aidspan

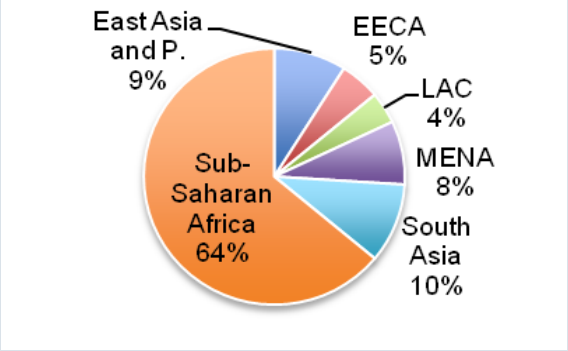
Independent observer of the Global Fund

The New Funding Model Allocations - An Aidspan Analysis

Report Overview

A central feature of the Global Fund's new funding model is the provision of lump-sum allocations to countries. The allocations replace the proposal-driven, first-come-first-served nature of the rounds-based system. This paper presents an analysis of the allocations for 2014-2017 and compares the allocations with the funding these countries received between 2010 and 2013. The data are presented across countries and regions, disease components, income levels, disease burdens and other variables.

Figure 1 *Geographical regional breakdown*



This report is written for a wide audience, including technical and non-technical readers who may be recipients or potential recipients of Global Fund grants; members of country coordinating mechanisms; other stakeholders at the country level; and persons operating at a more global or comparative (regional) level, such as Global Fund Board members, donors, technical partners and independent observers of the Fund.

The Global Fund provided countries with $14.67 billion in base allocations. The allocations included money to cover the existing grants pipeline as well as additional funding for new initiatives.

The 2014-2017 allocations

Our analysis found that 15 countries received over half of the total allocation of $14.67 billion. Nigeria topped the list; its allocation of $1.1 billion was 8% of the total. India was second with $850 million.

With respect to individual diseases, the components that received the largest allocations were:

- HIV: India ($560 million) and Nigeria ($477 million)
- TB: India ($233 million) and Pakistan ($175 million)
- Malaria: Nigeria ($500 million) and Democratic Republic of Congo ($419 million)

Among the Global Fund's geographic regions, not surprisingly, Sub-Saharan Africa had by far the largest share of the allocations (64%). No other region received more than 10%. See Figure 1.

Among the regions used by the Fund's Grant Management Division (GMD), High Impact Africa 2 received 23% of the allocations, and High Impact Africa 1 21%. See Figure 2.

Figure 2 *GMD regional breakdown*

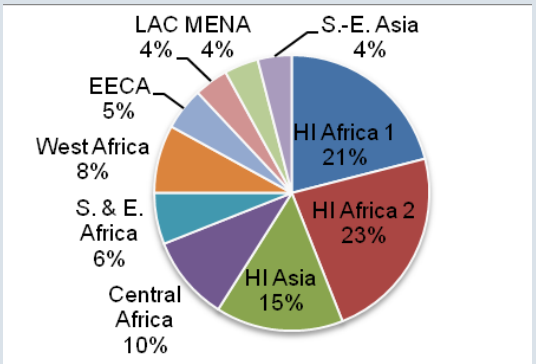


Table 1 *Five countries with the largest gains (allocations vs. disbursements) ($US)*

Rank	Country	Total allocation	Disbursed 2010-2013	Increase	
				Amount	%
1	Nigeria	1,137,414,849	564,427,510	**572,987,338**	101.5%
2	Malawi	574,342,956	309,540,728	**264,802,228**	85.5%
3	DRC	701,418,878	441,211,151	**260,207,728**	59.0%
4	Mozambique	450,276,363	191,145,824	**259,130,539**	135.6%
5	South Africa	464,819,551	253,019,432	**211,899,119**	83.7%

The breakdown by type of component was as follows: HIV 52%, malaria 29%, TB 17% and health systems strengthening (HSS) 2%.

Of the 302 components that received allocations, 44 received only enough money to cover existing grants. They received no additional funding for new initiatives. This is because (a) the amount of the existing grants pipeline for these components was equal to or exceeded the allocation that the components ought to have received based on the income/burden formula used in the allocations methodology; and (b) the Global Fund had pledged not to cut existing funding.

NFM allocations vs. recent funding

We compared the 2014-2107 allocations with disbursements for 2010-2013. The $14.67 billion in base allocations provided for components is $2.4 billion more than the $12.3 billion in disbursements these components received. Nigeria had by far the largest increase ($573 million). Table 1 contains information on the five countries with the largest gains.

Not surprisingly, most low-income (LI) countries experienced an increase in allocations compared to recent funding. However, some LI countries – as well as countries in other income categories – faced reductions because in recent years they received considerably more funding for some or all of their components than the income/burden formula said they should receive. This explains why two LI countries topped the list of biggest reductions in allocations compared to recent funding.

Ethiopia had a reduction of $226 million despite having a very large allocation ($591 million).

Rwanda's allocation was $132 million below disbursements. Table 2 contains information on the five countries with the largest reductions.

With respect to individual disease components, those with the largest increases were:

- HIV: Malawi ($245 million) and Nigeria ($185 million)
- TB: Nigeria ($88 million) and South Africa ($78 million)
- Malaria: Nigeria ($300 million) and DRC ($209 million)

Among the Global Fund geographic regions, Sub-Saharan Africa received the largest increase in allocations compared with recent funding: $2 billion. This is about 85% of the increase for all regions combined. In percentage, Sub-Saharan Africa's allocation was 28% higher than its recent funding. The Middle East and North Africa (MENA) region had a higher percentage gain (47%).

Among the regions used by the GMD, in dollar terms High Impact Africa 1 received $1 billion more in allocations compared with recent funding, about 44% of the increase for all regions combined.

Table 2 *Five countries with the largest reductions (allocations vs. disbursements) ($US)*

Rank	Country	Total allocation	Disbursed 2010-2013	Reduction	
				Amount	%
1	Ethiopia	591,183,361	816,946,240	**225,762,879**	27.6%
2	Rwanda	395,837,435	527,783,247	**131,945,812**	25.0%
3	Zambia	296,707,993	406,254,575	**109,546,582**	27.0%
4	Thailand	108,957,945	177,072,962	**68,115,017**	38.5%
5	Sudan	164,774,012	227,896,800	**63,122,788**	27.7%

In percentage terms, Western Africa had the largest increase (93%). Since there was more money available in allocations than had been disbursed during 2010-2013, not surprisingly all three diseases experienced an increase: TB +31%, malaria +26% and HIV +16%.

For the purposes of the NFM, countries were divided into four bands. Band 1 countries (lower income, high disease burden), received the largest increase in allocations compared to recent funding (25%). Band 3 countries (higher income, high disease burden) were next at 10%. Band 2 countries (lower income, low disease burden) and Band 4 countries (higher income, low disease burden) were essentially flat.

Looking through the lens of disease burden*, components whose burden was labelled as "Extreme" collectively experienced an increase of 52% compared to recent funding. Components with Severe disease burden were up by 29%. Components in the remaining categories experienced reductions.

In terms of income, LI and lower lower-middle-income (L-LMI) countries collectively experienced increases of between 22% and 23% compared to recent funding. Upper-middle-income (UMI) countries were up 12%, partially because some UMI countries had a very high disease burden, and partially because our analysis excluded disbursements to components that were not eligible to apply under the NFM. If these disbursements were factored in, UMI countries would have shown a reduction rather than an increase.

Over-allocated components

During the application of the methodology, many components were designated "over-allocated" (OA) or "significantly over-allocated" (SOA). These components ended up being allocated more than the income/burden formula called for because they had been receiving "more than their fair share" of funding in recent years, and the Fund did not want to impose sudden, drastic cuts. Overall, almost half of the components were OA or SOA; in the Eastern Europe and Central Asia region, it was two out of every three. Among the diseases, HIV was the most affected: OA and SOA components combined represented 46%-83% of all components, depending on the region.

These designations had various impacts on the allocations. Because OA and SOA components received more than what the income/burden formula called for, other components had their allocations reduced below the level generated by the formula. Under the NFM's allocation methodology, all adjustments to initial amounts generated by the formula had to net-out at zero. Components whose allocations were reduced are labelled "under-allocated." The Global Fund has not released any information on which components were under-allocated or by how much.

This situation was exacerbated by another factor: The allocations for OA and SOA components were based on their recent funding minus, wherever possible, 25%. But the Global Fund was able to reduce the OA and SOA allocations by at least 25% in only a third of the cases. In most of the other cases, the Fund was blocked by the fact that it had committed not to reduce existing funding.

Conclusion

Two aims of the NFM were to increase funding to components that had a high disease burden and to ensure that countries with the lowest ability to pay would also benefit. Several of our findings show that these two objectives were achieved:

- Countries in Band 1 experienced a much larger increase in allocations compared to recent funding than countries in the other three bands.
- Regarding income level, LI and L-LMI countries had the largest increases.
- With respect to disease burden, components with Extreme and Severe burdens experienced significant increases, while other components were down.

While, collectively, countries that had a very high disease burden and were also classified as lower income benefited the most from the allocations method used by the NFM, our findings suggest that many components with high disease burdens benefited *regardless* of their income level.

* We use the classification system developed by the Global Fund in conjunction with partner organisations, which contains five categories: Low, Moderate, High, Severe and Extreme. Definitions of the categories can be found in Annex 1 of the Aidspan Guide Understanding the New Funding Model.

For example, countries in Band 3 (higher income, higher burden) collectively received allocations that were 10% above their levels of recent funding.

In addition, our analysis showed that allocations to UMI countries were up compared to recent funding because they had high disease burdens. The increase for UMI countries was due entirely to one region, Sub-Saharan Africa. Of the 14 components in the UMI countries of Sub-Saharan Africa, seven had an Extreme disease burden, four Severe and three High.

There are limits inherent in comparing the NFM allocations with the pre-NFM disbursements. However, we believe that the comparison reveals interesting trends and shines a spotlight on some key policy decisions taken by the Global Fund, including the decision to include "minimum required level" in the adjustments (which resulted in a large proportion of components receiving more than the income/burden formula said they ought to receive); the decision to combine existing and additional funding in the allocations; and the decision to guarantee that no cuts would be made to existing funding. All three decisions had an impact on the allocations.

This report reveals gaps in the information that the Fund has published on how the allocations methodology was applied to arrive at allocations for individual components. The introduction of the NFM is a seminal event in the evolution of the Global Fund. The Fund is watching the implementation of the NFM very carefully and has already begun to document lessons learned. Observers of the Fund can play a role in providing independent analysis of the process. Such analysis would benefit the Fund. But the Fund will only achieve maximum benefit if it is more forthcoming in releasing information about how its allocations methodology was implemented.

This report includes 25 tables containing data on the Fund's 2014-2017 allocations, plus links to about twice that number of tables. The data, all of which are publicly available, have been assembled from various sources, and presented and framed in a way that we believe readers will find useful. Our goals are to inform and to spark discussion and debate. While we draw some conclusions from the data, we do not present opinions. Our paper is not a report card on NFM or even on the allocations methodology. A fuller evaluation will only be possible when the NFM is older and more information is available. We hope that this report will encourage other organisations to do more research on the allocations methodology and the NFM generally.

More information on the allocations is available in the tables included in the full report. The report provides links to additional tables that are housed on Aidspan's website.

The full report was published by Aidspan on 11 November 2014 and can be found at
www.aidspan.org/page/research

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