe" = 6, "High" = 4, "Moderate" – 2, "Low" = 1. For Cross-cutting HSS applications (including through the Health Systems Funding Platform): use of the average of the respective disease burden indicators based on the diseases benefiting from the HSS proposal (see table below); and

ii. TRP Recommendation Category: scored and reflected in the Composite Index as in the Round 10 model.[20]

Proposal Score based on Income Level and Disease Burden*

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

* Shaded cells reflect the combined score for a proposal
** Not eligible for the General Pool; eligible for the Targeted Pool

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