35th Board Meeting

Allocation Methodology 2017-2019

GF/B35/05 – Revision 1
Board Decision

PURPOSE: This paper presents the Board with the Strategy, Investment and Impact Committee's recommendation on holistic refinements to the allocation methodology for 2017-2019.

The Global Fund

I. Decision Point

1) Based on the rationale described below, the following decision point is recommended to the Board:

Decision Point GF/B35/DP10: Allocation Methodology 2017 - 2019

1. ***The Board notes:***
   a. ***Its decisions in September 2012 (GF/B27/DP07) and November 2012 (GF/B28/DP04) that established the principles and framework for the allocation-based funding model (the "Funding Model Principles");***
   b. ***Its decisions in October 2013 (GF/B29/EDP10 and GF/B29/EDP11) and March 2014 (GF/B31/DP06, GF/B31/DP07, GF/B31/DP08, GF/B31/DP09 and GF/B31/DP10) to define certain elements for the 2014 – 2016 allocation period that would be reviewed and refined, as appropriate, prior to the 2017 – 2019 allocation period (the "2014 – 2016 Elements"); and***
   c. ***Decisions by the Strategy, Investment and Impact Committee (the "SIIC") in October 2013, under authority delegated by the Board, to establish technical parameters for the 2014 – 2016 allocation period (GF/SIIC09/DP01) and the process for managing and awarding incentive funding and unfunded quality demand (GF/SIIC09/DP02) (the "Prior SIIC Decisions").***

2. ***Accordingly, based on the recommendations of the SIIC, as presented in GF/B35/05 – Revision 1, the Board:***
   a. ***Approves the allocation methodology presented in Annex 1 to GF/B35/05 – Revision 1 (the "Allocation Methodology");***
   b. ***Acknowledges the technical parameters for the 2017 – 2019 allocation period, as presented in Annex 2 to GF/B35/05 – Revision 1 and approved by the SIIC at its 17th meeting in March 2016 (the "Technical Aspects"); and***
   c. ***Affirms the restatement of core parts of the Funding Model Principles, as presented in Annex 3 to GF/B35/05 – Revision 1 (the "Affirmed Principles").***

3. ***Accordingly, the Board:***
   a. ***Requests the Strategy Committee to review and approve, at its June 2016 meeting, the method by which the Secretariat will apply and report on the qualitative-factor adjustment process;***
   b. ***Requests the Secretariat to present the priorities, activities or initiatives, including associated costs, that could be funded as catalytic investments, for the Strategy Committee to review at its June 2016 meeting and recommend to the Board; and***
   c. ***Acknowledges that the Allocation Methodology, Technical Aspects and Affirmed Principles shall apply for the 2017 – 2019 allocation period and supersede the Funding Model Principles, 2014 – 2016 Elements and Prior SIIC Decisions.***

There are no budgetary implications of this decision

II. Relevant Past Decisions

2) The following summary of relevant past Board and Committee decision points is submitted to contextualize the decision point proposed in Section I above.

Relevant Past Decision Point	Summary and Impact
GF/SIIC17/DP05: Allocation Methodology 2017 – 2019 (March 2016)	The SIIC decided that the following parameters for the 2017 – 2019 allocation replace those used for the 2014 – 2016 allocation period, as previously approved under decision point GF/SIIC09/DP01: (i) indicators for disease burden and country economic capacity, which represents a terminology update to ability to pay; (ii) maximum and minimum shares for the allocation; and (iii) external financing adjustment. The approved parameters for the 2017 – 2019 allocation period are set forth in Annex 2.
GF/B31/DP10: Composition of and Allocation to Country Bands (March 2014)[1]	Based on the recommendations of the SIIC, the Board approved: (i) the composition of four country bands for the 2014 – 2016 allocation period; (ii) the indicative amounts of funding allocated to each band; and (iii) the amount of incentive funding available for country bands 1, 2 and 3. These parameters no longer apply for the 2017 – 2019 allocation period.
GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period (March 2014)[2]	Based on the recommendations of the FOPC and SIIC, the Board approved the total amount of funds to be allocated to country bands (the "Total Allocation"). It also approved, to account for the shift from the rounds-based system to the allocation-based funding model, establishing the minimum required level as the greater of: (i) a 25-percent target reduction of a country-component's most recent available four-year disbursements; or (ii) a country component's existing grants pipeline as at 31 December 2013. These provisions addressed the unique circumstances of transitioning from the Third to the Fourth Replenishment and do not apply to the 2017 – 2019 allocation period.
GF/B31/DP07: Regional Programs (March 2014)[3]	Based on the recommendation of the SIIC, the Board approved US$200 million for new Regional Programs over the 2014 – 2016 allocation period, noting and distinguishing that multi-country applications would be funded through their constituent countries' allocations. If the Board adopts the decision point presented in this paper, a refined approach to multi-country programs will be reviewed by the Strategy Committee to prepare recommendations to the Board on the priorities, activities or initiatives that may be funded as catalytic investments for the 2017 – 2019 allocation period.
GF/B31/DP06: Special Initiatives (March 2014)[4]	Based on the recommendation of the SIIC, the Board decided that up to US$100 million would be available over 2014 – 2016 for a specified list of special initiatives, including potential reallocation of funding across the approved special initiatives upon the approval of the SIIC, in consultation with the FOPC. If the Board adopts the decision point presented in this paper, a refined approach to funding beyond country allocations will apply for the 2017 – 2019 allocation period based on the Strategy Committee's recommendations to the Board on the priorities, activities or initiatives that may be funded as catalytic investments.

[1] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP10/
[2] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/
[3] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP07/
[4] http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP06/

Relevant Past Decision Point	Summary and Impact
GF/SIIC09/DP01: Indicators for the Allocation Formula and the Band 4 Methodology (October 2013)	Under authority delegated by the Board, the SIIC approved the following parameters for the 2014 – 2016 allocation period: (i) indicators for disease burden and ability to pay; (ii) allocation methodology for Band 4 (i.e., countries with higher income and lower disease burden); and (iii) maximum and minimum shares for apportioning indicative funding to countries. At its 17th meeting in March 2016, the SIIC approved parameters for the 2017 – 2019 allocation period, which replace those approved for the 2014 – 2016 allocation period, and are presented in Annex 2 to this paper. If the Board adopts the recommendation presented in this paper, then a separate methodology to address needs in higher income and lower disease burden settings will no longer exist. However, catalytic investments towards strategic initiatives and to incentivize the use of country allocations for strategic priorities, including for key and vulnerable populations, in accordance with Global Fund and partner strategies, will be available following further recommendations by the Strategy Committee.
GF/SIIC09/DP02: Management of Incentive Funding and Unfunded Quality Demand (October 2013)	Under authority delegated by the Board, the SIIC approved the process and methodology for awarding incentive funding as well as prioritizing and awarding potential funding for unfunded quality demand. These processes and methodology are superseded and no longer apply if the Board adopts the decision point presented in this paper.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013)[5]	Based on the recommendation of the SIIC, the Board approved, for the 2014 – 2016 allocation period, the apportionment of resources available for allocation to country bands among the three diseases based on the following distribution: 50 percent for HIV/AIDS, 32 percent for malaria, and 18 percent for tuberculosis. The Board directed the Secretariat to ensure integrated TB/HIV services are addressed in the country dialogue and concept note development process for countries with high TB/HIV co-infection rates. Furthermore, the Board requested the SIIC to review this decision to develop and recommend appropriate modifications to the Board prior to the 2017 – 2019 allocation period. These parameters and principles are affirmed for the 2017 – 2019 allocation period if the Board approves the decision point presented in this paper.
GF/B29/EDP10: Division between Indicative and Incentive Funding (October 2013)[6]	Based on the recommendation of the SIIC, the Board approved the method for determining the amount of incentive funding available for the 2014 – 2016 allocation period. Accordingly, a fixed percentage would be applied to the amount of the Initial Allocation, after deducting the amount of resources for the country band with higher income and lower disease burden (Band 4), to determine the amount of incentive funding that would be available. For the 2014 – 2016 allocation period, incentive funding would be 10% for an Initial Allocation of up to USD 11 billion, 15% for an Initial Allocation over USD 11 billion and up to USD 13.5 billion, and 20% for an Initial Allocation over USD 13.5 billion. Furthermore, the Board approved a target minimum reduction of 20% of the most recently available three-year disbursement levels for the country components receiving funding above their formula-derived amounts. This served as the minimum required level in the form of a paced reduction of funding for such country components. Furthermore, the Board deemed those country components receiving more than 50 percent above their formula-derived amounts ineligible for incentive

[5] http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP11/
[6] http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP10/

Relevant Past Decision Point	Summary and Impact
	funding. The Board requested the SIIC to review this decision to develop and recommend appropriate modifications to the Board prior to the 2017 – 2019 allocation period. These approaches are replaced and superseded if the Board approves the decision point presented in this paper.
GF/B28/DP04: Evolving the Funding Model (Part Two) (November 2012)[7]	Based on the recommendation of the SIIC, the Board approved: (i) the alignment of three-year allocation periods with three-year replenishment periods; (ii) the principles for determining and composing country bands; (iii) the principles for allocating to country bands based on ability to pay and disease burden; (iv) the purpose and principles of indicative and incentive funding, as well as unfunded quality demand; and (v) the existence and role of certain qualitative factors that could adjust the results of the allocation formula, including, but not limited: 1. major sources of external funding; 2. minimum funding levels; 3. willingness to pay; 4. past program performance and absorptive capacity; 5. risk; 6. increasing rates of new infections in lower prevalence countries. Furthermore, the Board requested the regular review of the key elements decided prior to each allocation period. These principles of the allocation-based funding model are affirmed in their amended and restated form in the accompanying annexes to this paper that reflect the recommendation presented to the Board for approval, which supersedes decision point GF/B28/DP04.
GF/B27/DP07: Evolving the Funding Model (September 2012)[8]	Based on the recommendation of the SIIC, the Board adopted the principles for key elements of the allocation-based funding model, including a ceiling of 10 percent of the resources available for allocation that could be used for programs or strategic investments outside of the allocation to country bands, access to funding parameters for the allocation-based funding model, and requested the SIIC to work further towards evolving the funding model. Other than the access-to-funding parameters, which are affirmed by the decision point presented in this paper and restated in the accompanying annexes , the Board's approval of the decision point presented in this paper supersedes decision point GF/B27/DP07.

III. Action Required

3) The Board is requested to review and approve the Strategy, Investment and Impact Committee's (SIIC's) recommended refinements to the allocation methodology for the 2017-2019 allocation period.

4) Annex 1 to this paper sets forth the allocation methodology that the SIIC recommends to the Board for approval. Annex 2 to this paper presents the technical parameters that the SIIC has approved for the 2017 – 2019 allocation period. Annex 3 to this paper sets forth the updated access-to-funding principles initially approved with the allocation-based funding model, which are presented by the SIIC for the Board to affirm together with the SIIC's recommended refinements to the allocation methodology. Annexes 1 and 3, in particular, combine existing policies and principles, which remain relevant, with the refinements proposed by the SIIC. Upon approval by the Board, the three annexes will serve as a comprehensive reflection of the allocation methodology, superseding prior decisions or documents.

[7] http://www.theglobalfund.org/Knowledge/Decisions/GF/B28/DP04/
[8] http://www.theglobalfund.org/Knowledge/Decisions/GF/B27/DP07/

IV. Executive Summary

5) In November 2015, the Board requested that the allocation methodology be holistically refined to ensure greater impact, simplicity, flexibility and predictability, and to achieve aims of the 2017-2022 Global Fund Strategy. On this basis, the SIIC has rigorously assessed and debated various holistic approaches, taking into account lessons learned from implementation of the 2014-2016 allocation methodology and input and reviews from the TERG, TRP, and 2015 Partnership Forums. At its 17th meeting in March 2016, the SIIC concluded its deliberations and finalized its recommended package of refinements that will maximize the impact of Global Fund resources, enable delivery against the 2017-2022 Strategy, and ensure predictability, flexibility and a simplified approach. This paper presents the SIIC's recommended package of refinements for the 2017-2019 allocation period to the Board for review and approval.

V. Background

6) The Board's adoption of an allocation methodology represented a significant shift in how the Global Fund invests for impact. The allocation methodology increased the strategic focus and impact of Global Fund investments. For the 2014-2016 allocation period, 92% of allocations were actively targeted to lower and lower-middle income countries, and 95% of allocations to countries with high, severe or extreme disease burdens[9]. Nonetheless important lessons were learned from the roll out of the allocation approach for 2014-2016[9], and significant feedback and recommendations on the allocation methodology were received in the Partnership Fora and strategy development process, from the Technical Evaluation Reference Group's (TERG's) Thematic Review on the Allocation Methodology[10] and the Technical Review Panel. Refinements to the allocation methodology have also been guided by the *Global Fund Strategy 2017-2022: Investing to End Epidemics*[11] (Strategy) and its objective of focusing on the highest burden countries with the lowest economic capacity and on key and vulnerable populations disproportionately affected by the three diseases.

7) At its 34th meeting in November 2015, the Board recognised that allocation methodology was successful in shifting the Global Fund towards a more predictable, active and impactful approach to financing but that aspects of the model require evaluation and potential refinement to deliver on the aims of the 2017-2022 Strategy and further enable differentiated investments along the development continuum. The Board advised that adjustments should strive to ensure greater impact, simplicity, flexibility and predictability, and directed that achievement of these aims require the refinements to be considered in a holistic manner to ensure a coherent approach to achieving the aims of the allocation methodology.

01 Process of SIIC assessment of allocation packages

8) Based on a thorough assessment of lessons learned and guided by the Board's aims, the SIIC have undertaken a detailed and evidence-based process to assess a broad range of potential refinements to the allocation methodology for 2017-2019. Over a series of in-person meetings and teleconferences in 2015 and 2016, the SIIC have progressively narrowed options, which have been centered on two major deliverables: the technical parameters for the allocation approach for 2017-2019, for SIIC adoption under delegated authority from the Board (GF/B28/DP04); and refinements to major aspects of the allocation methodology for recommendation to the Board. These major aspects are: funding aspects beyond country allocations; the minimum required level (MRL); funding for concentrated burdens in higher income settings; and country groupings and flexibility in Board approval of allocations. To ensure a coherent approach to these issues, SIIC assessments have been made holistically by evaluating refinements in 'packages' representing progressive options and refinements to the major aspects of the allocation approach.

[9] GF/B34/12
[10] GF/B35/14
[11] GF/B35/02

9) Rigorous analytics have supported the SIIC's assessment of the packages. This included assessment of the resulting distribution of funding at the portfolio level by income levels, regions, country bands and disease burden categories; resulting funding to the top 15 high burden countries in each disease; and each package's effect on the individual country components, particularly the most above- and below-formula in the 2014-2016 allocation period. Analysis of the allocation refinements were also supported by the impact modelling used for the Global Fund's Investment Case[12], which was used to project the relative potential impact[13] of country allocations arising from each package. These analytics were used to assess the extent to which each option addressed the shortcomings of the 2014-2016 approach and balanced the need for both scale-up and predictability for countries. Qualitative assessments were also undertaken to evaluate the extent to which each package would enable delivery on the 2017-2022 Strategy and result in a more impactful, simple, flexible and predictable allocation model.

VI. Discussion

01 Overview of the SIIC-recommended allocation approach for 2017-2019

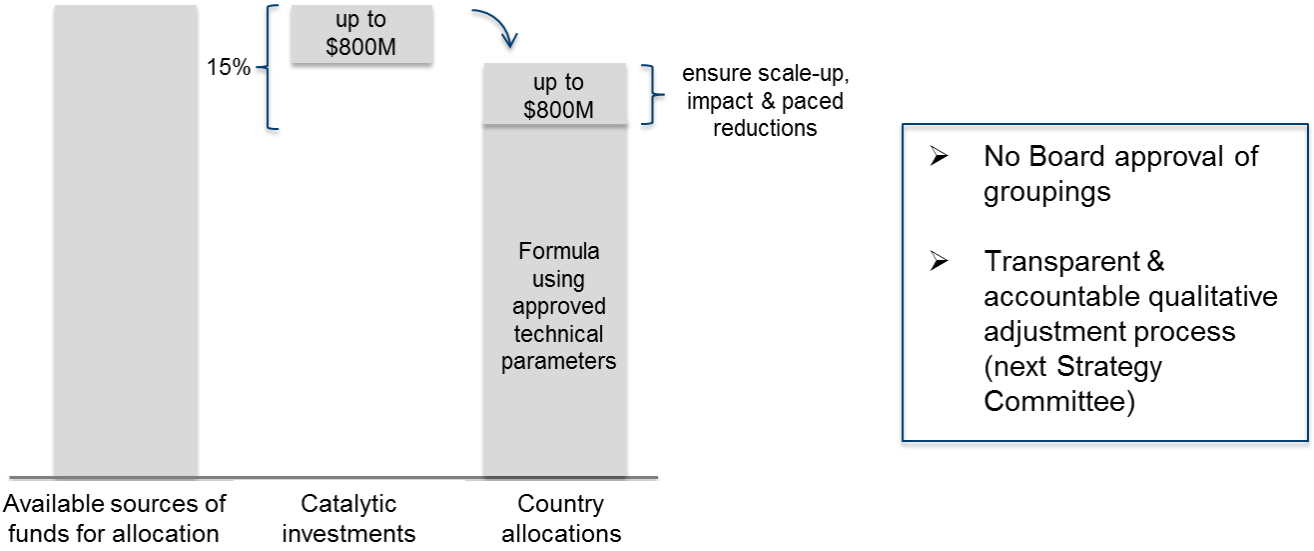


Figure 1: depiction of the SIIC's recommended allocation approach for the 2017-2019 allocation period.

10) The SIIC-recommended approach for the 2017-2019 allocation period aims to increase impact by directing a greater portion of the funding towards the countries with the highest disease burden and least economic capacity; retaining significant funds for catalytic investments in strategic priorities, including for key and vulnerable populations, women and girls, human rights, multi-country approaches and strategic initiatives; prioritizing both scale-up in below-formula and predictable decreases in above-formula components; and increasing the Global Fund's ability to flexibly address the needs of countries on a case-by-case basis. The SIIC-recommended approach is simplified, entailing only two funding approaches: country allocations and catalytic investments.

[12] Investment Case for the Global Fund's 2017-2019 Replenishment: The Right Side of the Tipping Point for AIDS, Tuberculosis and Malaria Presented on 17 December 2015 at the Global Fund's Fifth Replenishment Preparatory Meeting in Tokyo, Japan.
[13] The impact modelling can only be used to illustrate the impact of country allocations, not the important impact anticipated to be achieved with funds beyond country allocations, as it cannot yet be known to which country disease programs this funding will be attributed.

Country Allocations

11) This approach seeks to maximize funding through country allocations. It would move significantly more towards the formula-driven financing for countries than the Current Policy approach[14], resulting in a distribution of resources that is increasingly in line with disease burden and country economic capacity. This is based upon a major challenge of the 2014-2016 allocation methodology, where USD 1.25bn was set aside for incentive funding, multi-country, and strategic initiatives, yet many country allocations were insufficient, at least 10 of the highest burden country components had to shorten grants to maintain efforts against the three diseases, and incentive funding had to largely be appropriated to fill programming gaps.

12) As such, with the exception of up to USD 800m for catalytic investments, all funding available will be run through the allocation formula to ensure more robust and predictable country allocations. Instead of an MRL, once the formula has been run, up to USD 800m can be moved to ensure scale-up, impact and paced reductions across the portfolio. This approach will balance the need for scale-up in previously high burden and under-formula countries with paced reductions for countries which were previously above-formula. The funding for catalytic investments and to ensure scale-up, impact and paced reductions is limited to 15% of funding available to ensure robust allocations.

13) To define the technical parameters for use in the 2017-2019 allocation formula, the SIIC examined and assessed options, in consultation with Technical Partners. Under delegated authority from the Board (GF/B28/DP04), at their March 2016 meeting the SIIC approved the technical parameters for use in the allocation formula for 2017-2019. These parameters are: the disease burden and country economic capacity indicators, minimum and maximum shares and external financing adjustments. The approved technical parameters are detailed in Annex 2 of this paper.

14) According to the Investment Case impact modelling, country allocations arising through the SIIC-recommended approach would increase[15] the impact of Global Fund financing by an anticipated 38,000 additional lives saved, and an additional 16 million infections or cases averted. Significant additional numbers of lives saved and infections averted would be anticipated through the critical use of catalytic funds to incentivize and drive country allocations for greater impact.

Catalytic investments

15) As laid out in the founding principles of the allocation-based funding model[16], a portion of overall resources may be retained for programs, activities, and strategic investments not adequately accommodated through country allocations. This need remains for the 2017-2019 allocation period, in particular to deliver on the 2017-2022 Strategy. The SIIC recommends that USD 800m be retained for catalytic investments, to serve three purposes:

a) *Incentivizing the use of country allocations for strategic priorities in line with the Global Fund and partner disease strategies, including for key and vulnerable populations, gender-based programs and contributing to resilient and sustainable systems for health*:

   Funding for this purpose would catalyze and match use of country allocations towards critical strategic priorities of the Global Fund and its partners. These funds would be used to incentivize countries to prioritize and direct country allocations towards key epidemiological and context-specific challenges to addressing the three diseases and building resilient and sustainable systems for health. The approaches to respond to these priorities should be driven bottom-up by countries rather

[14] The 'Current Policy' approach uses the 75% MRL applied to four-year funding levels for the 2014 – 2016 allocation period and the same absolute funding amounts for beyond country allocation aspects (USD 1.25bn), even though the total sources of funds available will likely be different for the 2017 – 2019 allocation period. The Band 4 methodology approach and Country Bands used are as for 2014-2016. All other technical aspects of the model are updated in line with the SIIC-adopted technical parameters for 2017-2019. The MRL is updated to be based on funding levels derived from the 2014-2016 allocation period. Unlike for 2014-2016, the MRL does not include the pipeline of funds resulting from the transition from a rounds-based to allocation-based funding model.
[15] As compared with the Current Policy approach
[16] GF/B27/DP07

than dictated by the Global Fund. Such priorities and applicable contexts would be determined through consultations with relevant technical and community partners to ensure funding is prioritized according to critical strategic needs and that applications are not burdensome to countries. The SIIC specifically recommends that one aim of these funds should be to incentivize programming for key and vulnerable populations.

These funds would be operationalized through a simple matching fund aligned with strategic priorities, awarded at the time of reviewing the funding request for a country's allocation, and requiring the use of country allocations in addition to catalytic funding. Additional illustrative priority categories could be considered for catalytic investments include funding for human rights, gender-based programs, and for data collection, analysis and use in achieving impact and program quality and efficiency.

b) *Multi-country approaches*: to target key, strategic multi-country priorities deemed as critical to meet the aims of the 2017-2022 Strategy and in line with global disease priorities. A limited number of priority approaches would be identified prior to the 2017-2019 allocation period in conjunction with the Global Fund's relevant technical and community partners, and applications actively sought to meet these aims. Illustrative types of approaches that could be addressed could include cross-border and regional programs for key and vulnerable populations, human rights barriers to services, drug resistance and elimination in malaria; approaches for bringing MDR-TB care to the community or finding missing TB cases; and harm reduction.

c) *Strategic initiatives*: to continue the limited funding for critical approaches deemed necessary for the success of country allocations in line with the objectives of the 2017-2022 Strategy, but not able to be funded through allocations due to their cross-cutting, innovative or off-allocation cycle nature. The specific initiatives would be recommended to the Board by the Strategy Committee prior to the 2017-2019 allocation period, but illustratively could include continuation of impactful initiatives including the Emergency Fund and community, rights and gender technical cooperation engagement funds.

16) At its June 2016 meeting, the Strategy Committee would review the proposed priorities, activities or initiatives that could be funded within each of the three purposes for catalytic investments. Prior to the start of the 2017 – 2019 allocation period, the Strategy Committee, in consultation with the Audit and Finance Committee, would recommend the proposed priorities, activities or initiatives, with the associated costs of each, to the Board for approval. Once approved, the Strategy Committee would retain flexibility to move funding across the approved priorities, activities or initiatives, as needed.

17) Noting the challenges for the 2014-2016 allocation approach, where USD 1.25bn was set aside for incentive funding, multi-country and strategic initiatives, yet country allocations were insufficient and incentive funding had to largely be appropriated to meet programming gaps, the SIIC recommends the total funding for catalytic investments be limited to up to USD 800m. The SIIC considers this amount of funding appropriate to achieve a set of critical and prioritized aims, whilst remaining sufficiently bounded to ensure robust and predictable country allocations. Setting aside further funding available from country allocations would risk reducing predictability for countries and creating the same programming gaps that had to be filled by incentive funding for 2014-2016. For example, were funding for catalytic investments to be increased by an additional USD 400m[17], USD 300m of this would come directly from allocations to the top 15 high burden countries[18] in HIV, TB and malaria, risking the creation of new programming gaps.

[17] The additional USD 400m was modelled in absence of the limitation that funding for catalytic investments and to ensure scale-up, impact and paced reductions should be limited to 15% available resources for allocation.
[18] Burden measures for HIV, TB and malaria are per the burden indicators approved by the SIIC for allocation 2017-2019, as listed in Annex 2; and for allocations modelled for illustrative purposes with the assumption of a USD 13bn replenishment resulting in an approach where USD 11.1bn is the amount of sources of funds available for allocation, following an illustrative 7.5% adjustment for technical considerations (including conservative approach to foreign exchange) per Comprehensive Funding Policy, and USD 0.9bn for operating expenses over the 2017-2019 period. The top 15 high burden countries in each disease together form a list of 26 countries.

18) Furthermore, the SIIC recommends that the Secretariat should have flexibility to move funds for catalytic investments to the funding available to ensure scale up, impact and paced reductions (see below section) , if necessary, notifying the Board if so.

Ensuring scale up, impact and paced reductions in the allocation methodology

19) For 2014-2016, a 75% MRL was adopted to provide paced-reductions for country components that had previously received more funding under a rounds-based approach than they would through the allocation methodology[19]. However, prioritizing 75% minimum funding levels for all above-formula components significantly limited the ability to deliver scale-up in high burden below-formula components, with at least 10 of the highest burden country components having to shorten their grants to maintain programming levels. Furthermore, the 75% MRL was applied portfolio-wide, without consideration of potential funding gaps or reductions in impact arising from this one size fits all approach. For the 2017-2019 allocation period, the SIIC recommends taking a more progressive and differentiated approach to balancing scale-up, impact and paced reductions across the portfolio. The SIIC-recommended approach would ensure that the methodology is able to deliver on its aims of ensuring increased impact, whilst remaining predictable for countries and protecting the gains of past investments.

20) The SIIC recommends that the MRL be replaced by an approach that utilizes up to $800m to balance scale-up, impact and paced reductions across the portfolio after the initial allocation is run. The movement of these funds would be guided by the following approach:

a) First, the allocation would prioritize at least 50% scale-up towards the formula's initial calculated amounts in country components whose previous funding levels[20] were below these amounts;

b) Second, the allocation would prioritize providing paced reductions to country components whose previous funding levels [20] were above the formula's initial calculated amounts. In doing so:

   i) A country component with a larger gap between the formula's initial calculated amount and previous funding level would receive proportionately more funding than a country component with a smaller gap; and

   ii) No previously above-formula country component (i.e. with previous funding level above initial calculated amount) would receive funding greater than 75% of previous funding levels.

c) The Secretariat will have flexibility to refine funding to country components, as appropriate.

21) This approach balances the need for both scale-up and paced reductions aligned with burden of disease and country economic capacity. Under the overall funding levels simulated [21], the net effect of providing USD 800m for scale-up and paced reductions under the SIIC-recommended approach is expected to result in significant scale-up of 60%, 64% and 72% in for country components whose previous funding levels were below the allocation formula's initial calculated amounts in HIV, tuberculosis and malaria, respectively.[20].

22) Whilst the paced-reductions arising through this approach will be differentiated across country components, at portfolio level they would be equivalent to an average 63% MRL[21]. Beyond the initial step

[19] To address the transition from the Third to the Fourth Replenishment Period, which coincided with the transition from the rounds-based system to the allocation-based funding model, the Board agreed that the MRL would be the greater of a country component's existing grants pipeline or 75% of its most recent four-year disbursement levels (GF/B31/DP09).
[20] Previous funding levels represent actual and forecasted use of funds arising from the previous allocation period. Forecasted funds account for expected capacity of the program to utilize remaining funds. For the 2017-2019 allocation period, funding levels arising from the 2014-2016 allocation period (4-year allocations) will be adjusted to 3-year equivalent amounts and include country allocations, incentive funding and shortened grant duration funding.
[21] Modelled for illustrative purposes with the assumption of a USD 13bn replenishment resulting in an approach where USD 11.1bn is the amount of sources of funds available for allocation, following an illustrative 7.5% adjustment for technical considerations (including conservative approach to foreign exchange) per Comprehensive Funding Policy, and USD 0.9bn for operating expenses over the 2017-2019 period.

described above, the further refinement of funding levels will aim to ensure that paced reductions mitigate programming gaps. They will also account for a program's potential for impact and relevant contextual and implementation factors.

23) Additionally, should the funding available be insufficient to ensure scale-up, impact and paced reductions across the portfolio, the SIIC recommends that the Secretariat retain flexibility to move funding set for catalytic investments for these purposes[22].

24) Overall, this guided but flexible approach, subject to a limited amount of funding, is anticipated to better position the allocation methodology to ensure scale-up for impact in high burden, previously below-formula country components for 2017-2019. At the same time it will also guard against sudden drops in funding levels, while ensuring paced reductions are differentiated according to their needs.

Addressing the needs of concentrated burdens in higher income settings in the allocation approach

25) For the 2014-2016 allocation period, a "Band 4 methodology" was put in place to ensure funding for concentrated burdens in higher income settings, in order to account for contexts where the formula's main parameters (disease burden and country economic capacity) do not fully reflect a country's needs[23]. This methodology, which funded based on a country's population size, led to allocations that were insufficiently proportional and tailored to country contexts, with the approval of country bands significantly limiting the Global Fund's ability to flexibly move funds for greater impact. Furthermore, countries with concentrated burdens are situated across the portfolio, and not limited to the grouping of countries categorized for the 2014-2016 allocation period as "Band 4".

26) For 2017-2019, a more refined, multi-faceted package of responses to meet the needs of concentrated burdens in higher income settings is proposed, entailing:

a) Catalytic investments: the SIIC specifically recommends that one aim of catalytic funding be to incentivize programming of allocations for key and vulnerable populations.

b) Ensuring scale up, impact and paced reductions in the allocation methodology: this approach will ensure funding amounts can be appropriately refined to protect the gains of previous investments and enable greater impact.

c) Qualitative factor adjustments for 2017-2019[24]: could include an adjustment factor for each disease to refine allocations to account for the needs of concentrated burdens in higher income settings. In particular, the Secretariat could work with Technical Partners to define factors to: 1) address the needs of concentrated epidemics in HIV, potentially using the key population-specific estimates of people living with HIV (PLHIV) currently under development with UNAIDS; 2) to address the needs of key and vulnerable populations in the TB context, such as MDR-TB; and 3) to appropriately address the needs in countries classified as in pre-elimination, elimination and prevention of reintroduction of malaria[25] phases.

d) Focus of application requirements: the Sustainability, Transition and Co-Financing (STC)[26] that the SIIC is recommending for Board approval proposes that Global Fund financing in UMICs have 100% focus on key and vulnerable populations; and 50% in LMICs, as relevant to the country context.

[22] Notwithstanding any limitations on the funds available for such purposes
[23] GF/SIIC17/06
[24] The qualitative adjustment factors and the methodology for applying them will be determined by the Strategy Committee in June 2016.
[25] See World Malaria Report 2015
[26] GF/B35/04

e) Co-Financing: the new STC Policy[26] also proposes that a minimum 50% of domestic contributions target key and vulnerable populations in UMICs.

f) New KPIs 5 and 9A,B&C: the Strategic KPI Framework 2017-2022[27] in line with the 2017-2022 Strategy proposes new KPIs with the aim of reducing the number of new HIV infections in key and vulnerable populations (KPI 5); and reducing human rights barriers to services, including gender-related barriers, (KPI 9a); increasing the portion of Global Fund allocations dedicated to key populations programs and to programs to reduce human rights barriers to services in MICs (KPI 9b); and in UMICs nearing transition, increasing the percentage of funding from domestic sources for programs focusing on key populations and programs to reduce human rights barriers to access (KPI9c).

Unfunded Quality Demand

27) The SIIC recommends that the allocation methodology for 2017-2019 retain a *simplified evolution of Unfunded Quality Demand (UQD)*. This is in consideration of lessons learned[9] which recognize the critical nature of maintaining a mechanism to incentivize resource mobilization through the replenishment period and to facilitate reinvestment of efficiencies found during grant making. However, the same lessons learned indicate that the 2014-2016 approach to UQD was too burdensome on countries without any guarantee of reward. Going forward, costed National Strategic Plans and/or programmatic and financial gap tables in Global Fund funding requests would serve as basis for estimating beyond-allocation need. Across all country components, these gaps would serve as the estimate of total beyond allocation need. During development of the funding request, countries are encouraged to develop a set of key additional, evidence-based, prioritized and costed needs for programming, should resources become available. These costed, prioritized needs would be reviewed and registered at the time of initial submission of a funding request and maintained on a register to attract additional resources, and to facilitate reprogramming of savings or efficiencies during the grant lifecycle. As was the case with the current process for managing UQD, the Secretariat will develop a method for prioritizing the registered needs and present it to the Strategy Committee for review and approval prior to the start of the 2017 – 2019 allocation period.

Board approval and flexibility in qualitative adjustments

28) Lessons learned from the 2014-2016 allocation period indicated that Board approval of aggregate funding groupings, or country bands, led to a number of shortcomings. For example, bands were considered to have insufficient epidemiological or economic coherence, and to have introduced complexity and lack of flexibility into the allocation methodology, meaning that the Secretariat could not optimally refine country allocations through the qualitative adjustment process in line with need. This was one main reason for the creation of shortened grants across many high burden contexts. In their Thematic Review of the Allocation Methodology[28] the TERG concluded that *"country bands should be abolished as they have reduced flexibility of the allocation [methodology] without adding significant protection to vulnerable programs"*.

29) Accordingly, for 2017-2019 the SIIC recommends having no country groupings for Board approval of country allocations, given that:

a) The Board approves the total funding available for country allocations;

b) The Board approves the overall allocation methodology, which includes an allocation formula using parameters approved by the SIIC under authority delegated by the Board; and

c) Country allocations are therefore a direct outcome of these Board and Committee decisions.

[27] GF/B35/07
[28] GF/B35/14

30) The SIIC recommends that the Board should adopt a more transparent, accountable and flexible qualitative adjustment process. Furthermore, this process should be carried out under the Strategy Committee's oversight, with reporting and accountability to the Board. The recommended transparent, accountable and flexible qualitative adjustment process is as follows:

a) Prior to each allocation period, the Strategy Committee will approve the list of qualitative factors and the process for applying them;

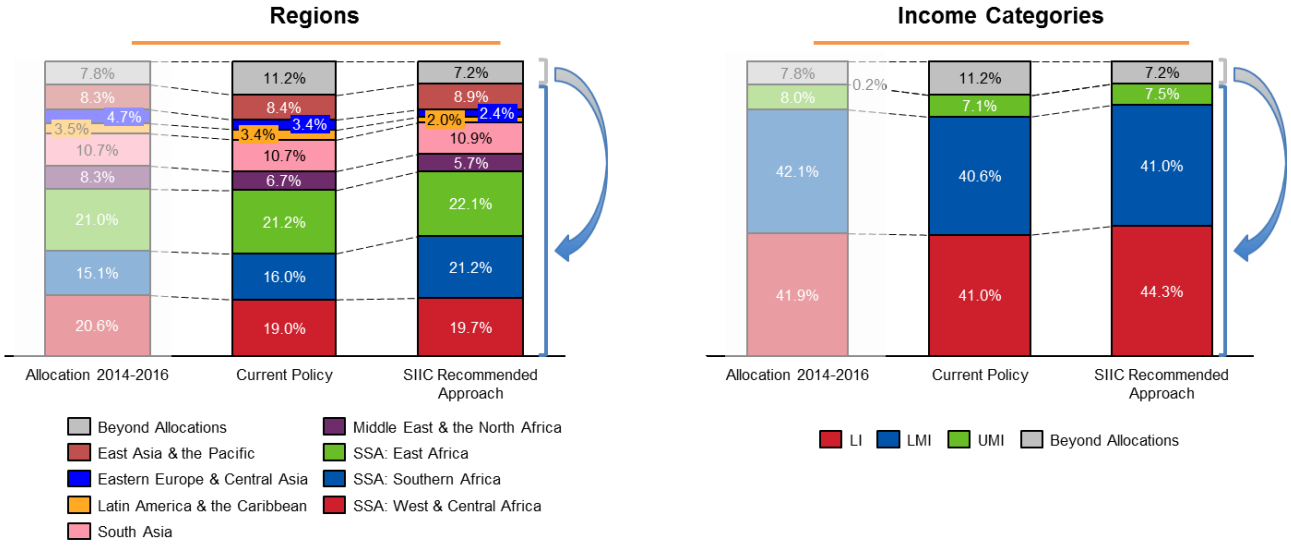
b) The Strategy Committee will oversee the adjustment process carried out by the Secretariat; and

c) Country components whose allocations changed by greater than 15% and greater than USD 5 million through qualitative adjustment process will be reported by the Strategy Committee to the Board.

31) For the 2017-2019 allocation period, the Strategy Committee will review and approve the list of qualitative factors[29] and the process for applying them at its June 2016 meeting.

02 Impact of the SIIC-recommended allocation approach for 2017-2019

32) The distribution of funding[30] resulting from the SIIC-recommended allocation approach for 2017-2019 is presented below by region, income category, band (as adopted for allocation 2014-2016) and by disease burden categories. These distributions are shown in comparison to results of the 2014-2016 allocation period "Allocation 2014-2016", and as the allocations would be if the policies approved for 2014-2016 were continued[31] for the 2017-2019 allocation period, but using updated data "Current Policy". The

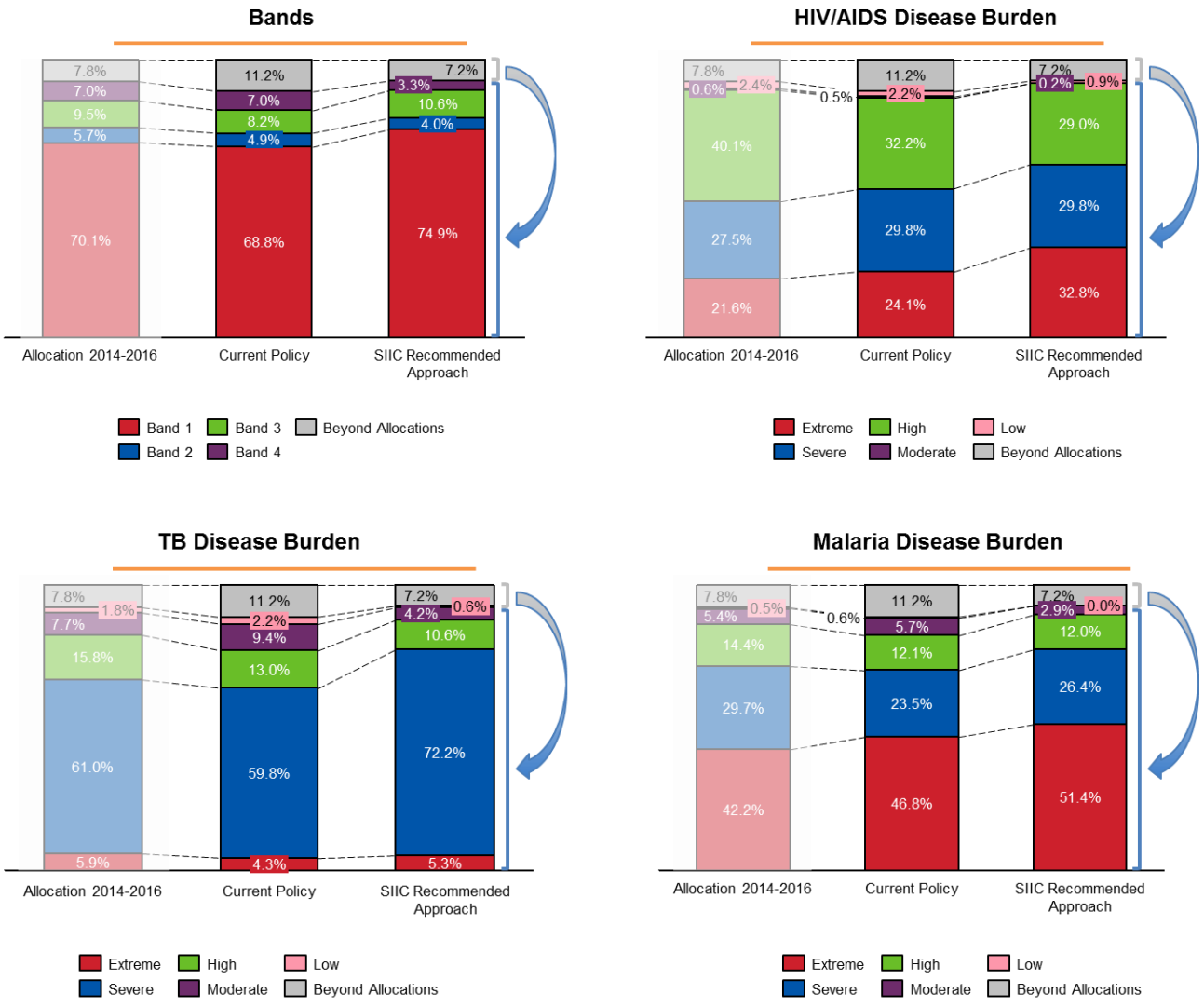


[29] The qualitative factors for the 2014-2016 allocation period were: major sources of external financing; minimum funding levels; willingness to pay; past program performance and absorptive capacity; risk and increasing rates of next infections in lower prevalence countries.

[30] The packages are modelled for illustrative purposes with the assumption of a USD 13bn replenishment resulting in an approach where USD 11.1bn is the amount of sources of funds available for allocation, following an illustrative 7.5% adjustment for technical considerations (including conservative approach to foreign exchange) per Comprehensive Funding Policy, and USD 0.9bn for operating expenses over the 2017-2019 period. The SIIC-recommended approach is modelled with $800 million for catalytic funding. It also reflects the movement of $800 million funds for scale up, impact and paced reductions, guided by the initial approach described in GF/B35/05 Annex 1 5.c). Data used to calculate funding levels arising from the 2014-2016 allocation period as the basis for the MRL in all calculations are as available 2 February 2016. Allocation 2014-2016 figures are at Post-MRL stage and include previously eligible, now ineligible, components (Russia HIV/AIDS and Seychelles HIV/AIDS), but do not include qualitative adjustments. Income and disease burden categories and eligibility are per Global Fund 2016 Eligibility List. For the distribution of funding by Band, under *Allocation 2014-2016* and *Current Policy* approaches, the funding does not sum to 100%. This is because Band 4 is 7% funding *inclusive* of incentive funding, but not of funding for strategic initiatives and multi-country approaches, whereas the Beyond Allocations funds represented here include incentive funding as well as multi-country and strategic initiatives.

[31] The 'Current Policy' approach uses the 75% MRL applied to four-year funding levels for the 2014 – 2016 allocation period and the same absolute funding amounts for beyond country allocation aspects (USD 1.25bn), even though the total sources of funds available

distributions of funding presented also show the total funds available for aspects beyond country allocations, which would result in additional impact at a country level once operationalized.



33) Compared to the Current Policy approach, the SIIC-recommended allocation methodology would lead to a significantly increased share of funding to sub-Saharan Africa, South Asia and East Asia and the Pacific; to low income and lower middle income countries; and to the previous high burden bands (bands 1 and 3).

34) In HIV, the SIIC-recommended approach would increase[32] funding to countries classified with extreme burden by more than a third; increase funding to sub-Saharan Africa by almost 15% in line with the global burden of disease; including to the sub-Saharan African countries with the highest rates of infection in

will likely be different for the 2017 – 2019 allocation period. The Band 4 methodology approach and Country Bands used are as for 2014-2016. All other technical aspects of the model are updated in line with the SIIC-adopted technical parameters for 2017-2019. The MRL is updated to be based on funding levels derived from the 2014-2016 allocation period. Unlike for 2014-2016, the MRL does not include the pipeline of funds resulting from the transition from a rounds-based to allocation-based funding model.

[32] In comparison to the Current Policy Approach; with reference to the % funding allocated to these countries for the disease, out of total funding available (including for beyond allocation purposes)

young women and adolescent girls[33] by almost 30%. In TB, the SIIC-recommended approach would increase funding to countries classified as having extreme or severe burden by more than 20%, as well as by 25% to the top 28 high MDR-TB[34] countries where the urgent scale-up of resources is especially critical. In Malaria, the SIIC-recommended approach would increase funding to countries classified as having extreme or severe burden by more than 10%; by more than 10% to sub-Saharan Africa where the greatest burden of disease lies; and by 5% to low and lower middle income countries.

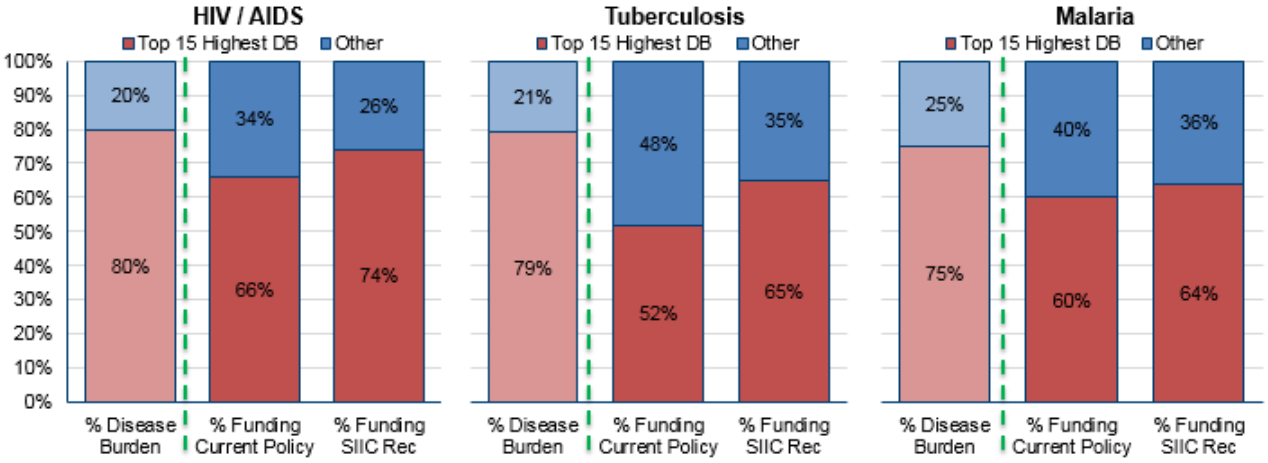


Figure 2: Funding to the top 15 high burden countries in each disease under the Current Policy and SIIC Recommended allocation approaches. Catalytic investments, whilst not represented here, may additionally be directed towards many of the top 15 high burden countries in each disease.

35) The top 15 high burden countries in HIV, TB and malaria[35], which make up 80%, 79% and 75% burden respectively, would be allocated 74%, 65% and 64% of funding respectively; representing an increase of 8%, 13% and 4% respectively compared to under the Current Policy approach

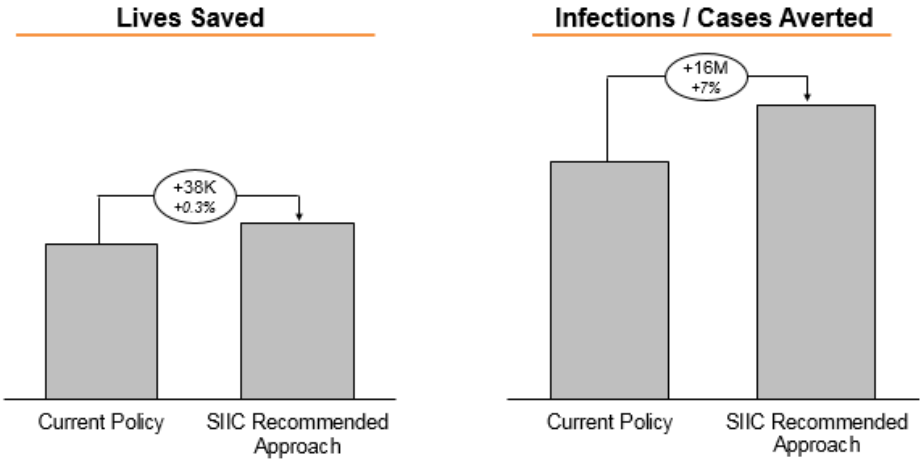


Figure 3: Increase in projected lives saved and infections/ cases averted between the Current Policy and SIIC Recommended allocation approaches

[33] Taken illustratively as the 10 DREAMS countries: Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe
[34] As classified by WHO and eligible for Global Fund financing
[35] Burden measures for HIV, TB and malaria are per the burden indicators approved by the SIIC for allocation 2017-2019, as listed in Annex 2, and according to the Global Fund's 2016 Eligibility List.

36) Finally, as undertaken to inform the SIIC's deliberations to date, the impact modelling for the Global Fund's Investment Case[36] has been used to project[37] the relative impact of allocation approaches. The modelling estimates that with the SIIC-recommended country allocation approach, an additional 38,000 lives could be saved, and an additional 16 million infections or cases averted compared with the Current Policy approach. Significant additional numbers of lives saved and infections averted would be anticipated through the critical use of catalytic funds to incentivize and drive country allocations for greater impact.

37) Illustrative country allocations under the SIIC recommended approach are detailed in Annex 4.

VII. Recommendation

38) Based on the rationale presented above, the SIIC recommends that the Board:

a) Approve the allocation methodology presented in Annex 1;

b) Acknowledge the technical parameters for the 2017 – 2019 allocation period, which have been approved by the SIIC and are set forth in Annex 2; and

c) Affirm the updated access-to-funding principles presented in Annex 3

[36] Investment Case for the Global Fund's 2017-2019 Replenishment: The Right Side of the Tipping Point for AIDS, Tuberculosis and Malaria Presented on 17 December 2015 at the Global Fund's Fifth Replenishment Preparatory Meeting in Tokyo, Japan.
[37] The impact modelling can only be used to illustrate the impact of country allocations, not the critical impact anticipated to be achieved with funds beyond country allocations, as it cannot yet be known to which country disease programs this funding will be attributed.

Annex 1 - Allocation Methodology

1. **Allocation Period**: The three-year period, aligned to each replenishment period, over which eligible applicants may apply for funding and the Board may approve such funding for grant programs.

2. **Implementation of Grants:** While the allocation period will be aligned with the replenishment period, the planning and implementation of grants will be aligned with country planning cycles. The standard period of Global Fund financing for an applicant will be three years, subject to flexibility where deemed appropriate by the Secretariat.[38]

3. **Apportioning Available Resources**: Prior to each allocation period, the Board will approve the total amount of available sources of funds for allocation based on the recommendation of the Committee responsible for financial oversight. From such amount, 15-percent will be used according to the following parameters:

    a. No more than USD 800 million will be used for catalytic investments, as described further in paragraph 6 below;

    b. No more than USD 800 million will be included as part of the available sources of funds for country allocations to ensure scale up, impact and paced reductions in funding; and

    c. The Secretariat maintains flexibility to move funds for catalytic investments to available sources of funds for the purposes described in paragraph 3.b. above and will notify the Board accordingly.

4. **Country Allocations:** The Board will approve the amount of available sources of funds for country allocations, which will then be allocated according to the approach outlined below:

    a. **Global Disease Split**: While applicants have flexibility in deciding how to allocate financing among their individual component programs, prior to the initial allocation of available sources of funds for each allocation period, the Secretariat will apportion such resources among the three diseases based on the following distribution:

        i. HIV/AIDS: 50%;
        ii. Tuberculosis: 18%; and
        iii. Malaria: 32%.

    b. **Allocation Formula**: The formula for allocating available sources of funds to eligible country components will be based on each country's economic capacity (measured by GNI per capita) and disease burden (following consultation with technical partners). These indicators for the allocation formula will be recommended by the Secretariat as part of the following allocation-formula parameters that the Committee responsible for oversight of strategic matters will assess and approve prior to each allocation period:

        i. Indicators for disease burden and country economic capacity;

        ii. Maximum and minimum shares for the allocation; and

        iii. External financing adjustment.

    c. **Formula-Derived Allocation:** After making the global disease split, the Secretariat will apply the allocation parameters to apportion a share of the available sources of funds for country allocations to each eligible country component based on the shares produced by the allocation formula to obtain the initial calculated amount. The Secretariat will have flexibility

[38] Justifications for variations from the three-year standard will be provided to the Board as part of the Secretariat's grant approval requests.

to apportion the funding described in paragraph 3.b. above to ensure scale up, impact and paced reductions in funding across the portfolio, and be guided by the following initial approach to obtain the formula-derived allocation:

i. Each eligible country component, which had a previous funding level below its initial calculated amount, will receive a funding level that is at least the midpoint between its initial calculated amount and its previous funding level;

ii. Each eligible country component, which had a previous funding level above its initial calculated amount, will receive a reduction of at least 25-percent from its previous funding level; and

iii. Previous funding level represents actual and forecasted use of funds arising from the previous allocation period.

d. **Qualitative Factors**: The Secretariat shall further adjust formula-derived allocations, to account for specific circumstances in each eligible country component under the oversight of the Committee responsible for strategy matters, in accordance with the following parameters:

i. Adjustments will be based on qualitative factors that may include, but are not limited to:
   1. Major sources of external financing;
   2. Minimum funding levels;
   3. Willingness to pay;
   4. Past program performance and absorptive capacity;
   5. Risk;
   6. Increasing rates of new infections in lower prevalence countries; and
   7. Adjustment factor for populations disproportionately affected by HIV and TB, and in low-endemicity malaria settings.

ii. Prior to each allocation period, the Committee responsible for strategy matters will approve the qualitative factors and the method for how they are applied, as well as oversee the adjustment process by the Secretariat; and

iii. Any adjustment greater than 15 percent of an eligible country component's formula-derived allocation and greater than USD 5 million shall be reported to the Board through the Committee responsible for strategy matters.

5. **Reallocation of Sources of Funds**: Upon confirmation by the Committee responsible for financial oversight, the Secretariat may conduct a strategic reallocation of available sources of funds according to the following parameters:

a. Sources of funds that are additional to the amount initially allocated to eligible country components shall be reallocated to prioritized and costed areas of need identified and registered at the time of initial submission and review of a funding request, in accordance with a prioritization developed by the Secretariat and approved by the Committee responsible for strategy matters that ensures priority based on the degree in which a country component's formula-derived allocation is below its initial calculated amount**;** and

b. All reallocations of available sources of funds to grant programs shall be recommended by the Secretariat to the Board for approval.

6. **Catalytic Investments:** Based on the recommendations of the Committee responsible for strategy matters, the Board approves the use of up to USD 800 million to finance catalytic investments through multi-country approaches, strategic initiatives and to incentivize use of country allocations for strategic priorities, including for key and vulnerable populations, in line with the Global Fund and partner disease strategies, as described in GF/B35/05 – Revision 1, according to the following principles:

a. The Secretariat may determine the portion of the sources of funds available for catalytic investments that may be utilized to provide additional sources of funds for country allocations, as appropriate;

b. Whenever possible, the Secretariat shall recover funding for catalytic investments from the funding provided through relevant grant programs;

c. The Committee responsible for Strategy matters will:

   i. Review the type of priorities, activities or initiatives to fund as catalytic investments, along with associated costs, prior to each allocation period, in consultation with the Committee responsible for financial oversight with respect to the amount of such costs, and present recommendations to the Board; and

   ii. Approve the Secretariat's reallocation of sources of funds approved by the Board for catalytic investments among the approved priorities, activities or initiatives upon consultation with the Committee responsible for financial oversight.

Annex 2 -Technical Aspects

01 Summary of approved parameters for the 2017-2019 allocation period

1. The parameters approved by the SIIC for the 2017-2019 allocation period are presented in Table 1 as follows:

Table 1: Technical Parameters for the 2017 – 2019 Allocation Period

Parameter	**Specification**
HIV burden indicator	Number of people living with HIV (PLHIV) Latest available data
TB burden indicator	[1*TB incidence] + [10*MDR-TB incidence] Latest available data
Malaria burden indicator	[1 * number of malaria cases] + [1 * number of malaria deaths] + [0.05 * malaria incidence rate] + [0.05 * malaria mortality rate] Data from 2000, all indicators normalized
Country economic capacity indicator	Smooth CEC curve
Maximum shares	10% funding at a disease level 7.5% funding at a country level
Minimum shares	USD 500,000 per component, subject to assessment of the impact that could be achieved, contribution towards achieving strategic objectives, and ability to efficiently manage such programs with differentiated and simplified grant management processes
External financing adjustment	Projections discounted by 50% for data quality, and can influence country allocations by up to 25%

Annex 3 - Affirmed Access to Funding Principles

1. **Allocation-based funding model:** The allocation-based funding model established by the Board under its September 2012 (GF/B27/DP07) and November 2012 (GF/B28/DP04) decisions created several access-to-funding principles that remain relevant for future allocation periods. As such, they are restated below, as amended to align with the allocation methodology refinements to become effective starting with the 2017 – 2019 allocation period.

2. **Access to Funding Process:** The access to funding process utilized by each applicant will include the following elements and be guided by principles of differentiation approved by the Strategy Committee:

3. **Guidance/Tools for Strategic Investments:** Countries, partners and the Secretariat should continue to use and develop tools to help applicants identify the highest impact interventions and technologies best suited to their country situation and most effective in reducing morbidity and mortality. The tools should also help applicants to identify strategic investments to build resilient and sustainable health and community systems.

4. **Country Dialogue:** As envisioned by the Global Fund Strategy, applicants[39] will utilize an inclusive, iterative process when applying for funding (for a disease program and/or related Resilient and Sustainable Systems for Health ("RSSH") investments). This iterative process will be based on a Country Dialogue in which the Global Fund takes part and which is based, where possible and appropriate, on a national strategic plan and be guided by applicable investment frameworks or other tools.

5. **Funding Request:** Based on the country dialogue, applicants will develop a single funding request per disease or consolidated,[40] aligned with country planning cycles, that gathers essential information for the Secretariat and the Technical Review Panel ("TRP") to assess the proposed program.

6. **TRP Review:** The TRP will review funding requests and will make a recommendation regarding the technical soundness and strategic focus of the proposed programs according to a set of criteria and modalities as set forth in their terms of reference.

7. **Applicant Funding Amount:** The Secretariat will determine, through a defined process, a final funding amount for each applicant based on available funding, the funding requested by the applicant, and the TRP's recommendations.

8. **Board Approval:** The Secretariat will work with applicants to transform the reviewed funding requests into disbursement-ready grants. Where there are material changes from the TRP recommendation, the Secretariat will seek further input from the TRP prior to finalizing a grant agreement. When finalized, the Board will approve funding.

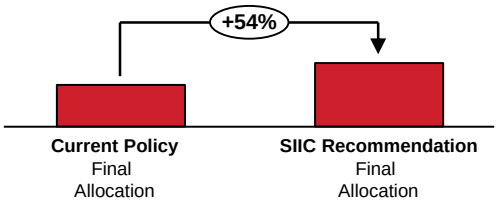
[39] Applicants will typically be Country Coordinating Mechanisms ("CCMs") but could, for instance, also be regional coordinating mechanisms, regional organizations or other non-CCM applicants.
[40] In accordance with the Board's prior decisions on the importance of core TB-HIV collaboration services to achieve successful outcomes in TB and HIV (GF/B18/DP12 and GF/B29/EDP11), the Secretariat shall ensure integrated TB-HIV services are addressed in the country-dialogue and funding-request development process for countries with high TB-HIV co-infection rates, as set forth in the WHO policy on collaborative TB/HIV activities: "Guidelines for National Programs and Other Stakeholder" (2012).

Annex 4 – Illustrative Country Allocations under the SIIC-Recommended Allocation Approach

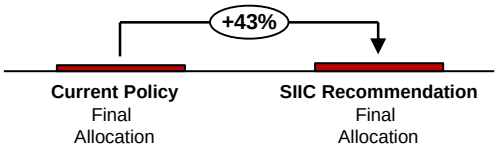
The SIIC-recommended allocation methodology for 2017-2019 will significantly increase impact by better aligning Global Fund financing to countries with the highest burden and least economic capacity and towards key and vulnerable populations disproportionately affected by the three diseases. Consequently, across the portfolio some country components will see funding increases, and others decreases, when compared to the Current Policy approach. Nonetheless, the allocations will be better positioned to balance scale-up in line with need with paced reductions. Significant funding will also be available for catalytic investments in key global Fund and partner strategic priorities, including for key and vulnerable populations, multi-country approaches and other strategic initiatives. Some illustrative examples[41] of allocations arising from the SIIC-recommended approach in comparison to the Current Policy approach are given below:

HIV

Country A: Significantly under-formula, high HIV burden country: This country has approximately 5% of global HIV burden[35]. Under the SIIC-recommended approach the country would be calculated over 50% more funding for HIV than under the Current Policy approach, and also 70% more than they were allocated for 2014-2016, when it had to create a shortened grant to keep programming at scale. Their funding level would be further refined through the qualitative adjustment process, and at the time of submitting a funding request, the country could additionally apply for catalytic funds to further incentivize programming of their allocation to achieve impact in line with key Global Fund and partner strategy priorities. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing.



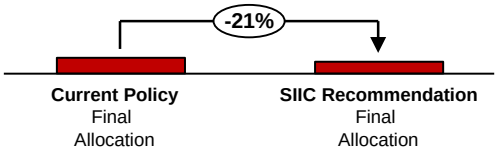
Country B: Previously Band 4 country, with high concentrated HIV burden: This country has high HIV burden in key and vulnerable populations, especially in MSM. Under the SIIC-recommended approach the country would be calculated 40% more funding for HIV than under the Current Policy approach. Their funding level could be further refined through the qualitative adjustment process, using key population-specific estimates of PLHIV. At the time of submitting a funding request, through demonstration of robust programming to respond to the needs of key populations in their setting, the country could additionally apply for catalytic funds for greater impact. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing, with a general requirement that at least 50% of domestic investment focus on key and vulnerable populations, as well as a general focus on RSSH activities to address roadblocks to transition; and 100% of their Global Fund funding request must be focused on key and vulnerable populations.



Country C: Above-formula, high concentrated HIV burden country: This country has high HIV burden in key and vulnerable populations, especially in people who inject drugs. Under the SIIC-recommended approach the country would be calculated just over 20% less funding for HIV than under the Current Policy approach. There would be potential for refinement of the funding amount given the

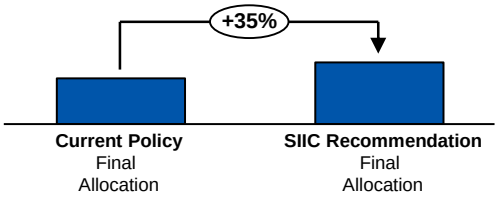
[41] The packages are modelled for illustrative purposes with the assumption of a USD 13bn replenishment resulting in an approach where USD 11.1bn is the amount of sources of funds available for allocation, following an illustrative 7.5% adjustment for technical considerations (including conservative approach to foreign exchange) per Comprehensive Funding Policy, and USD 0.9bn for operating expenses over the 2017-2019 period.

flexibility inherent in the approach to ensuring for scale-up, impact and paced reductions. Their funding level would then be further refined through the qualitative adjustment process, potentially using key population-specific estimates of PLHIV. At the time of submitting a funding request, through demonstration of robust programming to respond to the needs of key populations in their setting, the country could additionally apply for catalytic funds for greater impact. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing; and 50% of their Global Fund funding request must be focused on key and vulnerable populations.

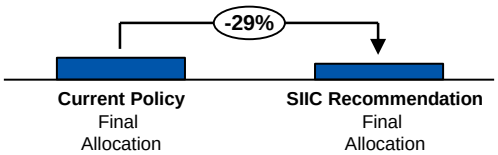


TB

Country D: Below-formula, high MDR-TB burden country: This country has more than 5% global burden of MDR-TB[35]. Under the SIIC-recommended approach the country would be calculated 35% more funding for TB than under the Current Policy approach, and 150% more than they were allocated for 2014-2016, recognising their significant disease burden. Their funding level would be further refined through the qualitative adjustment process, and at the time of submitting a funding request, the country could additionally apply for catalytic funds to further incentivize programming of their allocation to achieve impact in line with key Global Fund and partner strategy priorities. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing; and 50% of their Global Fund funding request must be focused on key and vulnerable populations.

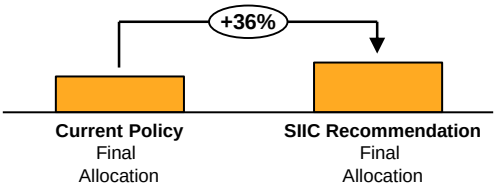


Country E: Above-formula, low TB burden country: This country has less than 1% global TB burden[35]. Under the SIIC-recommended approach the country would be calculated almost 30% less than under the Current Policy approach. This is recognising their limited disease burden, and given that their allocation was calculated based on disease burden and economic capacity rather than population size (as it would have been under the "Band 4 methodology" in the Current Policy approach). There would be potential for refinement of the funding amount given the flexibility inherent in the approach to ensuring for scale-up, impact and paced reductions. Their funding level would then be further refined through the qualitative adjustment process, and at the time of submitting a funding request, the country could additionally apply for catalytic funds to further incentivize programming of their allocation to achieve impact in line with key Global Fund and partner strategy priorities. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing, with a general requirement that at least 50% of domestic investment focus on key and vulnerable populations in the TB context, as well as a general focus on RSSH activities to address roadblocks to transition; and 100% of their Global Fund funding request must be focused on key and vulnerable populations.



Malaria

Country F: Below-formula, high malaria burden country: This country represents almost 5% of global malaria burden[35]. Under the SIIC-recommended approach the country would be calculated over 35% more funding for malaria than under the Current Policy approach, and also over 50% more than they were allocated for 2014-2016, when it had to create a shortened grant to keep programming at scale. Their funding level would be further refined through the qualitative adjustment process, and at the time of submitting a funding request, the country could additionally apply for catalytic funds to further incentivize programming of their allocation to achieve impact in line with key Global Fund and partner strategy priorities. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing.



Country G: Above-formula, low endemicity malaria country: This country has less than 1% global malaria burden[35]. Under the SIIC-recommended approach the country would be calculated 28% less funding for malaria than under the Current Policy approach, with the allocation based on disease burden and economic capacity, rather than on population size (as it would have been under the "Band 4 methodology" in the Current Policy approach). There would be potential for refinement of the funding amount given the flexibility inherent in the approach to ensuring for scale-up, impact and paced reductions. Their funding level would be further refined through the qualitative adjustment process, and at the time of submitting a funding request, the country could additionally apply for catalytic funds to further incentivize programming of their allocation to achieve impact in line with key Global Fund and partner strategy priorities. Under the new STC policy[26], at least 15% of their final allocation will be subject to additional co-financing, with a general requirement that at least 50% of domestic investment focus on key and vulnerable populations as relevant to the country context, as well as a general focus on RSSH activities to address roadblocks to transition; and 100% of their Global Fund funding request must be focused on key and vulnerable populations as relevant to the country context.