

41st Board Meeting

Allocation Methodology for the 2020-2022

Allocation Period

GF/B41/02

15-16 May 2019, Geneva

Board Decision

Purpose of the paper: This paper presents the recommendation of the Strategy Committee to the Board for approval of a revised allocation methodology for the 2020-2022 allocation period.

Decision Point

Based on the rationale described below, the Strategy Committee recommends the following decision point to the Board.

GF/B41/DP03: Allocation Methodology 2020 - 2022

1. The Board notes:
 - a. Its decision in April 2016 (GF/B35/DP10) that (i) established the allocation methodology for the 2017 - 2019 allocation period; (ii) acknowledged the technical parameters for the 2017 - 2019 allocation period; and (iii) affirmed the restatement of core parts of the principles and framework for the allocation-based funding model (the “Core Funding Model Principles”); and
 - b. The decision by the Strategy Committee (the “SC”) in March 2019 (GF/SC09/DP02), under authority delegated by the Board, to establish technical parameters for the 2020 – 2022 allocation period (the “Technical Parameters”).
2. Accordingly, based on the recommendations of the SC, as presented in GF/B41/02, the Board:
 - a. Approves the allocation methodology presented in Annex 1 to GF/B41/02 (the “Allocation Methodology”);
 - b. Acknowledges the Technical Parameters for the 2020 – 2022 allocation period, as presented in Annex 2 to GF/B41/02;
 - c. Approves that no more than USD 800 million of sources of funds available for country allocations be used to ensure scale-up, impact and paced reductions, as described in paragraph 4.c of the Allocation Methodology; and
 - d. Reaffirms the Core Funding Model Principles, as presented in Annex 3 to GF/B35/05 – Revision 1.
3. Accordingly, the Board:
 - a. Requests the SC to review and approve, at its July 2019 meeting, the method by which the Secretariat will apply and report on the qualitative adjustment process; and
 - b. Acknowledges that the Allocation Methodology and Technical Parameters shall apply for the 2020 – 2022 allocation period and supersede the 2017 – 2019 allocation methodology and technical parameters presented in GF/B35/05 – Revision 1.

Budgetary implications: none.

A summary of relevant past decisions providing context to the proposed Decision Point can be found in Annex 7.

Executive Summary

Context

To ensure that the allocation methodology for the 2020-2022 allocation period is robust, the Strategy Committee and the Secretariat have conducted a thorough review of the current allocation methodology, building on lessons learned from the process and outcomes of the 2017-2019 allocation period. This paper provides an overview of the technical parameters of the allocation formula approved by the Strategy Committee and proposes minor refinements to the overall allocation methodology for the 2020-2022 allocation period for approval by the Board.

Questions this paper addresses

- A. What refinements are proposed in the 2020-2022 allocation methodology?
- B. What do we need to do next to progress?

Conclusions

- A. The Strategy Committee unanimously approved the technical parameters for the allocation formula, in line with the authority delegated to it by the Board under GF/B35/DP10. The technical parameters reflect refinements to the malaria burden indicator, while the HIV and TB burden indicators remain unchanged. For the overall allocation methodology, the Strategy Committee recommends a minor update to the measurement of previous funding levels in the scale-up and paced reductions approach. In addition, minor revisions are proposed to move decisions about details specific to an allocation period into separate decision points, so that the policy in Annex 1 describes a methodology that can continue to be relevant for subsequent allocation periods. For example, the amount of funds that can be moved to ensure scale-up and paced reductions is in the decision point of this paper GF/B41/DP03, while the amount of catalytic investments is part of a separate decision point recommended to the Board in GF/B41/DP04.
- B. The Secretariat will further develop the qualitative adjustment process for the 2020-2022 allocation period, to be reviewed and approved by the Strategy Committee in July 2019 at its 10th Meeting.

Input Sought

The Board is asked to approve the allocation methodology for the 2020-2022 allocation period as described in Annex 1.

- Decision Point: GF/B41/DP03

Input Received

After an extensive year-long review process, the Strategy Committee agreed with technical partners as well the Secretariat, TRP and TERG that the Global Fund is largely on track to achieve its six-year Strategy¹ and only minor course corrections are needed. Based on this assessment, the Strategy Committee unanimously approved the technical parameters of the allocation formula, in line with its delegated authority, and recommended the overall allocation methodology for Board approval at its 9th meeting on March 28-29, 2019. The Strategy Committee recommended maintaining the global disease split for the 2020-2022 period while requesting that the Secretariat plan for a review of the disease split for the 2023-2025 allocation period. The Strategy Committee also recommended

¹ [Global Fund Strategy 2017-2022: Investing to End Epidemics](#), GF/B35/DP04.

incorporating minor refinements to better achieve the objectives of the allocation methodology. Specifically, it approved an update to the malaria burden indicator to refine the baseline period and account for country differences in population growth since the baseline period, and it recommended a simplified measurement of previous funding levels in the scale-up and paced reductions approach. Noting the importance of HIV incidence considerations, the Strategy Committee also recommended that incidence continue to be accounted for in the qualitative adjustments and that technical partners continue to identify opportunities to improve the measurement of new infections. On qualitative adjustments, the Strategy Committee had an initial discussion on potential factors and will be requested to approve the qualitative factors and process for the 2020-2022 allocation period in July 2019. Together with the country allocations, the Strategy Committee recommended the amounts and priorities for catalytic investments in a separate decision point detailed in GF/B41/DP04.

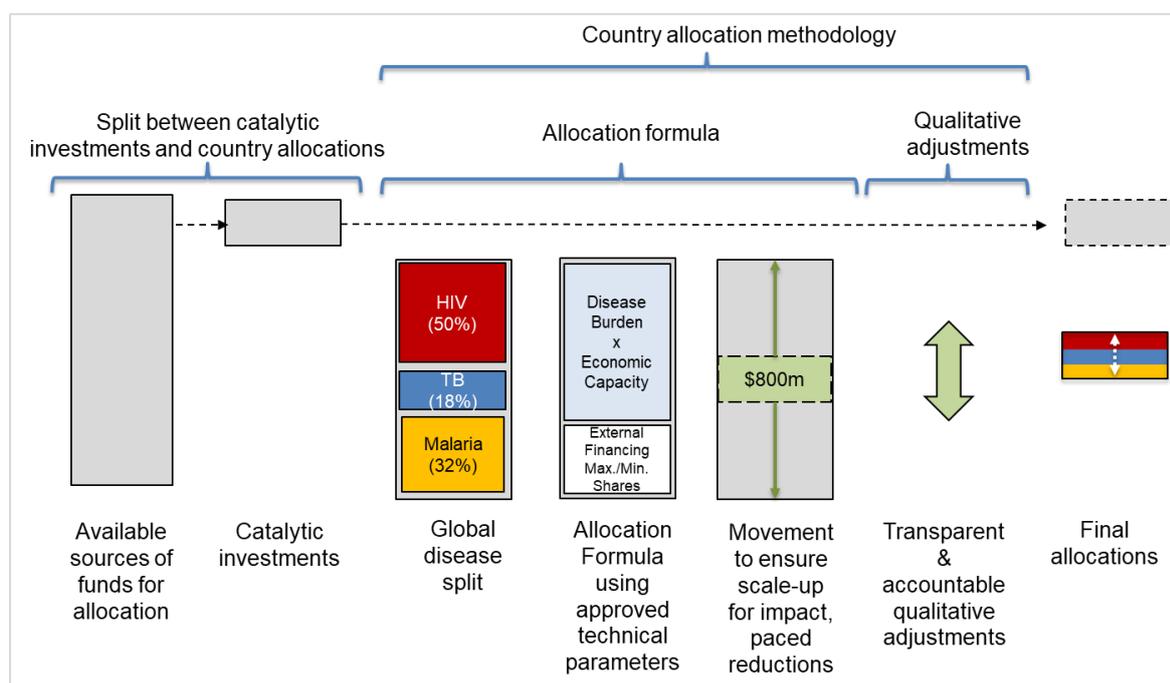
What is the need or opportunity?

1. The allocation methodology seeks to maximize the impact of Global Fund resources to prevent, treat and care for people affected by HIV, TB and malaria, and to build resilient and sustainable systems for health. This is achieved through country allocations and through funds set aside for catalytic investments.
2. To ensure that the allocation methodology for the 2020-2022 allocation period is robust, the Strategy Committee and the Secretariat have conducted a thorough review of the current allocation methodology, building on lessons learned from the process and outcomes of the 2017-2019 allocation period. The previous Strategy Committee provided a “lessons learned” document to the current Strategy Committee in March 2018, and the current Strategy Committee discussed the allocation methodology over meetings in July and October 2018, on a call in February 2019, and finally at its 9th meeting in March 2019.
3. Joint findings from a review by the Technical Evaluation Reference Group (TERG), the Technical Review Panel (TRP) and the Secretariat on the country allocations and catalytic investments for the 2017-2019 allocation period were presented to the Strategy Committee in July 2018. With respect to the 2017-2019 country allocations, the central joint conclusion of this review was that the allocation methodology “is working and effective” in delivering on its objectives and that “refinements should focus on areas with evidence and lessons learned.”

What do we propose to do and why?

4. This paper sets forth refinements to the allocation methodology for the 2020-2022 allocation period recommended by the Strategy Committee to the Board, as outlined in Annex 1 and explained in further detail in Annexes 4 and 5. The majority of revisions are due to moving allocation period-specific details described in the previous allocation methodology to separate Board and Strategy Committee decisions on catalytic investments and qualitative adjustments. The rationale for these revisions is to reflect the earlier timing of Board decision-making on catalytic investments and to describe a methodology that can continue to remain relevant for subsequent allocation periods. The proposed refinements to Annex 1 also reflect minor revisions aimed at updating terms and policy language. The Strategy Committee recommendation and Secretariat’s analysis relating to catalytic investments for the 2020-2022 allocation period are set forth in GF/B41/O3, for Board decision. Figure 1 provides an overview of the allocation methodology recommended by the Strategy Committee.

Figure 1: Overview of the Allocation Methodology



Country Allocation Methodology

5. Through the global disease split, allocation formula and qualitative adjustments, the country allocation methodology produces country allocations to maximize the impact of available resources by focusing funds on the countries with the highest disease burden and lowest economic capacity, while accounting for key and vulnerable populations disproportionately affected by the three diseases.² It also provides countries with predictable financing through an approach that is simple and flexible. For the 2020-2022 allocation period, the country allocation methodology will continue to support the delivery of the *Global Fund Strategy 2017-2022: Investing to End Epidemics* (the “Strategy”).
6. Available funds for country allocations are distributed upfront to the three diseases according to the global disease split.³ As part of its recommendation of the allocation methodology set forth in Annex 1, the Strategy Committee recommends maintaining the global disease split for the 2020-2022 allocation period, which allocates 50% of funding for country allocations to HIV, 18% to TB and 32% to malaria. The current disease split has been in place since the first allocation period of 2014-2016.⁴ While committee members expressed different views on the global disease split, the Strategy Committee ultimately acknowledged that maintaining the current disease split for the 2020-2022 allocation period was the most feasible option to avoid critical programmatic gaps that would likely result from significant shifts in the distribution of Global Fund investments across diseases. However, the Strategy Committee requested that the Secretariat incorporate a disease split analysis into planning for future allocation periods and the development of the next Global Fund Strategy, to reflect the latest epidemiological data, newly available tools and guidance for all three diseases.

² GF/B35/05 – Revision 1.

³ See Annex 1, paragraph 4.a.

⁴ GF/B28/DP05.

7. Within each disease pool of funding, funds are distributed across eligible components according to the technical parameters of the allocation formula to generate Initial Calculated Amounts. The technical parameters drive funding in line with disease burden and economic capacity, while accounting for other external financing and maintaining minimum and maximum shares. The technical parameters approved by the Strategy Committee, under delegated authority from the Board, are provided in Annex 2. Among these parameters, the malaria burden indicator has been updated to refine the period of peak burden and account for population growth differences among countries since the period of peak burden. The Strategy Committee acknowledged that the other technical parameters remain fit for purpose and achieve their intended objectives. *See section on “Technical Parameters of the Allocation Formula.”*⁵
8. Considering the previous funding levels of each component, the formula redistributes funds across the portfolio to provide paced reductions in financing for components previously receiving more than their Initial Calculated Amounts. At the same time, it prioritizes the scale-up of financing for components that previously received less than their Initial Calculated Amounts, to bring overall funding in line with disease burden and economic capacity. This redistribution of funds, prioritizing scale-up while ensuring paced reductions, produces the Formula-Derived Amounts.
9. The Strategy Committee recommends maintaining the approach to provide scale-up for impact and paced reductions in the allocation formula based upon its effectiveness in the 2017-2019 allocation methodology. However, it recommends simplifying the measurement of previous funding levels in the allocation formula to “allocations from the previous allocation period” (instead of “actual and forecasted disbursements”), now that the previous funding levels cover a three-year implementation period. *See section on “Ensuring Scale-up and Paced Reductions in the Allocation Methodology.”*⁶
10. The qualitative adjustment process allows for allocations to be adjusted up or down to address key epidemiological, programmatic and country characteristics, on a case-by-case basis, in order to determine final country allocations. The Strategy Committee had an initial discussion on potential factors for the qualitative adjustment process and will be requested to approve the qualitative factors and process for the 2020-2022 allocation period in July 2019. *See section on “Qualitative Adjustments.”*⁷

Technical Parameters of the Allocation Formula

11. In March 2019, the Strategy Committee approved the 2020-2022 technical parameters as provided in Annex 2. Prior to such approval, the Strategy Committee had reviewed all technical parameters of the allocation formula in 2018 and early 2019 to assess whether any revisions would be needed for the 2020-2022 allocation methodology. These parameters are the disease burden indicators for HIV, TB and malaria, the Country Economic Capacity (CEC) indicator, minimum and maximum shares, and the external financing adjustment. In addition, the Secretariat held consultations with technical partners to seek their review and recommendations on the disease burden indicators in light of current epidemiological context, as well as latest data and burden estimation methods. Annex 3 provides the full recommendations from technical partners. For the 2020-2022 allocation period the Strategy Committee agreed, based on the review and recommendations of technical partners, that the only technical parameter that requires updating is the malaria burden indicator, and confirmed that the other indicators remain relevant and appropriate.

⁵ See also Annex 1, paragraph 4.b and Annex 2.

⁶ See also paragraph 20 below and Annex 1, paragraph 4.c.

⁷ See also Annex 1, paragraph 4.d.

Disease burden parameters:

12. For malaria, technical partners recommend the continued use of historical data to reflect each country's malaria transmission potential in the absence of control interventions. However, they recommend two adjustments to the current burden indicator which has been used since the 2014-2016 allocation period. The first adjustment is to incorporate latest population-at-risk data to account for country differences in population growth since the period of peak burden. The second adjustment is to replace the original baseline year of 2000 with the average of 2000-2004 to better capture each country's relative malaria transmission potential, given that countries reached peak burden at different times during the period of 2000-2004. While improving the robustness of the malaria burden indicator, the adjustments have a small overall effect, shifting less than 2% of funds within malaria in comparison to the 2017-2019 burden indicator.⁸
13. For HIV, technical partners recommend maintaining the burden indicator that has been in place since the 2014-2016 allocation period. The indicator, defined as the number of people living with HIV (PLHIV), captures the current burden of disease, which is important for knowing the potential financial requirements for maintaining people on antiretroviral therapy, as treatment represents one of the largest costs of an HIV response and is a known recurrent cost. The number of PLHIV also provides the denominator against which efforts to scale up testing and treatment are measured. It is recognized that the number of PLHIV alone does not adequately reflect the disproportionate burden of HIV amongst key populations, which particularly affects the calculation of allocations for low prevalence settings. Therefore, technical partners recommend maintaining, as part of qualitative adjustments, an adjustment for key populations in low prevalence settings.
14. Technical partners also considered adult HIV incidence as a possible indicator to further capture prevention needs. It is, however, not recommended for use in the allocation formula for three primary reasons. Firstly, annual incidence would only reflect new cases per year and, on its own, would not account for the ongoing needs and cost implications of treatment. Secondly, most incidence estimates are modelled on prevalence data, and combining incidence with prevalence in the formula would reduce the interpretability of what the burden measure represents. Finally, there is significant uncertainty regarding estimates on incidence, which makes it less suitable for a formula and more appropriate to be accounted for on a case-by-case basis in the qualitative adjustments. As such, technical partners recommend that incidence instead be considered in the qualitative adjustment process.
15. For TB, technical partners recommend maintaining the current burden indicator, which was last revised for the 2017-2019 allocation period. The number of TB and multi-drug resistant TB (MDR-TB) cases remain the most relevant measures of TB burden as a basis for distributing available resources across eligible countries. In the allocation formula, the number of MDR-TB cases is weighted by a factor of 10, which based on a review of latest available cost information, remains an adequate weighting to account for the greater costs of treatment for MDR-TB compared to drug-susceptible TB.

Other technical parameters:

16. The Strategy Committee reviewed the aim of the other technical parameters – namely the CEC indicator, external financing adjustment, maximum and minimum shares – and their effects on the 2017-2019 allocations.

⁸ Scenarios of Formula-Derived Amounts applying the 2020-2022 and 2017-2019 malaria burden indicators, assuming total funding of \$10.3 billion for country allocations.

17. The *CEC indicator* aims to distribute relatively more funding to countries with lower capacity to finance their response to the three diseases, using Gross National Income (GNI) per capita as a proxy for economic capacity. The *minimum share* ensures that no components receive less than \$500,000 in the allocation formula, with the aim of providing meaningful allocation amounts to disease programs. The two *maximum shares* aim to ensure that overall funding does not become overly concentrated in a few countries. Components are limited to a maximum of 10% of total disease funding, and country allocations are limited to 7.5% of total funding. The *external financing adjustment* accounts for projections of non-Global Fund external financing. To account for data quality and uncertainty, the external financing projections are discounted by 50% and the effect of the adjustment on component allocations is limited to 25%.
18. The Strategy Committee determined that these parameters continue to be relevant and effective, and has approved, in line with its Board-delegated authority, these parameters for the 2020-2022 allocation period.

Ensuring Scale-up and Paced Reductions in the Allocation Methodology

19. To provide predictable financing and prevent steep decreases in funding from one allocation period to the next, funds are moved across the portfolio to country components that had previously received more funding than their Initial Calculated Amounts. At the same time, to continue to align investments towards the highest burden countries with the least economic capacity, the movement of funds ensures scale-up for impact in country components previously below their Initial Calculated Amounts. This approach balances both the need for scale-up and paced reductions towards the Initial Calculated Amounts of the allocation formula.
20. For the 2017-2019 allocation methodology, previous funding levels were measured as three-year equivalent actual and forecasted disbursements from the 2014-2016 allocation period. This was because the 2014-2016 allocations covered a range of implementation periods as part of the transition from the rounds-based funding model. From 2017-2019 onwards, allocations are fully aligned to a three-year implementation period, therefore the measurement of “previous funding levels” is updated and simplified as allocations from the previous allocation period.⁹
21. As described in GF/B35/05 – Revision 1, the movement of funds is guided by the following approach:
 - a) First, the allocation formula prioritizes at least 50% scale-up of funding towards the formula’s Initial Calculated Amounts for country components whose previous funding levels were below these amounts;
 - b) Second, the allocation formula provides paced reductions to country components whose previous funding levels 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 proportionally more funding than a country component with a smaller gap; and
 - ii. No country component with a previous funding level above its Initial Calculated Amount would receive funding greater than 75% of its previous funding level;¹⁰ and

⁹ The intention is to use post-program split allocations from the 2017-2019 allocation period as the basis for previous funding levels in the allocation formula.

¹⁰ Not applicable to components with Initial Calculated Amounts greater than 75% of their previous funding levels.

- c) A limit of \$800 million is applied to the movement of funds between scale-up and paced reduction components. The limit prioritizes scaling up in high burden contexts to bring allocation amounts in closer alignment with disease burden and country economic capacity.
22. In the 2017-2019 allocations, \$800 million was shifted using the above approach, which effectively increased funding for scale-up components at more than 50% towards the Initial Calculated Amount. In scenarios modelled for the 2020-2022 period, the approach continues to be effective in providing a minimum level of scale-up before funds are moved to paced reduction components. This focus on scale-up becomes especially important at lower funding levels to safeguard a minimum level of increased financing for components that have been historically below the formula's Initial Calculated Amount.
23. As the parameters of the approach continue to deliver on the objective of prioritizing funding for scale-up components, while mitigating steep decreases elsewhere in the portfolio, the Strategy Committee recommends maintaining the scale-up and paced reduction approach for the 2020-2022 allocation period and the \$800 million limit.

Scenario Projections of the Allocation Formula

24. The refined country allocation methodology for the 2020-2022 allocation period is expected to continue delivering its objective of aligning funding to disease burden and economic capacity, as well as addressing the needs of key and vulnerable populations.
25. Scenarios were modelled to apply the allocation formula with latest available data under different funding envelopes. The scenarios demonstrate that the methodology prioritizes funding for high burden and low-income countries at all funding levels. Since the first period of the allocation model in 2014-2016, the allocation methodology has increasingly aligned funds to countries that represent the greatest portion of the disease burden across the Global Fund portfolio (Figure 2). For the 2020-2022 allocation period, the allocation formula is expected to distribute approximately 50% of the funding to low-income countries, similar to the 2017-2019 allocations (Figure 3). Note that scenario results shown in Figures 2-4 are Formula-Derived Amounts only and do not account for potential qualitative adjustments.
26. The projections by region (Figure 4) demonstrate that the regions where the majority of components are on paced reduction may see significant decreases at lower funding levels, which highlights the criticality of a successful replenishment as well as the need to safeguard country allocations in considering the level of financing for catalytic investments. Regions with more components intended for scale-up of funding would gain a greater share of funding, particularly in higher funding scenarios.

Figure 2: Share of Funding for the Countries that Represent 80% of Disease Burden

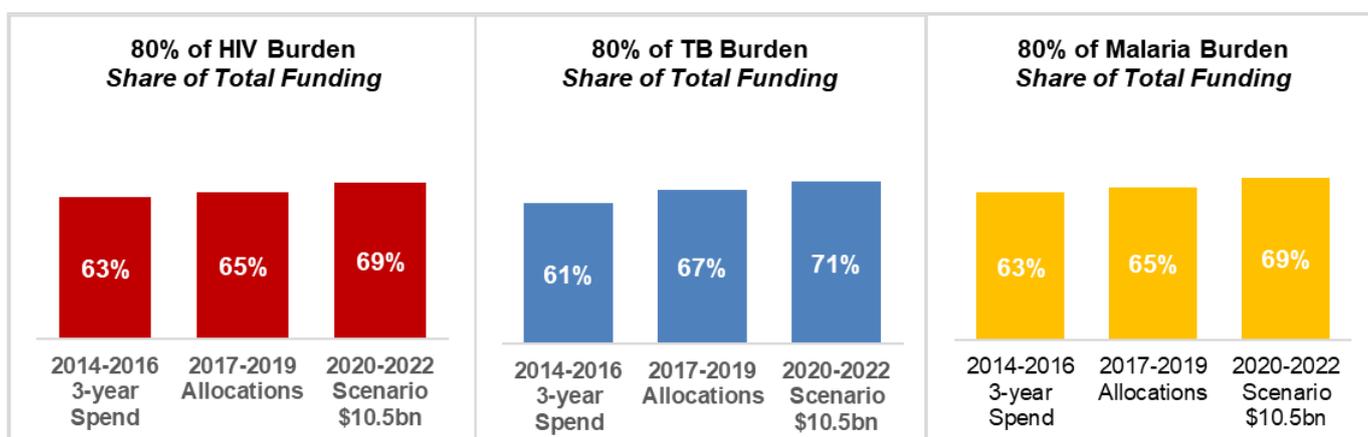


Figure 3: Formula-Derived Amounts by Income Group at Various Funding Levels for the 2020-2022 Allocation Period

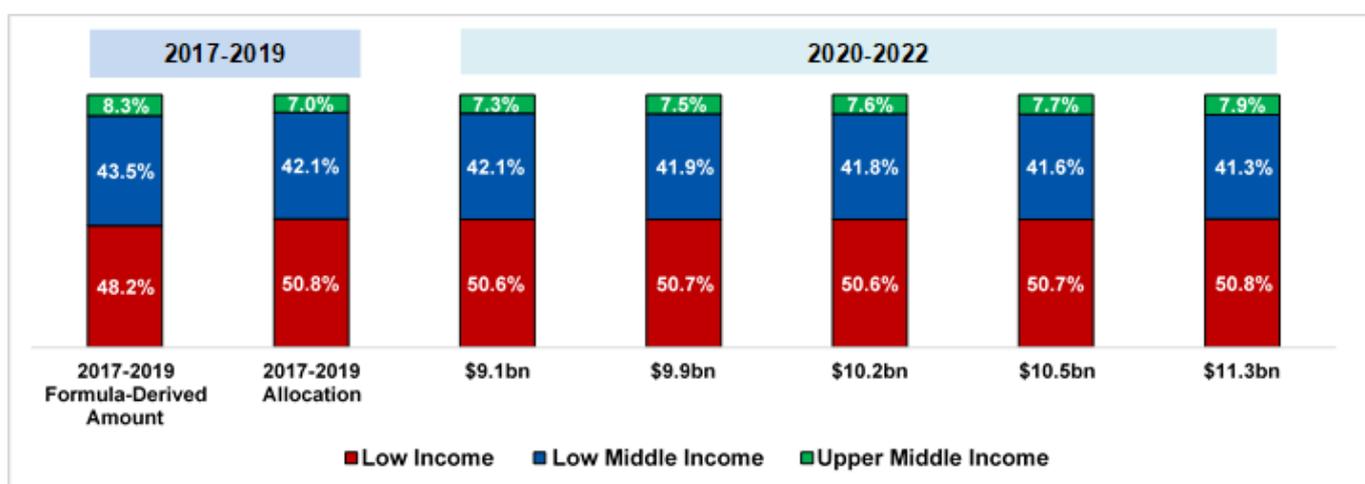
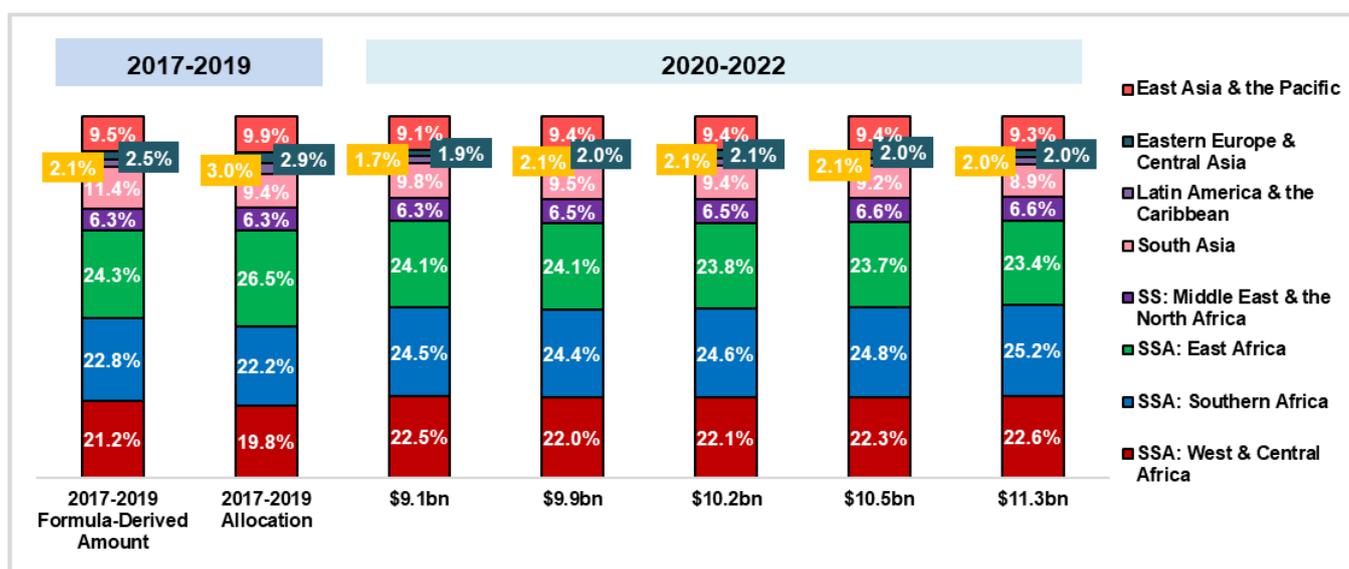


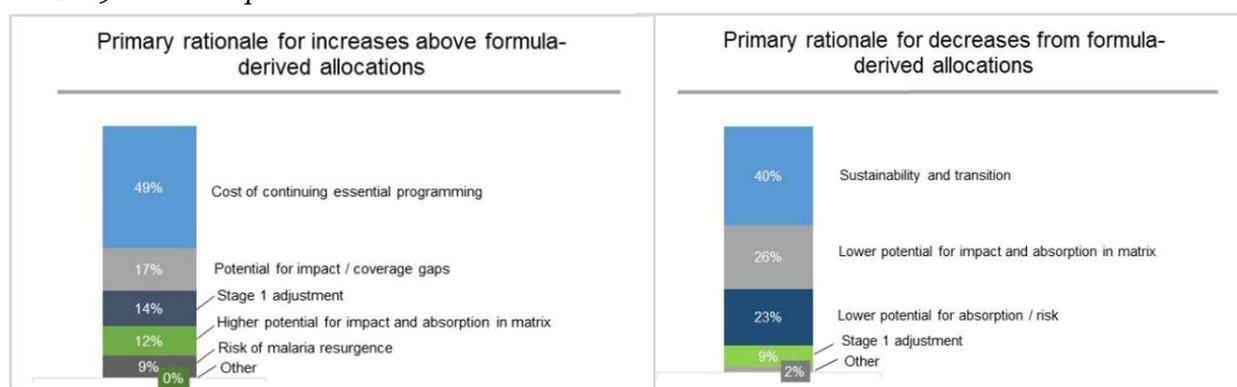
Figure 4: Formula-Derived Amounts by Region at Various Funding Levels for the 2020-2022 Allocation Period



Qualitative Adjustments

27. Formula-Derived Amounts are subsequently reviewed through a qualitative adjustment process to account for key epidemiological, programmatic and other country contextual factors that cannot be adequately captured in a formula. The qualitative adjustment process is carried out by the Secretariat under the oversight of the Strategy Committee. Prior to each allocation period, the Strategy Committee reviews and approves the qualitative adjustment factors and process for applying the factors. The approval of the qualitative adjustment process occurs after the Board approves the allocation methodology because the qualitative factors are dependent on the approved allocation formula. For the 2020-2022 allocation period, the review and approval by the Strategy Committee is scheduled for its 10th meeting in July 2019.
28. For the 2017-2019 allocation period, the Strategy Committee approved a transparent and flexible qualitative adjustment process, which was applied in two stages. Stage 1 was to refine for epidemiological contexts insufficiently addressed through the allocation formula. For HIV, an adjustment was applied in Stage 1 to account for key populations disproportionately affected by HIV in low prevalence settings. For malaria, a cap of \$6 per person at risk was applied in countries with population at risk of less than 1 million, to account for settings with low endemicity of malaria.
29. Stage 2 was a holistic adjustment to account for programmatic and other contextual factors. In 2017-2019 the factors considered during the qualitative adjustment process included potential for impact, potential for absorption, the cost of essential programming, HIV incidence rates in lower prevalence countries, as well as sustainability and transition considerations. Importantly, these adjustments could be up or down, based on country context.
30. All adjustments were made to arrive at zero net changes per disease to maintain the global disease split of resources in the final country allocations. Figure 5 provides the primary rationale for the increases and decreases from Formula-Derived Amounts through the qualitative adjustment process.

Figure 5: Primary rationale for changes made in the qualitative adjustment process for the 2017-2019 allocation period



31. Certain factors from the 2017-2019 allocation period will continue to be important considerations for the 2020-2022 allocation period, such as the key populations adjustment in Stage 1, as well as the cost of essential programming, potential for impact and potential for absorption in Stage 2. The Secretariat will work on refining these factors, including HIV incidence, to ensure the best available data is used and adjustments are made holistically to reflect country contexts. As recommended in initial discussions with the Strategy Committee, the Secretariat is considering other potential factors, such as fiscal space and how refugee population needs are accounted for, to be reviewed at the July Strategy Committee meeting.

32. For the 2017-2019 allocation period, the Strategy Committee received a report of all changes to country components through the qualitative adjustment process. Adjustments made through this process greater than 15% and greater than \$5 million were reported by the Strategy Committee to the Board. The Strategy Committee and the Secretariat recommend maintaining this approach for the 2020-2022 allocation period.

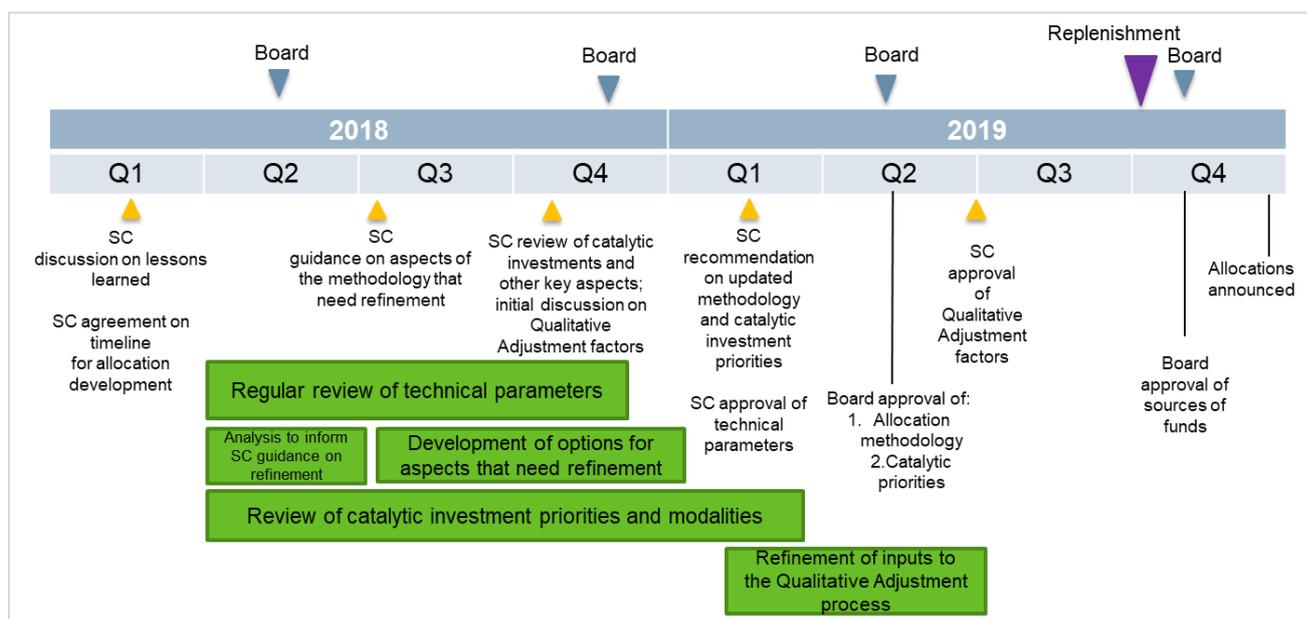
Catalytic Investments

33. As initially set forth in the founding principles of the allocation-based funding model, there is a continued need to retain a portion of funding for catalytic investments to maximize the impact and use of available funds. The objective of the 2020-2022 catalytic investments is to address priorities in ways that cannot be achieved through country allocations alone yet are deemed crucial to ensure that Global Fund investments are positioned to deliver against the Strategy.
34. Based on the recommendations of the Strategy Committee, the Board may approve funding amounts for catalytic priorities prior to each allocation period. The Board is requested to approve the 2020-2022 catalytic investments in May 2019 to allow for timely operationalization, drawing from the joint conclusions of the TERG, TRP and Secretariat review. The Board decision point includes scenarios of different funding amounts since the approval will be required before replenishment outcomes are known. The catalytic investments under scenarios of different funding amounts are presented to the Board for approval in GF/B41/DPO4.
35. Because of the expected sequencing of Board decisions on the allocation methodology and catalytic investments for the 2020-2022 allocation period, the amount retained for catalytic investments is now linked to the available sources of funds for allocation. In the 2017-2019 allocation methodology, the Board approved 15% of the sources of funds for catalytic investments and to enable scale-up, impact and paced reduction in the allocation formula. The current sequencing of Board decisions makes the 15% limit on sources of funds no longer relevant, therefore the limit has been removed from the allocation methodology itself, with amounts for catalytic investments stated separately in the Decision Point GF/B41/DPO4. A full description of other modifications to the allocation methodology described in Annex 1 is detailed out in the table of Annex 5 and a tracked-changes version of Annex 1 is also provided as Annex 4.

What do we need to do next to progress?

36. The Secretariat will further develop and refine the qualitative adjustment process for the 2020-2022 allocation period, under the oversight of the Strategy Committee. In July 2019, the Strategy Committee will be requested to approve the qualitative adjustment process, factors and reporting requirements. *See timeline in Figure 6.*
37. In November 2019, once the replenishment outcome is known, the Board will approve the available sources of funds for allocation, and the amount to be set aside for catalytic investments will be known. The Secretariat will then apply the allocation methodology to produce the country allocations for the 2020-2022 allocation period.

Figure 6: Timeline and process to develop the 2020-2022 allocations



38. A Board decision on the allocation methodology in May 2019 is critical to ensure timely progress towards producing the country allocations and operationalizing catalytic investments for the 2020-2022 allocation period. Any delay in the Board decision would consequently delay the application of the allocation methodology, including the Strategy Committee’s decision on qualitative adjustments, the Secretariat’s update of inputs to the allocation formula and the final roll-out of the allocation methodology, as well as multiple other internal Secretariat processes to prepare for the 2020-2022 cycle of grants, which would ultimately jeopardize the timely communication of allocations to countries.

Recommendation

The Board is requested to approve the refined allocation methodology presented in Annex 1 as recommended by the Strategy Committee.

Annexes

The following items can be found in Annex:

- Annex 1: Allocation Methodology
- Annex 2: Technical Parameters
- Annex 3: Recommendations from Technical Partners on Disease Burden Indicators
- Annex 4: Allocation Methodology in Tracked Changes
- Annex 5: Explanatory Note – Revisions to the Allocation Methodology
- Annex 6: Allocation Methodology Glossary
- Annex 7: Relevant Past Decisions
- Annex 8: Summary of Strategy Committee Input

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.¹¹
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, the Board may approve:
 - a. Amounts for catalytic investments, as described further in paragraph 6 below; and
 - b. Amounts to be included as part of the available sources of funds for country allocations to ensure scale up, impact and paced reductions in funding as described in paragraph 4.c below.

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

¹¹ Justifications for variations from the three-year standard will be provided to the Board as part of the Secretariat's grant approval requests.

flexibility 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 allocations from the previous allocation period.
 - d. **Qualitative Factors:** The Secretariat may 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.
 - i. 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
 - ii. 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 as unfunded quality demand, in accordance with a prioritization developed by the Secretariat and approved by the Committee responsible for strategy matters; 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:** As described in paragraph 3.a, based on the recommendations of the Committee responsible for strategy matters, the Board may approve amounts to finance catalytic investments in priorities necessary to maximize impact and use of available funds, that are unable to be addressed through country allocations alone yet critical to deliver the Global Fund strategy. The Committee responsible for strategy matters will 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 available amount of sources of funds for allocation, and present recommendations to the Board for approval.

Annex 2 -Technical Parameters

Summary of technical parameters for the 2020-2022 allocation period as approved by the Strategy Committee in Decision Point GF/SC09/DP02

The technical parameters for the 2020-2022 allocation period are presented in Table 1 as follows:

Table 1: Technical Parameters for the 2020 – 2022 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] Latest available data for the average values between 2000-2004 Number of malaria cases and deaths adjusted by latest Population-At-Risk (PAR) ratio: PAR (latest year) / PAR (2000-2004 average) All indicators normalized
Country economic capacity indicator	Weighting determined by GNI per capita and smooth CEC curve Latest available data
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 – Recommendations from Technical Partners on Disease Burden Indicators for the 2020-2022 Allocation Formula

HIV:

Submitted by co-chairs of HIV Situation Room

Technical partners represented: UNAIDS, WHO and USG PEPFAR

Recommended disease burden indicator for the 2020-2022 allocation formula

Number of people living with HIV, based on most recently available UNAIDS estimates.

Rationale for why this is the recommended burden indicator

The number of persons living with HIV (PLHIV) is the basis for calculating HIV treatment burden and associated costs at any given point in time. Treatment is one of the largest cost burdens of an HIV response and is a known recurrent cost.

The number of persons living with HIV accounts for incident HIV cases to the degree that UNAIDS' are annual estimates and include any growth of HIV epidemics in annual estimates.

This indicator captures the current burden of disease which is important for knowing the potential financial requirements for maintaining the population on ART and provides the denominator against which efforts to scale up testing and treatment are measured.

Any other metrics considered, and why they were not chosen

Adult HIV incidence was also considered. However, it is not recommended given that it does not capture the number of people requiring treatment. Annual incidence only represents new cases within a year, and on its own, it does not provide any relation to ongoing treatment needs and financial cost implications of the treatment burden. HIV incidence can drop to very low levels while there is still considerable effort required to identify people living with HIV, start and retain them on treatment. Incidence is useful in determining geographic focus of prevention investments. Also, Incidence may be useful in tracking rises in what will eventually be an increased disease burden that will show up in burden of disease, and in tracking outbreaks and the potential need for increased resources.

UNAIDS and partners have developed additional epidemic control metrics including (1) the ratio of incidence to mortality among all people living with HIV and (2) the ratio of incidence to prevalence. These metrics are in part focused on incidence and appear less appropriate to inform on the burden of the epidemic in the country. The incidence mortality ratio (2) is also only appropriate to use in countries with ART coverage over 81%.

Although not recommended as a disease burden indicator in the allocation formula, incidence values should be used where possible to track national HIV program progress or lack there-of. Incidence values obtained through surveys and modeling should be routinely used to inform changes in HIV program focus and intensity.

Potential limitations of recommended indicator and how these may be addressed elsewhere in the allocation methodology

The limitation on PLHIV burden metric is that it may not adequately represent the financial burden required to respond to HIV epidemic in certain contexts, specifically low prevalence settings where key populations are affected. (Note: PLHIV may be adequate for low prevalence/high burden settings, e.g. large populations with low prevalence).

For countries with concentrated epidemics overall adult prevalence might be low but prevalence among key populations may be considerable. Therefore, adjustments for key population epidemics and

prevalence among specific key populations should be considered in the qualitative adjustments. The challenge remains that currently standardized measures of prevalence (or incidence) among key populations are not available for most countries.

While the population living with HIV may be accurately estimated in a low prevalence setting, it may be inadequate in estimating the financial need for a country when used to create a financial share or allocation. The country may have limited political will to address key population issues and/or may not have a robust health budget to support the needs to adequately address the key population epidemic. PLHIV alone may underestimate the financial need/burden for a country with limited resources or limited interest in investing in specific populations.

TB:

Submitted by TB Situation Room

Technical Partners represented: Stop TB Partnership, WHO, USAID, BMGF

Recommended disease burden indicator for the 2020-2022 allocation formula

[1*TB cases] + [10*MDR-TB cases]

Source: WHO, latest available data

Rationale for why this is the recommended burden indicator

The absolute number of TB and MDR cases remain the most relevant measures of TB burden as a basis for distributing available for TB across eligible countries in the Global Fund's allocation formula.

The original weighting of 10 to 1 was defined for the 2017-2019 allocation period to recognize the greater costs of treating MDR-TB.

This weighting has been reviewed based on latest available data. Estimates indicate that the ratio of MDR to DS-TB costs ranges from 6:1 to 15:1, depending on the scope of what is captured in treatment costs as well as assumptions on future costs over the 2020-2022 allocation period. Taking into account the WHO's latest recommendations on MDR-TB treatment, uncertainty in cost estimates and uncertainty over projected cost (e.g. the initial increase with uptake of new MDR treatment guidelines, potential reduction in commodity costs due to market shaping efforts), it is recommended that that 10 to 1 weighting remain in place for the 2020-2022 allocation period.

Scenarios provided by the Global Fund's allocation team indicate that changing the weighting from 10:1 to 15:1 would have a small effect on the portfolio, as only 2% of funding would be moved across countries, and this effect would be even smaller once the other parameters of the allocation formula are applied.

Any other metrics considered, and why they were not chosen

The inclusion of TB key populations was considered, potentially for qualitative adjustments Stage 1, but are not recommended for Stage 1 due to difficulties in defining and measuring key populations affected by TB. Recommend considering other ways to account for key population needs, including support for data collection initiatives.

Malaria:

Submitted by CRSPC

Technical partners represented: WHO, US PMI, UNITAID, BMGF, ALMA, Malaria No More, RBM partnership, UCSF, UNF

Recommended disease burden indicator for the 2020-2022 allocation formula

Cases_2000-2004 * PAR_2017 / PAR_2000-2004

Deaths_2000-2004* PAR_2017 / PAR_2000-2004

0.05 * incidence rate_2000-2004

0.05 * mortality rate_2000-2004

Rationale for why this is the recommended burden indicator

Malaria partners recommend two adjustments to the malaria formula used in the previous round.

The first adjustment is to incorporate 2017 Population at Risk (PAR) data to account for country differences in population growth since 2000.

The second adjustment is to replace 2000 baseline burden estimates with the average burden estimates over the period 2000-2004 to better capture malaria transmission potential across countries in the absence of control interventions. This takes account of the fact that some countries experienced their peak burden in 2000, but other experienced their peak numbers later, up to 2004.

As a result of these two adjustments, the formula is refined to better capture (1) cross-country differences in population growth by applying the average 2000-2004 case incidence and mortality rates to the 2017 PAR, and (2) each country's relative transmission potential by using average burden estimates over the period 2000-2004.

Any other metrics considered, and why they were not chosen

1. We discussed using 2017 burden data but this had the impact of reducing significantly the resources to countries that have managed to reduce their malaria burden through vector control and prevention, but that still have ongoing malaria transmission. This would mean that these countries would be penalized and put them at significant risk of rebound. This metric option was rejected by all partners.
2. We considered the option of removing "0.05 * incidence rate_2000-2004" and "0.05*mortality rate_2000-2004" from the formula. However, this option penalized countries with relative small population size but high incidence and mortality rates. This metric option was rejected by all partners.
3. We suggested using country-specific highest burden estimate during the period 2000-2004. However, due to several limitations (e.g. high variability in peak year across countries, variability in peak year for morbidity and mortality burden metrics within a country; etc.), the implementation of the formula would be very complex. This metric option was therefore not explored further.

Potential limitations of recommended indicator and how these may be addressed elsewhere in the allocation methodology

The refined formula may decrease the amount of resources allocated to some high burden countries with lower increases in the population at risk. Post-formula qualitative adjustments will ensure that the required amount of resources is allocated to countries for "continuation of essential services." The qualitative adjustment phase will also consider a- case-by-case review of the potential impact that differences between country reported burden data and modelled estimates may have on the allocation when running the formula.

Annex 4 - Allocation Methodology in Tracked Changes

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.¹²
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, the Board may approve 15 percent will be used according to the following parameters:
 - a. ~~No more than USD 800 million will be used~~Amounts for catalytic investments, as described further in paragraph 6 below; and
 - b. ~~No more than USD 800 million will~~Amounts to be included as part of the available sources of funds for country allocations to ensure scale up, impact and paced reductions in funding as described in paragraph 4.c below; ~~and~~

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 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:

¹² Justifications for variations from the three-year standard will be provided to the Board as part of the Secretariat's grant approval requests.

- 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 allocations~~ from the previous allocation period.
- d. **Qualitative Factors:** The Secretariat ~~shall~~may 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:~~
 - e. ~~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.~~
 - iii. 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
 - iv. 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~~as unfunded quality demand, 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~~As described in paragraph 3.a. based on the recommendations of the Committee responsible for strategy matters, the Board ~~approves the use of up to USD 800 million~~may approve amounts to finance catalytic investments in priorities necessary to maximize impact and use of available funds, that are unable to be addressed 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 ~~alone yet critical to deliver~~ the Global Fund and partner disease strategies, as described in GF/B35/05 – Revision 1, ~~according to the following principles:~~

- ~~7. 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;~~
- ~~8. Whenever possible, the Secretariat shall recover funding for catalytic investments from the funding provided through relevant grant programs;~~
- ~~9. strategy. The Committee responsible for Strategy matters will:~~
- ~~10. Review 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 available amount of ~~such costs~~sources of funds for allocation, and present recommendations to the Board; ~~and~~~~
- ~~11.6. 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 oversightapproval.~~

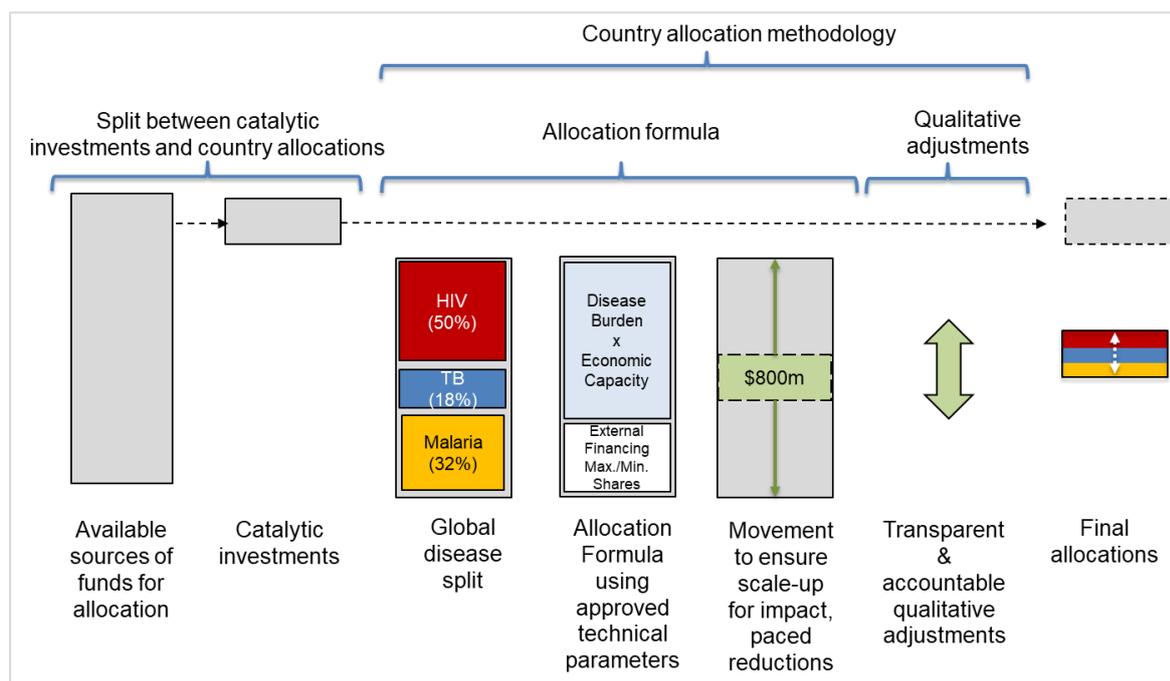
Annex 5 - Explanatory Note: Refinements to the Allocation Methodology

The table below describes the revisions that have been made to the previous allocation methodology (2017 - 2019). The majority of revisions are due to movement of issues described in the previous allocation methodology to separate Board and Strategy Committee decisions on catalytic investments and qualitative adjustments. These decisions were part of the 2017-2019 allocation methodology, but, due to changes to the timing of allocation decisions based upon lessons learned, have been appropriately moved to separate decision points. The remaining revisions are minor and are primarily aimed at refining the methodology to reflect an overall methodology that is not period specific and updating terms and policy language.

Area	Current reference	Revised reference	Comments/Rationale
Apportioning Available Resources	Paragraph 3	Paragraph 3	Removed the 15% cap for the use of available sources of funds for catalytic investments and to ensure scale-up, impact and paced reductions. The actual threshold amounts will be included in the relevant decision points that the Board approves for a specific allocation period, to render the methodology more general for continued use over time. Moreover, because of the expected sequencing of Board decisions on the allocation methodology and catalytic investments, the amount retained for catalytic investments is now linked to the sources of funds available for allocations, which means that the 15% cap is no longer relevant.
Apportioning Available Resources	Paragraphs 3a-b	Paragraphs 3a-b	Removed references to a maximum of USD 800 million funds to be used for catalytic investments and sources of funds for country allocations. The actual limit will be included in the relevant decision point that the Board approves for a specific allocation period.
Apportioning Available Resources	Paragraph 3b	Paragraph 3b	Added “as described in paragraph 4.c below” to refer to the relevant part of the allocation methodology.
Country Allocations	Paragraph 4c(iii)	Paragraph 4c(iii)	Changed previous funding level from “actual and forecasted use of funds” from the previous allocation period to “allocations from the previous allocation period.” For the 2017-2019 allocation methodology, previous funding levels were measured as three-year equivalent actual and forecasted disbursements from the 2014-2016 allocation period. This was because the 2014-2016 allocations covered a range of implementation periods as part of the transition from the rounds-based funding model. From 2017-2019 onwards, allocations are fully aligned to a three-year implementation period, therefore the measurement of “previous funding levels” is updated and simplified as “allocations from the previous allocation period”.
Country Allocations	Paragraph 4d	Paragraph 4d	“Shall” replaced with “may”, to reflect that not all Formula-Derived Amounts will be adjusted. Qualitative factors adjustments and the method by which they will be applied will be approved by the Strategy Committee as before.

Country Allocations	Paragraph 4(d)(i)	N/A	Removed list of illustrative factors for qualitative adjustments of formula-derived allocations, as qualitative factors will be approved by the Strategy Committee.
Reallocation of Sources of Funds	Paragraph 5a	Paragraph 5a	Replaced “at the time of initial submission and review of a funding request” with “as unfunded quality demand”. Prioritized above-allocation requests leading to registration of unfunded quality demand may be submitted at any point during a period.
Reallocation of Sources of Funds	Paragraph 5a	Paragraph 5a	Removed “that ensures priority based on the degree in which a country component’s formula-derived allocation is below its initial calculated amount”, as this principle is now embedded in the Strategy Committee-approved prioritization framework for portfolio optimization.
Catalytic Investments	Paragraph 6	Paragraph 6	<p>Revisions reflect that details for catalytic investments will be captured in other Board decisions. Minor adjustments clarify the authorities of the Strategy Committee, Audit and Finance Committee, and the Board to make further recommendations or decisions in this regard:</p> <p>The Strategy Committee reviews and makes recommendations to the Board on catalytic priorities and associated costs, as well as the total amount of sources of funds for allocations to be set aside for catalytic investments in a given allocation period.</p> <p>The Audit and Finance Committee reviews and makes a recommendation to the Board on the total amount of sources of funds for allocations for a given allocation period.</p> <p>The Board approves the total sources of funds for allocations, the total amount of such sources of funds for allocations to be set aside for catalytic investments, and the specific catalytic priorities and associated costs for a given allocation period.</p>

Annex 6 – 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 funding available for country allocations and catalytic investments as 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.

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 for selected countries to incentivize programming of country allocations towards key strategic priorities;
- **Multi-country:** investments to target a limited number of strategic multi-country priorities deemed critical to meet the aims of the Strategy and are best addressed through a multi-country approach; and
- **Strategic initiatives:** to provide limited funding for centrally managed approaches that cannot be adequately 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 and maintained throughout the allocation methodology.

Component: HIV, TB or malaria.

Technical parameters: the parameters of the allocation formula consisting of disease burden, country economic capacity, minimum and maximum shares, and external financing.

Disease burden share: a country's share of disease burden compared to the overall disease burden of all Global Fund eligible countries, based on the indicators in the allocation formula specified in the technical parameters.

Country economic capacity: a country's Gross National Income (GNI) per capita, used in the formula by weighting according to a smooth curve where the value decreases 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 adjustment 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 share: 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, country economic capacity, minimum shares, maximum shares and external financing. Does not include formulaic adjustments for paced reduction/scale-up components (see below), nor does it include qualitative adjustments.

Previous funding level: allocation amount in previous allocation period.

Scale-up components: components where previous funding level is *lower* than the allocation formula's Initial Calculated Amount. Scale-up components receive a Formula-Derived Amount that is *at minimum* the mid-point between their previous funding level and Initial Calculated Amount for the current allocation period.

Paced reduction components: components where previous funding level is *higher* than the allocation formula's Initial Calculated Amount. Paced reduction components receive up to 75% of their previous funding level.

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.

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 consisted 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 included 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 7 - Relevant Past Decisions

The following summary of past Board and Committee decision points is submitted to contextualize the decision point proposed in GF/B41/DP03:

Relevant past Decision Point	Summary and Impact
<p>GF/SC09/04: Allocation Methodology for the 2020-2022 Allocation Period (March 2019)</p>	<p>Based on its review and discussion of the Secretariat and technical partners' analysis and recommendations, the Strategy Committee (the "SC") (i) approved the updated technical parameters for the 2020 – 2022 allocation period, which replaced those used for the 2017 – 2019 allocation period, as previously approved under decision point GF/SIIC17/DP05; (ii) endorsed recommending the revised Allocation Methodology to the Board; and (iii) recommended to the Board that no more than USD 800 million of sources of funds available for country allocations be used to ensure scale-up, impact and paced reductions in funding.</p>
<p>GF/B36/DP06: Catalytic Investments for the 2017-2019 Allocation Period (November 2016)¹³</p>	<p>Based on the recommendation of 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>
<p>GF/B36/DP05: Sources and Uses of Funds for the 2017-2019 Allocation Period (November 2016)</p>	<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>
<p>GF/B35/DP10: Allocation Methodology 2017-2019 (April 2016)¹⁴</p>	<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>

¹³ <https://www.theglobalfund.org/board-decisions/b36-dp06/>

¹⁴ <https://www.theglobalfund.org/board-decisions/b35-dp10/>

Relevant past Decision Point	Summary and Impact
	<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>
<p>GF/SIIC17/DP05: Allocation Methodology 2017-2019 (March 2016)</p>	<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/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.</p>
<p>GF/B31/DP10: Composition of and Allocation to Country Bands (March 2014)¹⁵</p>	<p>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.</p>
<p>GF/B31/DP09: Transition from the Third to the Fourth Replenishment Period (March 2014)¹⁶</p>	<p>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.</p>
<p>GGF/B31/DP07: Regional Programs (March 2014)¹⁷</p>	<p>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.</p>
<p>GGF/B31/DP06: Special Initiatives (March 2014)¹⁸</p>	<p>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.</p>
<p>GGF/SIIC09/DP01: Indicators for the Allocation Formula and the Band 4 Methodology (October 2013)</p>	<p>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</p>

¹⁵ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP10/>

¹⁶ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP09/>

¹⁷ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP07/>

¹⁸ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B31/DP06/>

Relevant past Decision Point	Summary and Impact
	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/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.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013)¹⁹	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)²⁰	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. 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/DP04: Evolving the Funding Model (Part Two) (November 2012)²¹	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;

¹⁹ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP11/>

²⁰ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B29/EDP10/>

²¹ <http://www.theglobalfund.org/Knowledge/Decisions/GF/B28/DP04/>

Relevant past Decision Point	Summary and Impact
	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/DP07: Evolving the Funding Model (September 2012)²²	Based on the recommendation of the SIIC, the Board adopted principles for key elements of the allocation-based funding model, access to funding parameters for the allocation-based funding model, and requested the SIIC to work further towards evolving the funding model.

²² <http://www.theglobalfund.org/Knowledge/Decisions/GF/B27/DP07/>

Annex 8 – Summary of Strategy Committee Input

SC09 28-29 March Committee Input on Allocation Methodology

1. **Presentation, Strategic Overview:** The 2020-2022 allocation period represents the third period of the allocation model, which aligns financing with highest disease burden and lowest economic capacity, and to the needs of key and vulnerable populations – in order to maximize the impact of Global Fund resources. This period marks the second phase of the six-year Strategy that guides all investments in line with Strategic Objectives and KPI's. Joint reviews by the TERG, TRP and Secretariat found that the allocation methodology works well in delivering its objective of aligning funding to need, and refinements should be limited to areas with evidence. Catalytic investments should be increasingly prioritized, their operationalization improved and reviewed in complement with country allocations. The Global Fund has a range of process, control and incentive levers to maximize investments for impact within country allocations, with multiple platforms and tools for partner and civil society engagement. Based on these findings, the following minor refinements were proposed for the 2020-2022 allocation methodology. All other parameters are recommended to be maintained.
2. **Technical Parameters:** Malaria technical partners and the Secretariat recommended the continued use of historical data in order to capture the potential of malaria transmission across countries in the absence of control interventions. However, two adjustments to the malaria burden indicator are recommended to better account for country differences in population growth since the historical period of peak burden. The first adjustment incorporates latest population-at-risk data, which is expected to shift more funds to countries with higher than average population growth since peak burden period (between 2000 and 2004). The second adjustment is to use the average burden estimates over 2000-2004 instead of the year 2000 to account for countries that experienced peak burden during different periods within 2000-2004. Overall, the modelled effect of the revised malaria burden indicator indicates a minor shift of funding, with less than 2% of malaria funds moved across the portfolio.
3. **Scale-up and paced reductions:** The Secretariat recommended maintaining the parameters of this step in the formula to prioritize the level of increase for scale-up components, a limited adjustment for paced reduction components and an \$800 million limit on the aggregate movement of funds to balance scale-up and paced reductions. The update recommended is to simplify the measurement of previous funding levels to “allocations from the previous allocation period.”²³ Since the 2017-2019 allocation cycle is already aligned to a three-year implementation cycle, there is no further need to use actual and forecasted disbursements, and absorption considerations will be considered solely in the qualitative adjustments going forward, rather than also being accounted for in the allocation formula as in the 2017 – 2019 allocation period, to better reflect specific country contexts.
4. **Catalytic investments:** Catalytic investments have been moved to a separate decision point (GF/SC09/DPO4, as set forth in GF/SC09/05 – Revision 1) with scenarios of varying funding amounts linked to ranges of sources of funds. Therefore, there is no further need for referencing the 15% or fixed-amount ceilings on use of available sources of funds applicable to catalytic investments and scale-up, impact and paced reductions in the allocation methodology as was the case for the 2017 – 2019 allocation period.
5. **Qualitative adjustments:** *Qualitative adjustments* are planned for Strategy Committee approval in July 2019, after the 2020 – 2022 allocation methodology is approved by the Board so that the basis for adjustments is known. The aim is to refine the formula-derived allocations to adjust for specific epidemiological, programmatic and contextual considerations that cannot be accounted

²³ Post-program split allocations from the 2017-2019 allocation period as the basis for previous funding levels in the allocation formula.

for in the formula. The Secretariat noted the Strategy Committee's previous support for continuing a form of the HIV adjustment for key populations, which includes a measure of incidence, and presented a preview of potential factors to be considered including refined measurements of absorption, program performance, cost of essential programming, domestic financing commitments and health systems.

6. Strategy Committee discussion. Strategic Overview: The Chair noted that the recommendations were a result of an intensive nine-month process with expectations set by the committee in July and October 2018. The key lessons learned from 2017-2019 are the basis for minor refinements and for the earlier requested approval of catalytic investments. In responding to whether the ultimate objective of the allocation formula was to fully align to share of disease burden, the Secretariat clarified that while there is increased alignment to burden, the aim is not full alignment because of other important parameters like economic capacity and other external financing.
7. *Technical parameters:* The committee emphasized the importance of considering HIV incidence to account for prevention needs in the general population as well as key populations. Technical partners outlined the challenges with including HIV incidence in the allocation formula. These challenges include the uncertainty of population-at-risk size estimates, limited data availability and quality, and that incidence does not provide information related to ongoing treatment needs and the financial cost implications of treatment. For these reasons, partners recommended that incidence be accounted for in qualitative adjustments, which would make the impact on funding for specific contexts more transparent and flexible to adapt to different levels of data quality. There was strong Strategy Committee, partner and Secretariat support to continue and refine the key populations adjustment factor that was applied in Stage 1 of the 2017 – 2019 qualitative adjustment process, which included incidence. To address the evolution of HIV burden driven by trends in infection, the Strategy Committee requested partners and the Secretariat to review the possibility of using general incidence as a factor in qualitative adjustments. Given the insufficient quality of data, it recommended increased focus on improving data for both HIV and TB key populations.
8. The committee was supportive of the updated malaria burden indicator, but inquired if the change would impact continuity of services. Partners highlighted that modelling results have shown that the expected impact on malaria allocations is minor, and any significant changes could be addressed in qualitative adjustments with cost of essential programming.
9. *Scale-up and paced reductions:* The Strategy Committee sought clarifications on the proposed change to the measurement of previous funding levels and expected impact on the scale-up and paced reduction step. The Secretariat responded that matching funds and portfolio optimization are not recommended for inclusion in previous funding levels since the intention was that many of these were specifically awarded as one-off investments. However, qualitative adjustments would account for any specific cases where funds were used for essential coverage gaps that need to be continued. The Secretariat explained that the impact on allocations by this change in definition is expected to be minimal.
10. The Strategy Committee unanimously approved the decision point GF/SC09/DP02, which:
 - a. approved the technical parameters of the allocation methodology for the 2020-2022 allocation period (GF/SC09/04 - Annex 2); and
 - b. recommended the allocation methodology for the 2020-2022 allocation period to the Board (GF/SC09/04 - Annex 1).

Action points

- The Strategy Committee will:
 - recommend the allocation methodology for the 2020-2022 allocation period to the Board for approval in May 2019; and
 - be requested to review and approve qualitative adjustments in July 2019.

- The Secretariat will:
 - prepare a Questions & Answers document summarizing the rationale of the Strategy Committee's recommendation on the allocation methodology, and approval of the technical parameters with a particular focus on the three disease burden metrics, including clarification on the use of incidence for HIV in qualitative adjustments rather than the allocation formula;
 - discuss with technical partners how to further account for HIV incidence in the qualitative adjustments; and
 - consider and develop potential qualitative adjustments factors for Strategy Committee review and approval in July 2019.