Independent observer of the Global Fund

The New Funding Model Allocation Methodology Explained

(Version 2)

Note: On 14 June 2013, Aidspan published an article in GFO entitled "The NFM Allocation Methodology Explained." It was based on information publicly available at that time. Since then, several more pieces of the puzzle have been filled in. This paper provides an updated explanation.

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Introduction

This paper describes the methodology used by the Global Fund to allocate resources to country bands and to the countries themselves under the new funding model. The description is based on information that the Global Fund has made public as of 11 November 2013. Some decisions which will affect the allocations methodology have yet to be made.

Aidspan has identified nine steps in the allocation methodology, as follows:

1. Determine resources available for allocation.
2. Determine the incentive funding proportion.
3. Apply the global disease split.
4. Determine resource levels (incentive and indicative) for Bands 1–4.
5. Assign countries to bands and determine band allocations.
6. Determine the amount of incentive funding for Bands 1–3.
7. Determine indicative funding ceilings for each country (Bands 1–3).
8. Communicate indicative funding amount to each country.
9. Determine actual disease split.

The steps are described below, They are followed by an explanation of how the Global Fund plans to manage incentive funding and unfunded quality demand. In Annex 1, graduated reductions are explained.

Aidspan wishes to thank staff at the Global Fund Secretariat for reviewing a draft of this paper.

Step 1: Determine resources available for allocation

At the beginning of the Global Fund's three-year allocation period, 2014–2016, the Fund will determine the total amount of resources available for the period based on the results of the Fourth Replenishment.

The amount available will be based on a forecast approved by the Finance and Operational Performance Committee (FOPC). The Board will set aside some money for special initiatives and regional proposals, as well as resources to ensure that the operating expenses of the Global Fund are covered. The FOPC will then determine the initial allocation available for the four country bands.

Step 2: Determine the incentive funding proportion

The incentive funding proportion determines how much money will be set aside for incentive funding. The proportion is based on the initial allocation. The percentages approved by the Board are as follows:

- If the initial allocation is $11 billion or less, the proportion will be 10%.
- If the initial allocation is over $11 billion and up to $13.5 billion, the proportion will be 15%.
- If the initial allocation is over $13.5 billion, the proportion will be 20%.

Step 3: Apply the global disease split

The global disease split will be applied to the initial allocation to produce three global envelopes, one per disease. The split has been determined by the Board. It is 50% HIV, 32% malaria and 18% TB. Thus, if the initial allocation were $14.5 billion, the disease envelopes would contain the following amounts: HIV $7.25 billion, malaria $4.64 billion and TB $2.61 billion.

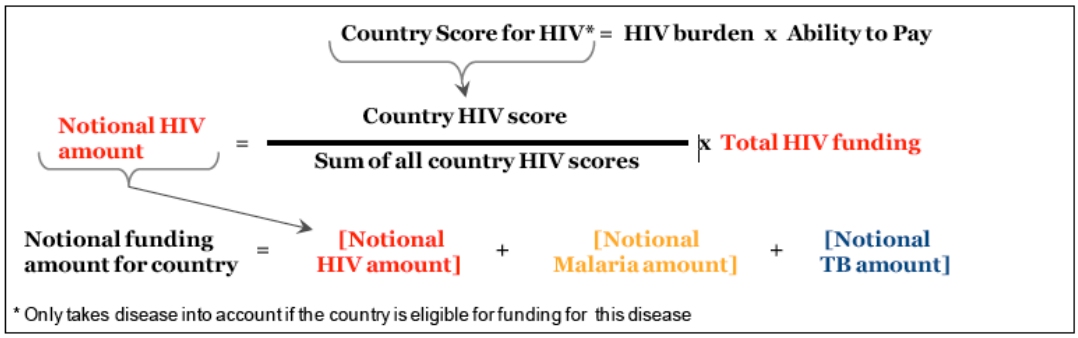
Step 4: Determine resource levels (incentive and indicative) for Bands 1–4

Bands 1-3

For Bands 1–3, this will involve running the country allocation formula, which is based on ability to pay and disease burden. "Ability to pay" refers to a country's income level, calculated as gross national income per capita. (In the balance of this paper, we refer to the country allocation formula as the "income/burden formula.")

The following diagram, taken from a paper prepared for the Strategy, Investment and Impact Committee (SIIC) in October 2012, provides an overview of the income/burden formula.

Figure 1: Income/burden formula for calculating notional country shares



The Global Fund has determined the indicators that will be used to calculate disease burden and ability to pay. The disease burden indicators are described in Table 1.

Table 1: Disease burden indicators

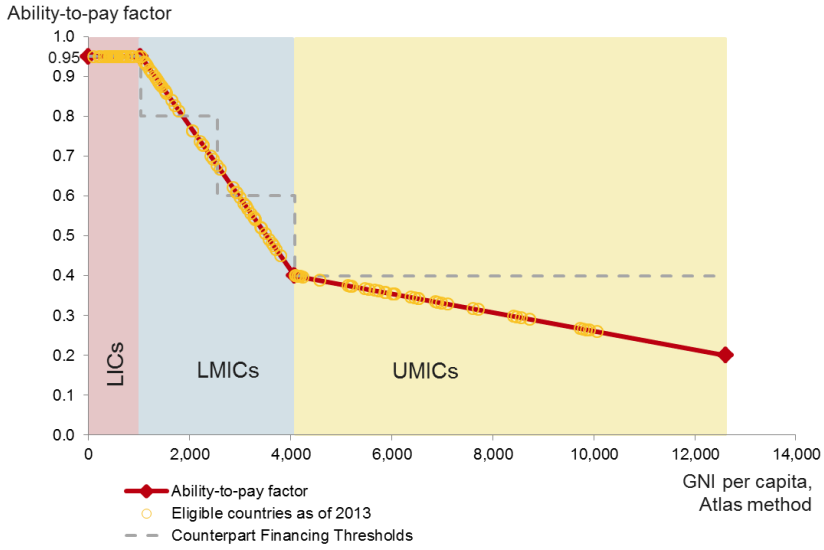
Disease	Indicators	Notes
HIV	No. of people living with HIV	Based on data from 2012 or most recent year.
TB	No. of HIV-negative incident cases + 1.2 * No. of HIV-positive TB incident cases + 8 * estimated MDR-TB incidence + 0.1 * 50% of estimated no. of people with known HIV-positive status	Based on data from 2012. Assumes that the entire budget for antiretrovirals for HIV-positive TB patients is included in the budget for HIV components.
Malaria	No. of cases + No. of deaths + 0.05 * incidence rate + 0.05 * mortality rate	Based on data from 2000, indicators normalised.

Applying the indicators in Table 1 will produce a disease burden score for each disease.

The ability to pay indicator is expressed as a factor by which the disease burden score is multiplied. This is illustrated in the Figure 2, taken from SIIC Document GF-SIIC09-08.

For all low-income countries, the factor by which the disease score is multiplied is 0.95. For lower-middle-income countries, the factor ranges between 0.95 and 0.4. It is a sliding scale; countries with the lowest income levels will be at the top end of the scale; countries with the highest income levels will be at the bottom end of the scale. For upper-middle-income countries, the factor ranges between 0.4 and 0.2; again, it is a sliding scale.

Figure 2: Ability to pay indicator



The following are the stages involved in applying the income/burden formula:

Stage 1. For each disease, a country score will be derived by multiplying a disease burden score by the ability to pay indicator.

Stage 2. For each disease, what the Global Fund refers to as the "notional" country share for the disease will be derived by dividing the country score by the total scores of all countries.

Stage 3. The "notional" funding amount for each disease for each country will be determined by multiplying the amount available for that disease by the notional country share for that disease.

("Notional" means "initial." The notional funding amount for each disease in each country is subject to some adjustments; see Stages 4 and 5 below. See also Step 7.)

Stage 4. The notional funding amount for each disease will then be adjusted up or down to reflect the amount of external donor financing available for that disease.

Stage 5. The notional funding amounts for each disease may then be further adjusted based on three factors: (a) minimum required levels; (b) maximum shares; and (c) minimum shares.

"Minimum required levels" is also known as the principle of graduated reductions. Under this principle, if the allocation for a specific disease as determined by the application of the income/burden formula is less than what the country has received lately, the country will receive an amount closer to what it has received lately; and the amount will be reduced

gradually in future allocation periods until it reaches the level set by the income/burden formula. Graduated reductions are further explained in Annex 1 to this paper.

"Maximum shares" refers to provisions to ensure that allocations to countries and components do not go above a specified ceiling. The maximum share that any one country can receive is 7.5% of the total allocated to countries. In addition, for a given disease, a country cannot receive more than 10% of the total allocated to all countries for that disease.

"Minimum" shares refers to provisions to ensure that allocations to countries do not go below a specified floor. The Global Fund has decided that the minimum share for countries in Bands 1–3 is the greater of (a) the minimum required level (see above) and (b) the amount the country would receive by applying the Band 4 methodology.

Stage 6. The notional amounts for each disease are added up to determine the total notional funding amount for the country. (Note that more adjustments will be made later; see Step 7 below.)

Band 4

For Band 4, the countries with lower disease burdens and higher income levels, a separate methodology has been developed so that these countries will not be disadvantaged as they might have been if their allocations were based on disease burden and income alone. Under the Band 4 methodology, indicative funding ceilings are based on population size. See Table 2 for details.

Table 2: Band 4 methodology

Population	Indicative funding ceiling per disease
Fewer than 500,000	No more than $X million
Between 500,000 and 1 million	No more than 2 * $X million
Between 1 million and 5 million	No more than 4 * $X million
Between 5 million and 10 million	No more than 8 * $X million
Over 10 million	No more than 10 * $X million

The amount represented by "X" in the table cannot be determined until the overall level of resources for the 2014–2016 allocation period is known, the composition of the bands is established and the proportion to be set aside for Band 4 is determined. (These decisions are expected to be taken in February 2014.) The proportion allocated to Band 4 was 7% in the transition phase. It may or may not be the same for 2014–2016. "X" will be set such that the total allocation for all countries in Band 4 does not exceed the amount of funding allocated to Band 4.

Step 5: Assign countries to bands and determine band allocations

Countries are assigned to one of four bands on the basis of ability to pay and disease burden. The bands are as follows:

Band 1 Lower income Higher burden	**Band 3** Higher income Higher burden
Band 2 Lower income Lower burden	**Band 4** Higher income Lower burden

The composition of the bands are expected to be announced by the Board in February 2014. Precisely what criteria will be used to determine the "boundaries" of each band is not yet known.

The allocations for each band will be determined by adding up the notional funding amounts of all countries within the Band. The allocations are expected to be announced by the Board in February 2014.

Step 6: Determine the amount of incentive funding for Bands 1–3

Using the proportion established in Step 2, the amount of incentive funding for each band will be calculated. Since Band 4 is not be eligible for incentive funding, only the allocations to Bands 1–3 will be divided between indicative and incentive funding. The Global Fund has determined some general parameters for how incentive funding will be managed (see below).

Step 7: Determine indicative funding ceilings for each country (Bands 1–3)

In Step 4, the notional funding amounts per disease per country were calculated. At that point, the amounts included both indicative and incentive funding. In the first stage of Step 7, the notional amounts from Step 3 will be reduced to account for the money set aside for incentive funding. For example, if the rate of incentive funding was 20%, and if the notional funding for malaria for Country X was $46 million, then the notional indicative funding for malaria for Country X will be $46 million * 80% = $36.8 million.

The second stage will involve adjusting the notional indicative amounts for each disease based on qualitative factors (such as absorptive capacity and past performance). These adjustments are based on general guidance, including standard adjustment ranges. The application of the factors allow for country-specific circumstances to be taken into account. Any upwards adjustments made have to be offset by other downwards adjustments in the same band. Put another way, the total adjustments within each Band have to net out at zero. The Grant Approvals Committee will make the final determination concerning all adjustments. The Global Fund Secretariat is currently working on the methodology for applying the qualitative factors. The factors are expected to be the same as those used in the transition period, but there will be some differences in how the factors are applied.

Once the adjustments are completed for each country, the indicative funding amounts for the three diseases will be added up to arrive at the total indicative funding amount for the country.

***Note**: It is not possible for anyone to calculate an individual country's theoretical share of the funding from the information in this paper even if one were to assume what the total allocation for the allocation period might be. For one thing, the amounts produced by the formulas for a given country will be adjusted to reflect qualitative factors, and precisely how these factors will be applied is not yet known. For another, the adjustments made as a result of the application of the qualitative factors in one country will affect the allocation for other countries because, as explained above, adjustments for qualitative factors must net out at zero for each band.*

Step 8: Communicate indicative funding amount to each country

The Secretariat will tell each country what its indicative funding amount is. It has not yet been decided whether each country will be provided with only a total allocation, or whether the country will also receive a breakdown by disease component. If the country is given this breakdown, it has not yet been decided whether this will be provided for informational purposes only or as guidance. The Secretariat is expected to make these decisions shortly.

Step 9: Determine actual disease split

It has not yet been decided whether and to what extent countries will have the flexibility to decide on the disease split for their indicative funding amount. This is related to the decisions required in Step 8.

Management of Incentive Funding

High-level decisions concerning the management of incentive funding are the responsibility of the Strategy, Investment and Impact Committee (SIIC). The SIIC has decided that components that are "over-allocated" by more than 50%, even after applying a graduated reduction, will not be eligible for incentive funding. "Over-allocated" refers to components that will receive more funding than what the income/burden formula provides.

The SIIC also decided that the amount of incentive funding available will be apportioned proportionately across each review window and, within each window, by country band according to the proportion of indicative funding for disease components eligible to receive incentive funding.

The SIIC also decided that if there is any unused incentive funding left over for a particular band after all awards have been made for that band in a given review window, then the leftover funds may be apportioned to the same band in a subsequent review window **and** added to the resources for financing unfunded quality demand (UQD) when the resources available for UQD are determined. [Emphasis added]

> ***Note**: The "and" that is bolded in the paragraph above is confusing. How can unused incentive funding be handled in two different ways? But that is how the SIIC decision is worded. Based on the contents of a paper prepared for the SIIC, Aidspan believes the intent is, where possible, to apportion leftover incentive funding to a subsequent review period in the same year; but to apportion any incentive funding left over at the end of the year to the UQD register. It is at the end of the year that the amount of resources for the UQD register is determined.*

Management of unfunded quality demand

In 2012, the Global Fund Board decided that funding requests which are above the amount that can be financed by indicative and incentive funding, and which the TRP recommends as technically sound and strategically focused, will be added to a register of unfunded quality demand (UQD).

The purpose of maintaining an unfunded quality demand register is to allow for some of the UQD to be funded if and as more resources became available.

The Global Fund Board has decided that all UQD funding requests will be prioritised. The Board also decided that additional resources that become available during the allocation period – including supplementary contributions from donors as well as accelerations in graduated reductions – will be used to fund the UQD; and that all bands will be eligible for funding from this register.

When funding requests are added to the register, they will remain in the register for up to three years. The funding requests in register may be financed by Global Fund resources or other sources.

The SIIC has decided that funding requests in the register for disease components that receive funding at levels below their notional shares under the income/burden formula will receive higher priority than funding requests for disease components that receive funding at levels above their notional shares. (This is a reference to over-allocated components; see Annex 1 for an explanation. Because some components will be over-allocated compared to what the income/burden formula says they should receive, other components will, by necessity, be under-allocated.)

Funding requests in the register will be prioritised based on recommendations from the Technical Review Panel (TRP) and confirmed by the Secretariat. It is not yet known what criteria the TRP will use to prioritise the funding requests.

The Secretariat will engage the TRP, as appropriate, to validate the continued technical soundness and strategic focus of funding requests in the register over the course of an allocation period.

The resources available to finance UQD will be determined by the Secretariat based on an annual financial assessment; the determination will be endorsed by the FOPC. The resources will be awarded across the entire grant portfolio based on the priority of funding requests in the register. This means that countries in all four bands are eligible for UQD resources and that there will be just one register of UQD (as opposed to a register for each band).

Annex 1 – Graduated reductions

The Global Fund Board has decided that a graduated reduction will be applied to the funding levels of disease components that have received funding in the previous three years at levels considerably above what the income/burden formula says they should receive. (The Global Fund refers to these disease components as being "over-allocated.")

This means that countries with over-allocated disease components won't be forced to live with the amounts generated by the income/burden formula. Instead, the level of funding for these components will be pegged initially at what the countries had received for the previous three years minus about 20%.

(A minimum 20% reduction is the target for all over-allocated disease components. Some may experience reductions of more than 20% following discussions with the Secretariat.)

The effects of this decision is illustrated in the following scenario:

- Country X's allocation for TB, for 2014–2016, according to the income/burden formula, would be $75 million.
- Over the past three years, Country X has received $125 million in disbursements for TB.
- Country X's allocation for TB for 2014–2016 is therefore set at $125 million minus a 20% reduction ($25 million), which equals $100 million.

The Board further decided that if any disease component is over-allocated by more than 50% even after the graduated reduction, the country will not be eligible for incentive funding for that component. The following scenario illustrates the effect of this decision:

- Country Y's allocation for TB, for 2014–2016, according to the income/burden formula would be $75 million.
- Over the past three years, Country Y has received $160 million for TB.
- Country Y's allocation for TB for 2014–2016 is therefore set at $160 million minus a 20% reduction ($32 million), which equals $128 million.
- Because $128 million is more than 50% higher than what the income/burden formula says the allocation should be, Country Y is not eligible for incentive funding for its TB component in 2014–2016. (Country Y may be eligible for incentive funding for other components.)

In future allocation periods, i.e. 2017–2019 and beyond, the allocations for the over-allocated components will continue to be gradually reduced until they reach the level determined by the application of the income/burden formula.