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Independent observer of the Global Fund

Board Decisions Made on Several Elements of the Allocation Methodology

Several pieces have been added to the jigsaw puzzle of the Global Fund's allocation methodology for the new funding model with the 3 October announcement of two Board decisions. These decisions covered the global disease split; TB-HIV collaboration; the split between indicative and incentive funding; graduated reductions for countries deemed to be over-allocated; and the disposition of additional resources that become available after the initial allocation is determined.

Disease split

The Board declared that prior to the allocation of resources to the country bands for 2014–2016, the Secretariat will divide up the resources among the three disease as follows: 50% for HIV, 32% for malaria and 18% for TB. This is known as the "global disease split."

The Board decision reiterated that despite the existence of the global disease split, applicants will still have flexibility in deciding how to allocate funding among the disease components. Countries will also be able to allocate funds to health systems strengthening components.

The agreed split is slightly different than the split used during the transition phase – 52% HIV, 32% malaria and 16% TB – which is also the Fund's historical disease split.

The Board was acting on recommendations from the Strategy, Investment and Impact Committee (SIIC). In its paper to the Board with its recommendations, the SIIC said the change in the HIV percentage from 52% to 50% was in no way intended to convey that adequate funding was being committed to HIV. The paper said the modest changes in the global disease split would not likely result in any more than minor

changes in allocations to countries, even among countries with uneven disease profiles.

The global disease split will be applied at the beginning of the allocations process to divide available resources into three global envelopes, one per disease. Initial amounts for each eligible disease component for each country are calculated within these envelopes. Some adjustments to the initial amounts will then be made as a result of the application of qualitative factors. The amounts for each disease component will be totalled to arrive at the allocation for the country. Eventually, after a certain proportion of available funding is reserved for the incentive stream (see below), countries will be provided with their indicative funding ceilings.

Note: 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 were to be given this breakdown, it has not yet been decided whether this information will be provided for informational purposes only or as guidance. The Secretariat told GFO that the precise way in which the Board-agreed principle of flexibility regarding the country-level disease split will be implemented will be determined in the coming weeks. Because all of this is still undecided, it is not known yet whether and to what extent each country will be required to explain the disease split it elects to go with.

TB-HIV collaboration

The Board noted that insufficient progress has been made in implementing a previous decision calling for more progress in establishing core TB-HIV collaborative services. The Board asked the Secretariat to ensure that integrated TB-HIV services are addressed at the concept note development stage in countries with high TB-HIV co-infection rates.

Indicative and incentive funding split

The Board decided that the countries in Band 4 – those with higher income and lower disease burden – will not be eligible for incentive funding because Band 4 will be subject to a separate allocation methodology.

The Board decided that a fixed proportion of the amount of resources approved by the Board for the initial allocation for all countries in Bands 1–3 will be reserved for incentive funding. For 2014–2016, the proportion will depend on how much money is available for the initial allocation, 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%.

Thus, for example, if the initial allocation were $12 billion, then 15% of the full $12 billion, or $1.8 billion, would be reserved for incentive funding.

Graduated reduction

The Board 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 allocation 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 allocation methodology. 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 allocation 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 allocation 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 allocation 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 allocation formula.

Disposition of additional resources

The Board decided that additional resources that become available during the allocation period – including supplementary contributions from donors as well as accelerations in the graduated reductions described above – will be used to fund the register of unfunded quality demand. All bands will be eligible for funding from this register. (See GFO article of 14 June on how the allocation methodology works, based on information available at that time.)

Finally, the Board decided that the two decisions announced on 3 October apply to the 2014–2016 allocation period, and that the decisions will be reviewed before the 2017–2019 allocation period.

The SIIC is expected to make decisions on certain other elements of the allocation methodology at its meeting in Geneva on 8–10 October. At the same meeting, the SIIC is expected to make recommendations to the Board on additional elements.

No specific date has been announced for the full roll-out of the NFM. However, the Secretariat informed GFO that the composition of the bands and the funding amounts for each band will be determined by the Global Fund Board in February 2014. This suggests that the full rollout will not start until some time after that date.

Some of the information for this article was taken from Board Decisions GF-B29-EDP10 and GF-B20-EDP11; and from GF-B29-ER06 and GF-B20-ER07, two papers prepared for the Board by the SIIC. These documents are not currently available on the Global Fund website. Additional information was provided by the Secretariat. The Board decision referred to in the section of the article on TB-HIV collaboration is GF-B18-DP12, available here; look under “18th Board Meeting.”

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