

40th Board Meeting

Reviewing the 2020-2022 Allocation Methodology in Preparation for the May 2019 Board Decision

GF/B40/07

14-15 November 2018, Geneva

Board Information

Purpose of the paper: To provide an update on the Strategy Committee discussions on the review of the allocation methodology and agreed next steps for the 2020-2022 allocation period.

Executive Summary

The Strategy Committee, in collaboration with the Secretariat and partners, has been conducting a holistic review of the allocation methodology in preparation for the 2020-2022 allocation period in order to strengthen the methodology's ability to maximize impact in line with the *Global Fund Strategy 2017-2022: Investing to End Epidemics* (Strategy). Joint findings from the Technical Evaluation Reference Group (TERG), the Technical Review Panel (TRP) and the Secretariat on the 2017-2019 allocation period have concluded that the allocation methodology is effectively delivering on its objectives by increasing funds to countries of higher burden and lower economic capacity while accounting for populations disproportionately affected by the three diseases. While the Strategy Committee is not considering any major changes to the allocation methodology for the 2020-2022 allocation period, potential refinements are being discussed to ensure that the allocation formula continues to reflect the current epidemiological context and that key contextual factors are accounted for in the qualitative adjustments. In addition to funding distributed through country allocations, catalytic investments are likely to remain important to deliver on strategic priorities that country allocations alone cannot fully address. For the 2020-2022 allocation period, a review and prioritization of catalytic priorities is in progress to ensure that these resources are best aligned to achieve the aims of the Strategy.

This report provides a summary of the Strategy Committee discussions held in March, July and October 2018 on the allocation methodology. The aim of this progress update is to support the Board in moving to a decision in May 2019 on the 2020-2022 allocation methodology, and catalytic investment priorities.

Context

1. The 2020-2022 allocation period will mark the third cycle of the Global Fund's allocation-based funding model. This model was designed to maximize the impact of Global Fund resources by distributing funds in line with the disease burden and economic capacity of eligible countries through a predictable, flexible and simple approach.
2. Refinements were made to the allocation methodology for the 2017-2019 allocation period to increase the impact of Global Fund resources, building on lessons learned from the first allocation period of 2014-2016 and in line with the Strategy. These refinements include prioritizing the scale-up of funding in low income countries with high burden, redistributing funds more flexibly to address critical gaps, a transparent and accountable qualitative adjustment process, accounting for key populations affected by HIV, addressing malaria elimination needs and improving the measurement of TB burden to better reflect MDR-TB.¹
3. For the 2017-2019 allocation period, US\$10.3 billion was available for country allocations.² As per the allocation methodology, this amount was distributed upfront to HIV, TB and malaria according to the Board-approved global disease split (see Figure in Annex 1).³ Within each disease pool of funding, the allocation formula was applied using technical parameters approved by the Strategy Committee to distribute resources in line with disease burden and country economic capacity, while accounting for other external financing and applying maximum and

¹ GF/SCO6/13.

² GF/B36/DP05.

³ GF/B35/DP10.

minimum shares.⁴ Based on previous funding levels, US\$800 million was redistributed across the portfolio to balance the need for scale-up (to components that previously received less than what the formula recommends) with the need for providing paced reductions (to components historically receiving more than what the formula recommends) to bring funding in line with disease burden and economic capacity.⁵

4. To account for key epidemiological and contextual factors that a formula cannot capture adequately, qualitative adjustments were then applied to produce the final country allocation amounts.⁶ The Secretariat reported all qualitative adjustments to the Strategy Committee, and changes of more than US\$5 million and 15% were reported to the Board immediately following the issuance of the allocation letters to countries.⁷
5. As the 2020-2022 allocation cycle will cover the second half of the period of the Strategy⁸, the objective of the allocation methodology remains delivering on the aims of the Strategy, specifically to:
 - Scale up evidence-based interventions with a focus on the highest burden countries with the lowest economic capacity and on key and vulnerable populations disproportionately affected by the three diseases; and
 - Evolve the allocation model and processes for greater impact, including innovative approaches differentiated to country needs.
6. In line with these aims, the allocation methodology will seek to maximize the impact of resources through both the country allocations and the distribution of funds retained for catalytic investments.

Key outcomes and lessons learned from the 2017-2019 allocation methodology

7. According to the joint TERG, TRP and Secretariat review presented to the Strategy Committee in July 2018,⁹ the 2017-2019 allocation methodology is delivering effectively on its objectives to increase the impact of resources through a predictable, simplified and flexible approach. Compared to 2014-2016, the 2017-2019 allocation methodology directed a greater proportion of funding towards higher burden, lower income countries while accounting for key populations and malaria elimination. In total, 63% of the 2017-2019 allocations went to the 15 highest burden countries of each disease, compared to 60% in 2014-2016.¹⁰ The share of funding to low income countries also increased over this timeframe: 51% of the 2017-2019 allocations went to low

⁴ GF/B35/05.

⁵ GF/B36/DP05.

⁶ GF/B35/DP10; GF/SC01/DP01.

⁷ GF/B36/ER05.

⁸ GF/B35/DP04.

⁹ GF/SC07/03.

¹⁰ Based on 3-year equivalent actual and forecasted disbursements for 2014-2016. To obtain the top 15 burden countries for each disease, burden is defined according to the disease burden indicator of the 2017-2019 allocation formula, using latest available data.

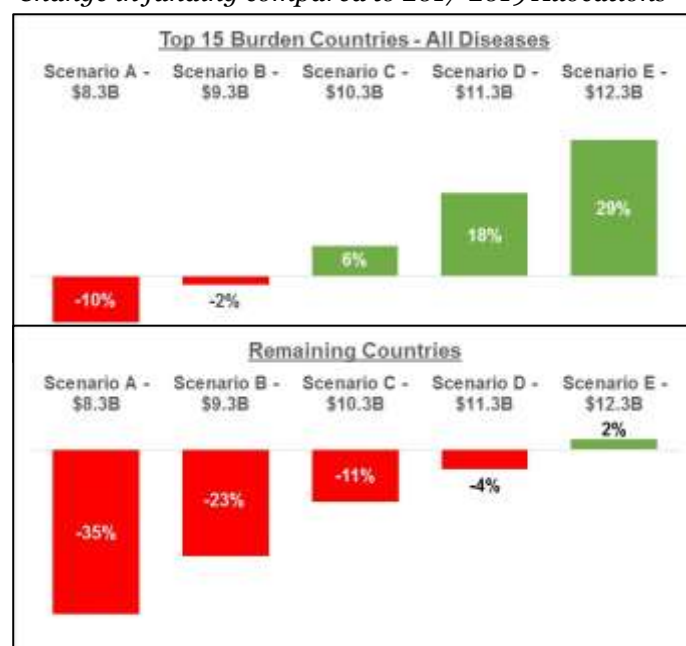
income countries compared to 49% in 2014-2016.¹¹ The TERG, TRP and Secretariat concluded from the review that no major shifts to the allocation methodology for the 2017-2019 allocation period are needed.¹²

8. For 2017-2019, catalytic investments have contributed to a greater share of resources going to key priorities of the Strategy, including programs for Adolescent Girls and Young Women, key populations, programs to remove human rights related barriers, finding missing TB cases and malaria elimination.¹³ However, there have been challenges in operationalizing the 2017-2019 catalytic investments, in particular the matching funds, due in part to the timing of Board approval of the catalytic priorities¹⁴, which occurred in November 2016, only a month before the allocations were announced. Building on these lessons, the Board decision on catalytic priorities for 2020-2022 is scheduled for May 2019, six months earlier than the 2017-2019 cycle. This timeline should enable a more effective and seamless integration of any recommended matching funds into country allocations and additional time to operationalize any recommended strategic initiatives and multi-country approaches. However, it is complicated by the timing of the next replenishment, from which the final amount available for allocation will be determined.

Allocation methodology

9. *Funding scenarios:* The Board's decision on the 2020-2022 allocation methodology and catalytic investment priorities will come before the replenishment outcome is known. To enable the Strategy Committee to present its recommendations for the 2020-2022 allocation period in May 2019, the Secretariat was requested to present illustrative scenarios of applying the 2017-2019 country allocation methodology against different funding levels for 2020-2022. The aim of these scenarios was to highlight the effects of the methodology on various country groupings (e.g. Figure 1), and to help determine the amount required for country allocations and catalytic investments.¹⁶

Figure 1: 2020-2022 Scenarios of Funding Levels - Change in funding compared to 2017-2019 Allocations¹⁵



¹¹ The share of the 2017-2019 allocations for lower middle income countries and upper middle income countries was 42% and 7% respectively, compared to 43% and 8% respectively in 2014-2016. All figures for 2014-2016 are based on 3-year equivalent actual and forecasted disbursements for 2014-2016.

¹² GF/SC07/03.

¹³ GF/B36/04 – Revision 2.

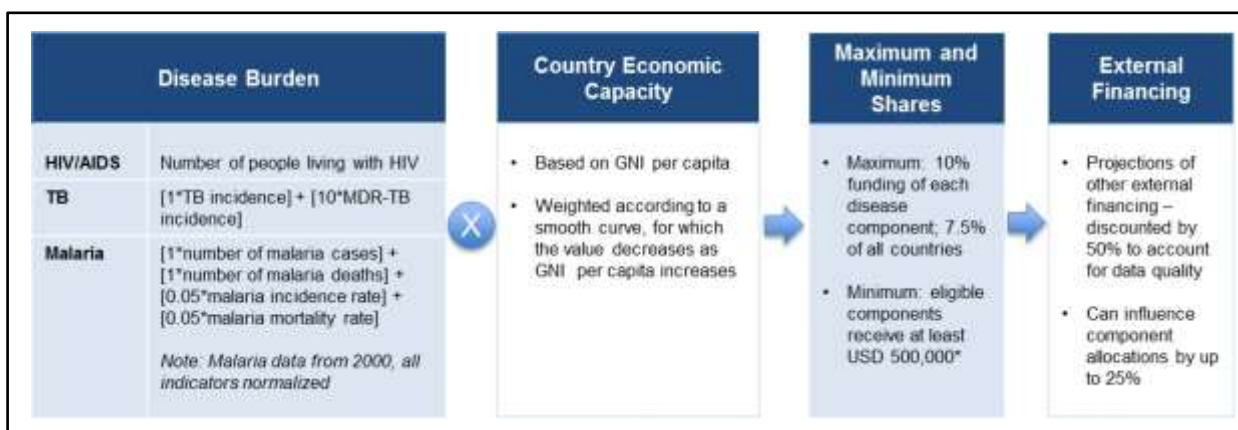
¹⁴ GF/B36/DP06.

¹⁵ Funding levels represent a range of available sources of funds for country allocations from the \$10.3 billion available for 2017-2019 (between +/- US\$2 billion). Scenario results are formula-derived amounts only and do not account for any potential qualitative adjustments. The change in funding is in aggregate for the top 15 burden countries and the remaining portfolio. The top 15 burden countries in all three diseases were determined based on the allocation formula's disease burden indicators with latest available data, representing US\$6.5 billion (63%) of the 2017-2019 communicated allocations.

¹⁶ Scenarios should not be interpreted as replenishment targets nor are they a reflection of the process to calculate available sources of funds. They are illustrative scenarios meant to demonstrate the relationship between various factors in the allocation methodology and are necessary to facilitate timely decision making by the Strategy Committee and the Board.

10. The illustrative scenarios showed that the formula effectively prioritizes funding for high burden countries at every funding level. At lower funding levels, however, scale-up among the highest burden countries is limited or non-existent, and in the rest of the portfolio a number of countries would experience significant reductions compared to their 2017-2019 allocations (Figure 1).
11. *Global disease split*: The current split of 50% for HIV, 18% for TB and 32% for malaria has been in place since the first allocation period of 2014-2016.¹⁷ For the 2020-2022 allocation period, the Strategy Committee acknowledged that maintaining the current disease split was the most appropriate option to avoid creating critical programmatic gaps by shifting the distribution of Global Fund investments across diseases. The Strategy Committee requested that the Secretariat incorporate a disease split analysis into planning for future allocation periods and the development of the next Strategy that reflects the latest epidemiological data, availability of new tools, and guidance for all three diseases.
12. *Resilient and sustainable systems for health (RSSH)*: There was general support from the Strategy Committee on the Secretariat's recommendation that the amount of RSSH investments should not be determined through the allocation methodology. The Strategy Committee was also supportive of seven key actions proposed jointly by the TERG, TRP and the Secretariat to strengthen the prioritization and implementation of the significant Global Fund investments in RSSH, noting that the implementation of these actions should be differentiated based on a country's capacity and position across the development continuum.

Figure 2: Technical Parameters of the 2017-2019 Allocation Methodology



13. *Technical parameters*: For the 2020-2022 allocation period, the Strategy Committee, under delegated authority from the Board,¹⁸ will approve the technical parameters of the allocation formula in March 2019. Figure 2 provides the technical parameters for the 2017-2019 allocation methodology, as approved by the Strategy, Investment and Impact Committee (SIIC, the precursor to the Strategy Committee). The Global Fund's technical partners for HIV, TB and malaria are currently reviewing the disease burden indicators, with the aim of recommending the disease burden indicators for the 2020-2022 allocation formula to the Strategy Committee by December 2018. For HIV, technical partners noted that the current measure continues to accurately reflect disease burden and is based on data that is available across all countries; while noting the importance of incidence data, where available, to identify prevention needs. For TB, technical partners will continue to recommend the use of TB incidence but are reviewing the weighting of MDR-TB in the disease burden indicator in light of new WHO treatment recommendations. Malaria partners emphasized the need to maintain 2000 data in the

¹⁷ GF/B28/DP05.

¹⁸ GF/B28/DP04.

allocation formula to avoid penalizing countries that have succeeded in decreasing their malaria burden as reducing coverage of key services could enable resurgence and increase deaths from malaria. However, malaria partners are exploring ways to better account for elimination, population growth, resurgence, and drug and insecticide resistance challenges through qualitative adjustments or catalytic priorities. The Committee reviewed the aim of the other technical parameters – namely the Country Economic Capacity indicator, external financing adjustment, maximum and minimum shares – and their effects on the 2017-2019 allocations, and acknowledged that these parameters have been effective in adjusting the allocations as intended.

14. *Qualitative adjustments*: For the 2017-2019 allocation period, and under delegated authority from the Board¹⁹, the Strategy Committee adopted a transparent and flexible qualitative adjustment process applied in two stages: (1) to adjust for specific epidemiological contexts insufficiently addressed through the allocation formula; and (2) to account for country-specific contextual considerations, including each country component's potential for impact and potential for absorption, as well as other information (e.g. coverage gaps, cost of continuing essential programming).²⁰ Following a discussion of the key factors applied in qualitative adjustments, the Committee recommended that the Secretariat consider, for the 2017-2019 allocation period, additional factors for Stage 2, including HIV incidence among Adolescent Girls and Young Women and key populations affected by TB.

Catalytic investments

Update on the 2017-2019 catalytic investments

15. The inclusion of catalytic investments in the 2017 – 2019 allocation methodology reflected the continued need to retain a portion of funding for investments that cannot be adequately addressed through country allocations, as initially set forth in the founding principles of the allocation-based funding model, in particular to deliver on the 2017 – 2022 Strategy.²¹ Of the US\$11.1 billion sources of funds available for allocations, the Board approved US\$800 million to be set aside for catalytic investments for the 2017-2019 allocation period.²² The objective of the 2017-2019 catalytic investments has been to address priorities that are unable to be addressed by country allocations alone, yet are deemed crucial to ensure that Global Fund investments are positioned to deliver against its 2017-2022 strategic aims.²³
16. The Global Fund provides country allocations to achieve as much impact as possible. Country allocations provide a single source of funding for countries to prioritize and utilize, enjoy the benefits of independent TRP review, and are fully aligned with the staffing of the Secretariat to provide strong support, performance management and oversight of grants.

¹⁹ GF/B35/DP10.

²⁰ GF/SC01/13 – Annex 1.

²¹ GF/B35/05.

²² GF/B36/DP05.

²³ GF/B36/04 – Revision 2.

17. The Board-approved catalytic priorities for 2017-2019 (listed in Figure 3) were determined by technical partners in consultation with the Secretariat and under the oversight of the Strategy Committee.²⁴ These priorities were strategically chosen as the most critical areas where investments beyond allocations were needed to achieve progress against the Strategy and to maximize impact.

Figure 3: 2017-2019 Catalytic Priorities by Strategic Objective



18. The US\$800 million for catalytic investments have been implemented through three modalities (Figure 4²⁵): matching funds, multi-country approaches and Strategic Initiatives, with each modality having a different approach in how it is intended to catalyze funding to ensure the delivery of the Strategy:²⁶

Figure 4: 2017-2019 Catalytic Investments by Modality

Funding Modality	Total Funding (US\$ m)	% of Funding
Matching Funds	346	43%
Multi-Country Proposals	260	33%
Strategic Initiatives	194	24%
Total	800	

- *Matching Funds*: to incentivize the programming of allocations in selected countries towards key strategic priorities, in line with the Strategy and partner disease strategies;
 - *Multi-Country approaches*: to target a limited number of strategic priorities deemed critical to meet the aims of the Strategy and needing to be addressed at a multi-country level;
 - *Strategic Initiatives*: to provide limited funding for centrally managed approaches that cannot be addressed through country allocations due to their cross-cutting or off-cycle nature, but critical to ensure country allocations deliver against the Strategy.
19. While the 2017-2019 catalytic investments have only recently begun implementation, the Secretariat has gathered initial findings to inform the deliberations on catalytic priorities and modalities for the 2020-2022 allocation period. It presented the following early findings regarding modalities to the Strategy Committee in October:²⁷
- *Matching funds*: have generally succeeded in incentivizing investments and in improving the quality and effectiveness of implementation for underfunded priority areas. For example, the

²⁴ GF/B36/04 – Revision 2.

²⁵ The funding amounts by modality differ from those presented in Table 1 of GF/B36/04 – Revision 2 due to changes in the modality for implementing approved priorities.

²⁶ GF/B36/04 – Revision 2.

²⁷ GF/SC08/03

matching funds for human rights have led to a significant increase in investments in programs to reduce human rights related barriers to services in the 20 countries which received these funds. However, the operationalization of matching funds has been notably burdensome for countries, the Secretariat and the TRP, due mainly to the extremely short timeline between the Board approval of catalytic investments and their roll-out.

- *Multi-country approaches*: have focused on a limited set of cross-border activities that are critical for achieving progress against the three diseases. For example, the Elimination of malaria in southern Africa (E8) initiative and the Regional Malaria Elimination Initiative (RMEI) in Mesoamerica and Hispaniola have contributed to leveraging additional funds from multiple donors towards the common goal of malaria elimination in their respective regions. Additionally, the TERG and TRP have highlighted the strategic value of the Regional Artemisinin-Resistance Initiative (RAI) in the Greater Mekong Sub-region of South-East Asia, which has funded interventions critical to addressing drug resistance and focusing on elimination at scale. For the eight TB multi-country grants, initial learnings suggest that the funding may have been scattered across too many initiatives and could benefit from consolidation.
- *Strategic initiatives*: have mobilized additional technical assistance on priority issues and catalyzed actions that are not possible or are inefficient to manage within country allocations. These include improving peer-to-peer learning and exchange across countries, accelerating the roll-out of next generation bed nets, and supporting transition readiness assessments to prepare countries for eventual transition from Global Fund financing. A challenge in implementing the Strategic Initiatives is that the funding has been divided in multiple small pools of funding, which has been significantly burdensome for the Secretariat to operationalize as each initiative requires staffing for grant creation, management and ongoing oversight. For the 2020-2022 allocation period, prioritization and consolidation of the Strategic Initiatives should be considered, as well as dedicated Secretariat resources for their operationalization.

Determining the catalytic priorities for 2020-2022

20. To develop the catalytic investments for 2020-2022 and recognizing the joint TERG, TRP and Secretariat recommendation to further review and prioritize catalytic investments²⁸, the Secretariat presented to the SC a prioritization approach to assess existing and potential new priorities²⁹. The principles of this approach are to select catalytic priorities that 1) maximize the impact and use of available funds to achieve the aims of the Strategy, and 2) are unable to be addressed through country allocations alone, and yet are deemed crucial to ensure Global Fund investments are positioned to deliver against its strategic aims.
21. The prioritization approach is intended to assess new and existing priorities based on two sets of criteria: their strategic impact and operational considerations. On strategic impact, catalytic investments would be assessed according to their relative contribution to achieving the Strategy targets, their catalytic effect and the risks of not funding this priority in 2020-2022. Operationalization criteria will consider the degree to which investments must be made outside country allocations and the long-term sustainability of proposed investments.
22. Overall indicative funding amounts for potential groupings of 2020-2022 catalytic investments have been provided to the SC to guide the prioritization process and help ensure that catalytic

²⁸ GF/SC07/03.

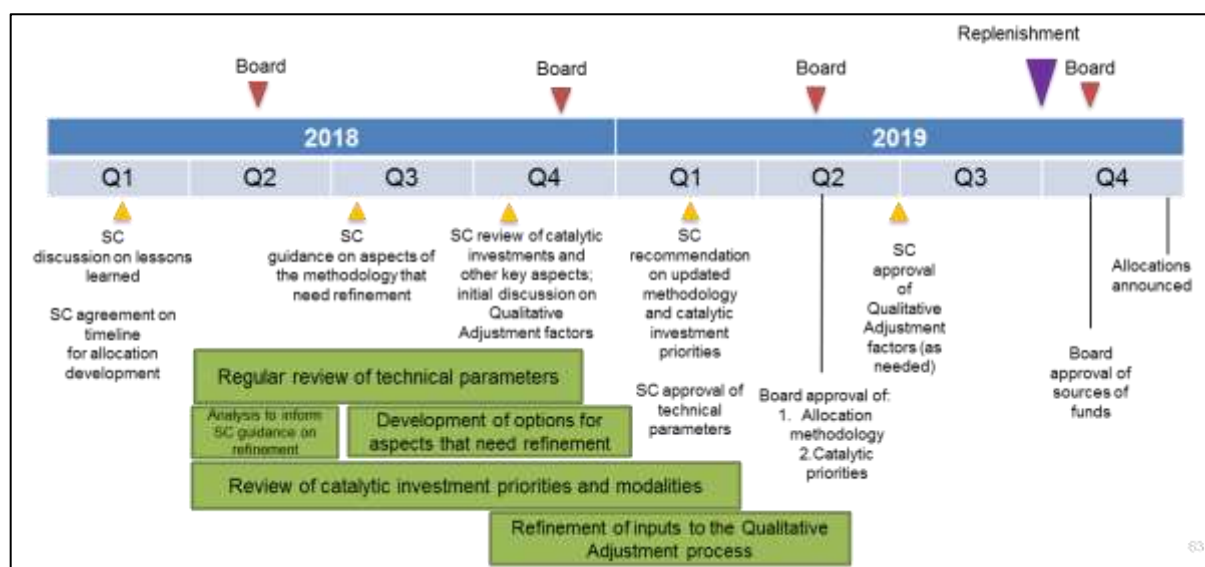
²⁹ GF/SC08/03.

investments can be operationalized in a timely manner once the replenishment outcome is known. These potential amounts to set-aside for catalytic investments were derived from the illustrative funding scenarios, determined by the minimum amounts of funding needed for country allocations to ensure a minimum increase in the highest burden countries and to limit steep reductions across the portfolio.

23. The Strategy Committee expressed support for the proposed prioritization approach, highlighting that certain catalytic priorities will be critical to continue at any funding level. The Committee also acknowledged the importance of prioritizing country allocations to ensure core service delivery, and recognized the synergies between catalytic investments and country allocations which help to increase the impact of total resources.
24. The catalytic priorities for 2020-2022 will be determined after a consultative process led by the Secretariat and involving the Strategy Committee, technical partners, communities and civil society. Between now and March 2019, the Secretariat will apply the prioritization approach in close consultation with key stakeholders, and will provide regular updates to the Strategy Committee for guidance. The Strategy Committee will provide its recommendations to the Board on the 2020-2022 catalytic priorities for consideration at the Board's May 2019 meeting.

Timeline and next steps

Figure 5: Timeline to develop the 2020-2022 allocations



25. In summary, the following next steps will enable the timely review and approval of the 2020-2022 allocation methodology:

- The Secretariat:
 1. Will continue consultations with technical partners on the disease burden indicators to receive the recommendation from technical partners by December 2018;

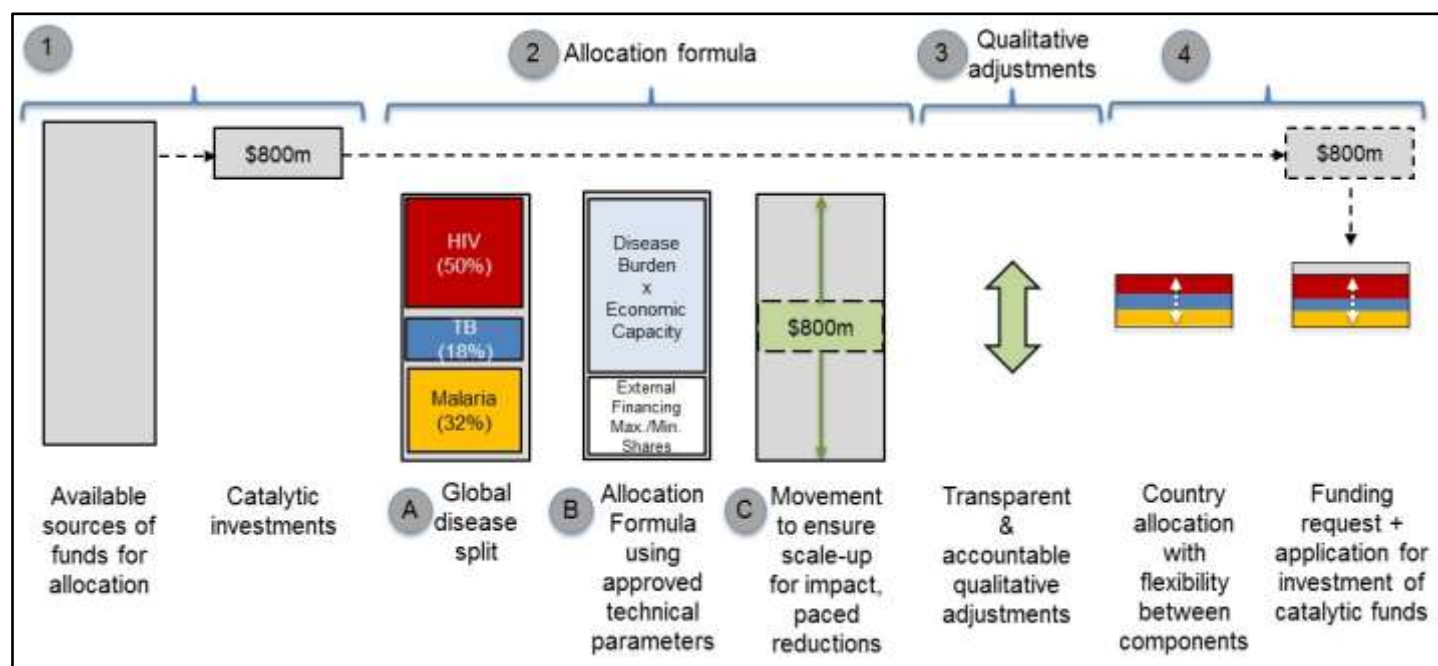
2. Will apply the prioritization approach of catalytic investment priorities for different funding scenarios, in close consultation with partners, and will provide interim updates to the Strategy Committee.
- The Strategy Committee:
 1. Will review and approve the technical parameters of the allocation formula in its March 2019 meeting;
 2. Will review the catalytic investment priorities presented by the Secretariat and agree on its recommendations to the Board at the Committee's March 2019 meeting.
 - The Board:
 1. Will be asked to approve the 2020-2022 allocation methodology and catalytic investment priorities in May 2019, based on the Strategy Committee's recommendation.

Annexes

The following items can be found in Annex:

- Annex 1: Allocation Methodology Glossary
- Annex 2: Relevant Past Decisions
- Annex 3: Links to Relevant Past Documents & Reference Materials

Annex 1 – Allocation Methodology Glossary



Allocation period: the three-year period, aligned to each replenishment period, over which eligible applicants that receive an allocation may apply for funding and the Board may approve such funding for grant programs.

Available sources of funds for allocation: amount of sources of funds for country allocations and catalytic investments approved by the Board prior to each allocation period.

Country allocation methodology: is the methodology to determine the distribution of funds for country allocations, comprising of the allocation formula and qualitative adjustments. *See 2 and 3 in Figure above.*

Catalytic investments: funding set aside to invest in priorities that are unable to be addressed through country allocations alone, and considered to be crucial to ensure delivery against strategic aims. Funds are implemented through one of the following modalities:

- **Matching funds:** additional funds to incentivize programming of country allocations towards key strategic priorities;
- **Multi-country:** investments to target a limited number of key, strategic multi-country priorities deemed critical to meet the aims of the Strategy and not able to be addressed through country allocations alone;
- **Strategic initiatives:** funding for centrally managed approaches that cannot be addressed through country allocations due to their cross-cutting or off-cycle nature, but critical to ensure country allocations deliver against the Strategy.

Global disease split: distribution of total country allocation resources across HIV, TB and malaria. This distribution is done upfront in the allocation formula (*see 2-A in Figure above*) and maintained throughout the allocation methodology.

Component: HIV, TB or malaria.

Disease burden: a country's disease burden compared to the overall disease burden of all Global Fund eligible countries, based on the following indicators in the 2017-2019 allocation formula:

- **HIV/AIDS:** number of people living with HIV
- **TB:** [1*TB incidence] + [10*MDR-TB incidence]
- **Malaria:** [1*number of malaria cases] + [1*number of malaria deaths] + [0.05*malaria incidence rate] + [0.05*malaria mortality rate]

Country economic capacity: A country's GNI per capita, used in the formula by weighting according to a smooth curve where allocations decrease as GNI per capita increases.

Minimum share: no component may receive less than US\$500,000 in the allocation formula. Allocation amounts are brought to at least this amount in the formula. Components at this minimum amount may be brought to zero in the qualitative adjustments process – this is 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.

Maximum shares: components are limited to a maximum of 10% of total disease funding. Country allocations are limited to 7.5% of the total funding.

External financing adjustment: adjustment to component allocations based on projections of other external financing (non-Global Fund). To account for data quality and uncertainty, the projections are discounted by 50% and the adjustment can influence component allocations by up to 25%.

Initial Calculated Amount (ICA): initial allocation amount based on the technical parameters of disease burden, economic capacity, minimum shares, maximum shares and external financing adjustments. Does not include formulaic adjustments for paced reduction/scale up components (see below) nor does it include qualitative adjustments.

Previous funding level: total funding amount in previous allocation period.

Scale-up components: components where previous funding level is *lower* than the allocation formula's Initial Calculated Amount. Significantly lower funding than the ICA usually indicates low funding during the rounds system and/or previous absorption/risk/OIG challenges. For the formula-derived allocation, scale-up components receive *at minimum* the mid-point between their previous funding level and Initial Calculated Amount for the current allocation period. *See 2-C in Figure above.*

Paced reduction components: components where previous funding level is *higher* than the allocation formula's Initial Calculated Amount. Significantly higher funding than the ICA usually indicates high funding during the rounds-based system that exceeds current disease burden and economic capacity. For the formula-derived allocation, paced reduction components receive *a maximum* of 75% of their previous funding level. *See 2-C in Figure above.*

Formula-Derived Amount (FDA): allocation amount after scale-up and paced reduction adjustments based on funding levels in previous allocation period. Movement of funds limited to a maximum of US\$800 million in 2017-2019 allocation period. *See 2-C in Figure above.*

Qualitative adjustments: refinements to formula-derived allocations to account for epidemiological, programmatic and other factors insufficiently addressed through the allocation formula, to maximize the impact of Global Fund resources in line with the Strategy. For the 2017-2019 allocation period, Phase 1 consists of adjustments for key populations for HIV and for malaria elimination to account for epidemiological contexts that are insufficiently captured in the formula. Phase 2 includes adjustments for key programmatic factors and other contextual considerations. All changes and rationale are reported to the Strategy Committee, and all changes greater than US\$5 million and 15% are reported to the Board.

Program split: the distribution of country allocations across eligible disease components and standalone funding requests for RSSH. Based on the allocation methodology, the Global Fund provides countries with an indicative split of allocation funding between disease components. Countries have the flexibility to revise this distribution to address country contexts. The Country Coordinating Mechanism (CCM) uses a documented and inclusive process to determine the proposed split, which is agreed with the Global Fund Secretariat before submitting a funding request.

Annex 2 – Relevant Past Decisions

The following summary of past Board and Committee decision points is submitted to contextualize the information provided on the allocation methodology.

Relevant past Decision Point	Summary and Impact
GF/B36/DP06: Catalytic Investments for the 2017-2019 Allocation Period (November 2016) ³⁰	<p>Based on the recommendation of the Strategy Committee (the "SC") and the amount of sources of funds for allocation recommended by the Audit and Finance Committee (the "AFC") in GF/B36/03, the Board:</p> <p>(i) Approved USD 800 million for catalytic investments over the 2017 - 2019 allocation period for the priorities and associated costs presented in Table 1 of GF/B36/04 - Revision 2, of which no portion will be moved to further balance scale up, impact and paced reductions through country allocations.</p> <p>(ii) Noted the Secretariat will have flexibility to operationalize catalytic investments, update the SC and Board on such operationalization, and present any reallocations of the associated costs among the approved priorities for the SC's approval.</p> <p>(iii) Requested the Secretariat to provide the SC with a scope of effort and expected outcomes at the start of all strategic initiatives and to seek SC approval during implementation if there is a substantial change to the relevant strategic initiative's scope.</p>
GF/B36/DP05: Sources and Uses of Funds for the 2017-2019 Allocation Period (November 2016)	<p>The Board approved USD 800 million for catalytic investments. The Board also decided that USD 10.3 million would be available for country allocations for the 2017-2019 allocation period, of which USD 800 million is to ensure scale up, impact and paced reductions.</p>
GF/B35/DP10: Allocation Methodology 2017-2019 (April 2016) ³¹	<p>Based on the recommendation of the SIIC, the Board:</p> <p>(i) Approved the allocation methodology presented in Annex 1 to GF/B35/05 - Revision 1 (the "Allocation Methodology");</p> <p>(ii) Acknowledged 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</p> <p>(iii) Affirmed the restatement of core parts of the Funding Model Principles, as presented in Annex 3 to GF/B35/05 - Revision 1 (the "Affirmed Principles").</p>
GF/SIIC17/DP05: Allocation Methodology 2017-2019 (March 2016)	<p>The SIIC decided that the following parameters for the 2017 – 2019 allocation replaced those used for the 2014 – 2016 allocation period, as previously approved under decision point GF/SIIC09/DPO1: (i) indicators for disease burden and country economic capacity, which represents a</p>

³⁰ <https://www.theglobalfund.org/board-decisions/b36-dp06/>

³¹ <https://www.theglobalfund.org/board-decisions/b35-dp10/>

Relevant past Decision Point	Summary and Impact
	terminology update to ability to pay; (ii) maximum and minimum shares for the allocation; and (iii) external financing adjustment.
GF/B31/DP10: Composition of and Allocation to Country Bands (March 2014)	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/DPO9: Transition from the Third to the Fourth Replenishment Period (March 2014)	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/DPO7: Regional Programs (March 2014)	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.
GF/B31/DPO6: Special Initiatives (March 2014)	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.
GF/SIIC09/DPO1: 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.
GF/SIIC09/DPO2: 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.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013)	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

Relevant past Decision Point	Summary and Impact
	recommend appropriate modifications to the Board prior to the 2017 – 2019 allocation period.
GF/B29/EDP1: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013)	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.
GF/B29/EDP10: Division between Indicative and Incentive Funding (October 2013)	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 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.
GF/B28/DPO4: Evolving the Funding Model (Part Two) (November 2012)	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: major sources of external funding; minimum funding levels; willingness to pay; past program performance and absorptive capacity; risk; and 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.
GF/B27/DPO7: Evolving the Funding Model (September 2012)	Based on the recommendation of the SIIC, the Board adopted principles for key elements of the allocation-based funding model, including a ceiling of 10 percent of

Relevant past Decision Point	Summary and Impact
	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.

Annex 3 – Relevant Past Documents & Reference Materials

GF/B35/05 – Revision 1: Allocation Methodology 2017-2019:

https://www.theglobalfund.org/media/4224/bm35_05-allocationmethodology2017-2019_report_en.pdf

GF/B36/04 – Revision 2: Catalytic Investments for the 2017-2019 Allocation Period:

https://www.theglobalfund.org/media/4258/bm36_04-catalytic-investments_report_en.pdf