

Global Disease Split for the 2023-2025 Allocation Methodology

46th Board Meeting

GF/B46/04 Revision 1
8-10 November 2021, *Virtual*

Board Decision

Purpose of the paper: To provide options for the Board to decide on the global disease split for the 2023-2025 allocation methodology.

Decision

GF/B46/DP04: Global Disease Split for the 2023-2025 Allocation Methodology

Based on its review of the Secretariat's analysis and recommendations on the global disease split for the 2023-2025 allocation period, and the Strategy Committee's related deliberations, the Board:

1. Acknowledges that the total amount of funds available for country allocation (including approved sources of funds for country allocation and any additional funds approved as available for country allocation) will be decided by the Board in November 2022, based on the recommendation of the Audit and Finance Committee following announced replenishments results from the 7th Replenishment;
2. Approves that the apportionment of available country allocation funds across disease components ("Global Disease Split") for the 2023-2025 allocation period will be determined by the total amount of available funds for country allocation for the 2023-2025 allocation period approved by the Board;
3. Acknowledging the increased share of deaths from tuberculosis among the three diseases, approves the following Global Disease Split for the 2023-2025 allocation period, which increases funding for tuberculosis while preserving funding and potential for scale-up for HIV and malaria:
 - a. Any available funds for country allocation up to and including US\$ 12 billion will be apportioned as follows: 50% for HIV/AIDS, 18% for tuberculosis, and 32% for malaria; and
 - b. Any additional available funds for country allocation above US\$ 12 billion will be apportioned as follows:
 - i. 45% of such funds will be apportioned to HIV/AIDS;
 - ii. 25% of such funds will be apportioned to tuberculosis; and
 - iii. 30% of such funds will be apportioned to malaria.
4. Recognizing the need to further increase funding for tuberculosis and maximize the quality and impact of tuberculosis programs in line with the ambition of the Global Fund Strategy Narrative, requests the Secretariat, partners and committees, as relevant, to propose and implement specific options to address these needs, including:
 - a. Presenting to the Board, at its 47th meeting, a proposal to leverage catalytic investments for the 2023-2025 allocation period to mobilize additional resources to reduce deaths from tuberculosis;
 - b. Aggressively exploring, on an ongoing basis, evidence-based portfolio optimization and prioritization opportunities in order to more effectively address tuberculosis incidence and mortality in high burden countries;
 - c. Continuing to pursue and monitor domestic co-financing commitments required to increase overall financing for tuberculosis; and
 - d. Continuing to pursue innovative finance opportunities to increase funding to tuberculosis in high burden countries.

5. Requests the Global Fund's Independent Evaluation Function to commission, in consultation with the Strategy Committee, technical partners and Secretariat, an external evaluation of the Global Fund's approach to resource allocation to maximize impact, to inform evidence-based decision making on these issues ahead of the 8th replenishment, and to support more effective delivery of the Global Fund Strategy.

Budgetary implications (included in, or additional to, OPEX budget): None.

A summary of relevant past decisions providing context to the proposed Decision Point can be found in Annex 4.

Executive Summary

Context

The review of the Global Fund's Allocation Methodology is underway for the 2023-2025 allocation period. A key parameter in the methodology is the global disease split, which determines the overall distribution of resources across HIV, TB and malaria for the allocations communicated to countries.

Since the Global Fund launched its allocation model in 2013, the global disease split has remained fixed at 50% for HIV, 18% for TB and 32% for malaria. Nearly 10 years later, the context has changed. Relative disease burden has shifted with a rise in TB's share of deaths, domestic financing has increased, and more recently, progress against all three diseases has been dramatically reversed with the onset of the COVID-19 pandemic. In addition, after three cycles of allocation to provide countries with more predictable financing, the Global Fund has significant commitments to the programs it invests in and the lives these programs support.

Taking the opportunity of a new Strategy period about to begin, the Secretariat has conducted an in-depth review of the evidence and options – with guidance from the Strategy Committee and technical partners – to determine the most appropriate division of resources across HIV, TB and malaria in the allocation methodology. This paper provides an overview of options for the global disease split and the trade-offs involved.

Questions this paper addresses

- A. Does the latest evidence indicate that the global disease split should change?
- B. What are the parameters to define how much the global disease split could change?
- C. What are the options in changing the global disease split?
- D. What options has the Strategy Committee put forward to the Board for decision, and why?

Conclusions

- A. Considering TB's increased share in mortality, reliance on Global Fund financing, and resources diverted for COVID-19, the SC concluded there was a need for greater financing for TB and justification to consider a change in the global disease split to provide a TB share of allocations greater than 18%. However, it was recognized that all three diseases have significant resource needs, and all have essential life-saving interventions supported by the Global Fund.
- B. Noting that the global disease split decision will be made before the resource envelope for country allocations is known, and based on guidance from the Strategy Committee, the parameters that define how much the global disease split could change are: a) enabling more funding for TB, b) mitigating the effect on HIV/AIDS and malaria allocations, c) ensuring the ability to scale-up funding for countries with the highest burden across all three diseases, and d) protecting the allocations for low-income countries and for the most vulnerable populations.
- C. The following options were considered: 1) No change to the global disease split; 2) changing the global disease split based on the available funding for country allocations; and 3) changing the global disease split regardless of the amount of funding available. Various options were considered to change the global disease split based on the funding level. In terms of a change to

the global disease split regardless of available funding, the Secretariat and Strategy Committee considered the effects of 21% and 25% for TB with changes coming from HIV and malaria.

- D. The Strategy Committee did not reach consensus on a recommended global disease split for the 2020-2022 allocation cycle. To enable adequate time for Board constituency preparations, the Strategy Committee has put forward two options for the Board's consideration. Option 1 is to change the global disease split based on available funding according to the following approach: (1) apply the existing global disease split to the first US\$ 11 billion available for country allocations,¹ and (2) apply a new global disease split of 45% for HIV, 25% for TB and 30% for malaria to additional amounts of funding over US\$ 11 billion. Option 2 is to maintain the existing global disease split of 50% for HIV, 18% for TB and 32% for malaria. The Secretariat's recommendation is Option 1, as this will drive additional resources towards TB at certain funding levels while protecting HIV and malaria programs from large decreases compared with the 2020-2022 allocation period. Keeping the global disease split unchanged in any funding scenario would be a missed opportunity to respond to the increased need for investments in TB. The Strategy Committee did not recommend the option of changing the split regardless of available funding, or other suggested options, as these would undermine efforts against HIV and malaria and lower resources available to low-income countries in the event of less resources available.

Input Sought

The Board is requested to review the options presented by the Strategy Committee, to reach a decision on the global disease split for the 2023-2025 allocation methodology. Two options for decision points are set out in Annexes 1 and 2.

Input Received

This paper builds on the input received from the Strategy Committee discussions in July and October 2021, consultations with technical partners, as well as Committee statements and requests for additional analysis to inform the global disease split decision. Inputs from the Strategy Committee are summarized in detail in Annex 3: Summary of Previous Committee Input.

¹ As approved by the Board, and including any potential additional amounts approved by the Board for inclusion in determining country allocations. All references to available funding in this paper refer to the total available amount of funding for country allocations.

Report

What is the need or opportunity?

1. The global disease split is a parameter in the allocation methodology that determines the overall distribution of funding across HIV, TB and malaria for the allocations communicated to countries. Every three years, all parameters of the allocation methodology are reviewed, including the global disease split, in preparation for the next allocation period. While the global disease split is an important factor, it does not determine solely the final distribution of Global Fund resources across the three diseases because of other important levers that also play a role, including catalytic investments, program split flexibilities and portfolio optimization.
2. When the Global Fund established the allocation-based funding model for the 2014-2016 allocation period, the Board approved a global disease split of 50% for HIV, 18% for TB and 32% for malaria.² This split was based on the independent reviews of three expert institutions and approximately in line with the historical share of disbursements.³ Since then, the global disease split has remained unchanged in the allocation methodology. During the development of the 2020-2022 allocation methodology, the Strategy Committee (SC) requested an in-depth review of the global disease split for the following cycle, in line with the start of a new Strategy.
3. In July and October 2021, the SC reviewed the global disease split for the 2023-2025 allocation methodology, drawing on the analysis provided by the Secretariat and input from technical partners. Considering the evidence on disease burden, the financing landscape and other policy levers that affect how Global Fund resource are distributed across the three diseases, the SC requested in-depth analysis to inform a recommendation on the global disease split, including allocation scenarios of global disease split changes that increase the share of TB. Building on key inputs from the SC and technical partners, options for the global disease split are presented in this report, along with a consideration of the implications.
4. Although there was some convergence towards recommending the Secretariat-proposed option of changing the global disease split based on total funding available for country allocations, the SC did not reach an agreement. The SC concluded that TB needs should be urgently addressed, that HIV/AIDS and malaria programs and low-income countries should be protected, and that other policy levers could mobilize additional resources for TB with partner collaboration. The SC has provided to the Board options in Annexes 1 and 2, requesting the Board to decide between either the Secretariat's proposal or the proposal to maintain the current split. A detailed summary of the SC's deliberations is set out in Annex 3.

Does the latest evidence indicate that the global disease split should change?

5. The analysis presented to the SC in July and October provided context for all three diseases on the trends in disease burden, trends in the financing landscape, coverage gaps and funding needs to

² <https://www.theglobalfund.org/board-decisions/b29-edp11/>

³ GF/SIIC/08/09

achieve global plan targets, building on the methodology of two of the previous independent reviews that considered DALYs⁴ and global resource needs. The latest evidence shows that over the last decade, the share of TB burden has risen: for example, TB deaths as a proportion of total deaths from the three diseases increased from 45% in 2010 to 52% in 2019. While domestic financing has increased for all three diseases, the Global Fund remains the major international donor for TB and malaria programs. In low-income countries, programs for all three diseases rely heavily on Global Fund investments. Large coverage gaps persist in HIV, TB and malaria programs, and the impact of COVID-19 has reversed progress in all three diseases.⁵ As a result, the resources needed to achieve the Global Plan targets are significant for all three diseases.

6. After three cycles of allocation-based funding, the Global Fund has significant commitments to the programs it invests in. Further analysis on Global Fund investments by module shows that for all three diseases, funding is driven towards essential life-saving interventions for prevention, care and treatment. An examination of the movement of funds across the grant lifecycle shows that other policy levers, including program split flexibilities and grant-making, are used by countries to prioritize funding based on needs throughout the implementation period. Expenditure data from the 2017-2019 allocations indicate that absorption is high across all components and modules.
7. Considering evidence on TB such as the increased share of mortality, reliance on the Global Fund for international financing, and diversion of resources to fight COVID-19, the SC converged towards supporting an increase in the TB share of Global Fund resources, though there was no consensus position on the extent to which this would be achieved through the global disease split.

What are the parameters to define how much the disease split could change?

8. Recognizing that all three diseases have significant resource needs to achieve the global plan targets, some Strategy Committee members stated in July that the degree of change in the split, if any, should be moderate. In addition, the SC noted that changing the global disease split to a greater share for TB would drive more funding to middle-income countries where TB burden is concentrated, compared to no change in the split. As malaria is concentrated in lower income countries that rely heavily on Global Fund financing, many SC members noted that the shift of resources should not adversely affect countries with the least ability to finance their health needs.
9. Noting that the global disease split decision will be made before the resource envelope for country allocations is known, the parameters that define by how much the global disease split could change are: a) enabling more funding for TB; b) mitigating the effect on HIV and malaria allocations; c) ensuring the ability to scale-up funding for countries with the highest burden; and d) protecting the allocations for low-income countries and for the most vulnerable populations.

⁴ Disability-Adjusted Life Years.

⁵ *The Global Fund Results Report 2021*, https://www.theglobalfund.org/media/11304/corporate_2021resultsreport_report_en.pdf

What are the options in changing the global disease split?

10. The Secretariat and Strategy Committee considered the following options: 1) No change to the global disease split; 2) changing the global disease split based on available funding; and 3) changing the global disease split regardless of available funding. For each option, the effect on disease allocations was considered under various funding scenarios. To maintain the allocation principles of aligning funds to where there is high burden and low economic capacity, the effects on allocations by income group and region were also reviewed for each option.
11. *No change to the global disease split*: Keeping the global disease split unchanged would provide more predictability of financing for countries. However, it would be a missed opportunity to address critical program gaps in TB and to improve the alignment of funding to burden.
12. *Change the global disease split based on available funding*: There was support among SC members that setting the global disease split based on available funding would be the most appropriate way to balance increasing TB funding while protecting the gains for HIV and malaria programs as well as the allocations of low-income countries. Various options were considered to change the global disease split based on available funding for country allocations.
13. The option to apply a global disease split of 45% for HIV, 25% for TB and 30% for malaria to additional amounts of funding over US\$ 11 billion has been put forward to the Board for decision, which is recommended by the Secretariat. This proposal is described in the following section.
14. An alternative approach would be to change the global disease split at a discrete threshold of funding – whereby the current global disease split applies if funds available for country allocations are below the threshold, and the new global disease split applies if funds available for country allocations are above the threshold. However, in this approach, HIV/AIDS and malaria allocations would be greater at funding levels just below the threshold versus just above it. To avoid such a cliff-edge inconsistency, a discrete threshold option has not been put forward.
15. Other options were considered to change the global disease split based on available funding and provide a steeper increase for TB. One approach put forward by the Canada-Switzerland-Australia (CSA) constituency and discussed by the Strategy Committee was to 1) maintain the existing global disease split up to US\$ 11 billion, 2) apply a new global disease split of 48%-21%-31% at US\$ 14 billion and above, and 3) apply an intermediary split in between US\$ 11 and US\$ 14 billion – with a more than proportionate share of funds going to TB to reach 21% at US\$ 14 billion.⁶ Compared to the Secretariat-recommended option described in the following section, the CSA proposal would enable a more ambitious scale-up of funding for TB. However, the parameters outlined in the CSA proposal would provide less protection for HIV and malaria allocations and for low-income countries under similar levels of funding as in the 2020-2022 allocation period. In addition, the approach would introduce more complexity, requiring three disease splits, two funding thresholds and a more than proportionate amount going to TB between two funding thresholds. For these reasons, this option has not been put forward by the SC.⁷

⁶ In this scenario, an intermediary split of 41% for HIV, 32% for TB and 27% for malaria would be applied to amounts above US\$11 billion to reach 48%-21%-31% by US\$14 billion.

⁷ This proposal and scenario results are described in GF/SC17/11.

16. *Change the global disease split regardless of available funding:* Options were also considered to change the global disease split regardless of the amount of available funding. Specifically, the Strategy Committee and Secretariat considered the effects of 21% and 25% for TB with changes coming from HIV and malaria (see GF/SC/17/11 for the results of these scenarios). A more significant change in the split would drive more funding to TB. However, a significant change would also risk undermining efforts to fight HIV/AIDS and malaria. For example, under similar funding levels as in 2020-2022, a scenario of 25% to TB would provide almost no scale-up in HIV and malaria allocations for the top 15 burden countries overall while the rest of country allocations decrease significantly. At higher funding levels, scale-up in HIV/AIDS and malaria allocations would be limited for the highest burden countries if the split were to change significantly.
17. A moderate change in the global disease split – such as 21% to TB – proposed by WHO and supported by Stop TB Partnership - applied under any funding scenario would result in no scale-up of HIV/AIDS and malaria funding for the top 15 burden countries even at slightly lower funding levels, limiting the fight against these diseases. In a much lower funding scenario, at US\$ 10 billion for example, HIV/AIDS and malaria allocations would already experience significant reductions, putting at risk the Global Fund’s ability to continue to support essential programming for HIV/AIDS and malaria. This would be further exacerbated with a change in split as HIV/AIDS would see reductions of 14% among the 15 highest burden countries and 44% in the rest of the portfolio, while malaria allocations would see a 16% reduction across the 15 highest burden countries and a 37% decrease in the rest of the portfolio. For this reason, a change to the global disease split regardless of available funding has not been recommended by the SC to the Board.

What options are presented to the Board for decision, and why?

18. The SC agreed that TB needs should be urgently addressed, that HIV/AIDS and malaria programs and low-income countries should be protected, and that other policy levers could mobilize additional resources for TB with partner collaboration. However, the SC concluded that more time was needed to allow for constituency consultations and potential refinements to the options proposed. The SC recommended Decision Point GF/SC17/DP07, requesting the Board to consider two options: (1) the Secretariat’s proposal of a change in the global disease split based on total funding available for country allocations; and (2) maintaining the current split.

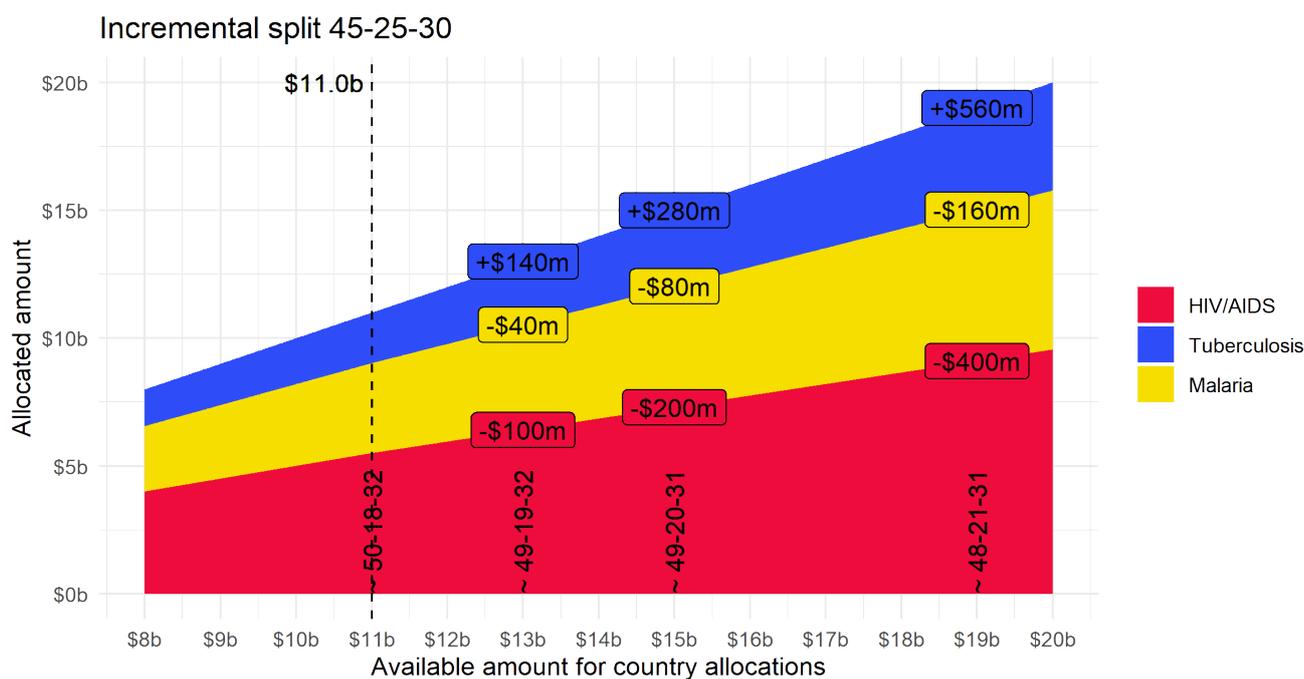
What is the Secretariat’s recommended option?

19. The Secretariat recommends Option 1. This option is to (1) apply the status quo global disease split to the first US\$ 11 billion available for country allocations, and (2) apply a new global disease split of 45% for HIV, 25% for TB and 30% for malaria to additional amounts of funding over US\$ 11 billion. This approach will drive a greater share of funding to TB while protecting the 2020-2022 investments made in HIV/AIDS and malaria under similar amounts of available funds for country allocations.
20. Given the progressive nature of this approach, the proposal is to apply the more significant share of 25% for TB to the additional amounts of funding, which would enable a steeper trajectory of increase for the share of TB at higher funding levels. To ensure equity and mitigate adverse impact

on the other diseases while enabling an increase in TB, the approach of adjusting HIV/AIDS to 45% and malaria to 30% is recommended over applying the reduction to one disease alone.

21. The US\$ 11 billion threshold for change was determined considering the effect at similar or higher funding levels. With no change in the global disease split, at US\$ 12 billion HIV and malaria allocations for the highest burden countries would see a 1% scale-up in funding overall. If the revised split were to apply to all funds above US\$ 11 billion, then with US\$ 12 billion available funding, HIV and malaria allocations would receive US\$ 50 million (0.8%) and US\$ 20 million (0.5%) less funding respectively than if the global disease split were to remain unchanged. Despite these decreases, the amounts would still ensure no reductions in HIV and malaria allocations for the highest burden countries overall, similar to if there were no change in the global disease split. At US\$ 12 billion available funding, TB would receive US\$ 70 million more funding (3%) than if the global disease split were to remain unchanged. In higher funding scenarios, the effect would be even greater. For example, at US\$ 14 billion available funding, TB would receive US\$ 210 million (8%) more than under the existing global disease split.
22. If the change were to be applied at a higher threshold (for example, US\$ 12 billion), then the increase would be more gradual for TB. If the change were to be applied at a lower threshold, for example, US\$ 10 billion, then with US\$ 12 billion available funding, HIV and malaria allocations would receive US\$ 100 million and US\$ 40 million less respectively than if the global disease split were to remain unchanged. The parameters have therefore been determined to strike an appropriate balance between scaling up the share of funding for TB and mitigating the negative impact on HIV and malaria allocations.

Figure 1: Secretariat-Recommended Option for the Global Disease Split



Labels show the difference in funding from 50-18-32 disease split at \$13b, \$15b, and \$19b

<u>Amount for country allocations</u>	<u>Recommended methodology for Global Disease Split</u>
Up to \$11 billion	Apply the 50%-18%-32% split
Above \$11 billion	Apply the 45%-25%-30% split to the additional amount of funding over \$11 billion

Why is this option recommended by the Secretariat?

23. A key issue is that the Board will approve the global disease split before the available amount for country allocations is known. If the funding envelope is lower than for the 2020-2022 allocations, a change in the global disease split in favor of TB would result in steeper reductions in financing for HIV/AIDS and/or malaria which could jeopardize the continuity of essential services.
24. Increasing the Global Fund’s share of resources to TB would help address significant gaps in TB treatment coverage, prevention and access to care, which have been exacerbated by the COVID-19 pandemic.
25. At the same time, it is critical to protect the gains made by HIV/AIDS and malaria programs, where needs remain significant. For all three diseases, the Global Fund supports essential life-saving interventions, moreover absorption rates are high across all components. Significant reductions in financing for any disease must therefore be avoided.

26. Given that TB burden is concentrated in middle-income countries, an increase in TB's share of funding would drive a greater proportion of funds to middle-income countries. Applying a progressive shift based on the overall funding level would help protect allocations for lower income countries.
27. Considering these implications, the Secretariat-recommended option would enable a moderate shift in the distribution of funds that would be impactful for TB without undermining HIV/AIDS and malaria programs. It also ensures that overall allocations for low-income countries would increase at similar or higher funding amounts. This option is designed to have a limited effect at funding amounts similar to 2020-2022, with a more impactful increase for TB at higher funding levels.
28. For example, in a funding scenario of US\$ 13 billion for country allocations, TB would receive nearly US\$ 200 million more than in the 2020-2022 allocation period, of which US\$ 140 million would be due to the change in the global disease split; HIV would receive US\$ 45 million more and malaria would receive US\$ 53 million more than in 2020-2022. In a funding scenario of US\$15 billion, all three diseases would have significant increases in funding due to the higher funding envelope; of the US\$ 692 million increase that TB would receive, nearly US\$ 300 million would be due to the change in the global disease split.
29. For low-income countries and for the sub-Saharan African region, overall allocations would still increase compared to 2020-2022 under the recommended option, though the increase would be slightly less than with no change in the global disease split. In a US\$ 13 billion scenario for example, Sub-Saharan Africa allocations would increase by US\$ 456 million from 2020-2022 allocations, which is US\$ 50 million less than if the current split was maintained. Low-income country allocations would increase by US\$ 152 million, which is US\$ 20 million less than with the status quo split. Annex 6 provides scenario results of this option compared to the option of maintaining the existing global disease split under various funding levels.

Other policy levers to drive more funding to TB

30. The global disease split is not the sole determinant of how Global Fund resources are distributed across HIV, TB and malaria. Beyond the global disease split, the Global Fund's funding model has other mechanisms that affect the total distribution of resources across the diseases. These include catalytic investments, country implementation of funds through program split flexibilities, additional financing throughout the grant lifecycle through portfolio optimization and C19RM.
31. Across the full spectrum of policy levers, other options must be explored to increase resources for TB. These include enhanced efforts across the Global Fund partnership to mobilize more resources for TB, including innovative financing transactions. Robust processes for program split flexibilities must be encouraged so that countries may adapt their allocations across the three diseases and RSSH according to their health needs. The catalytic investments provide an opportunity to drive more funding to TB in a targeted way to high TB burden countries, though the trade-offs are less funding for other priorities that will also be critical to advance the new Strategy. Future rounds of C19RM funding are also relevant, considering the strong linkages between COVID-19 and TB.
32. Such policy levers have demonstrated impact on funding. For example, program split flexibilities have shifted US\$ 456 million between disease and RSSH components based on country needs.

Catalytic investments in 2020-2022 have directed US\$ 890 million to important priorities, with 23% of funds dedicated to TB. Ultimately, the replenishment outcome will have the greatest impact on the amount of Global Fund resources for all three diseases. In addition to more resources, equally important are improvements in implementation to increase the impact of available investments.

What do we need to do next to progress?

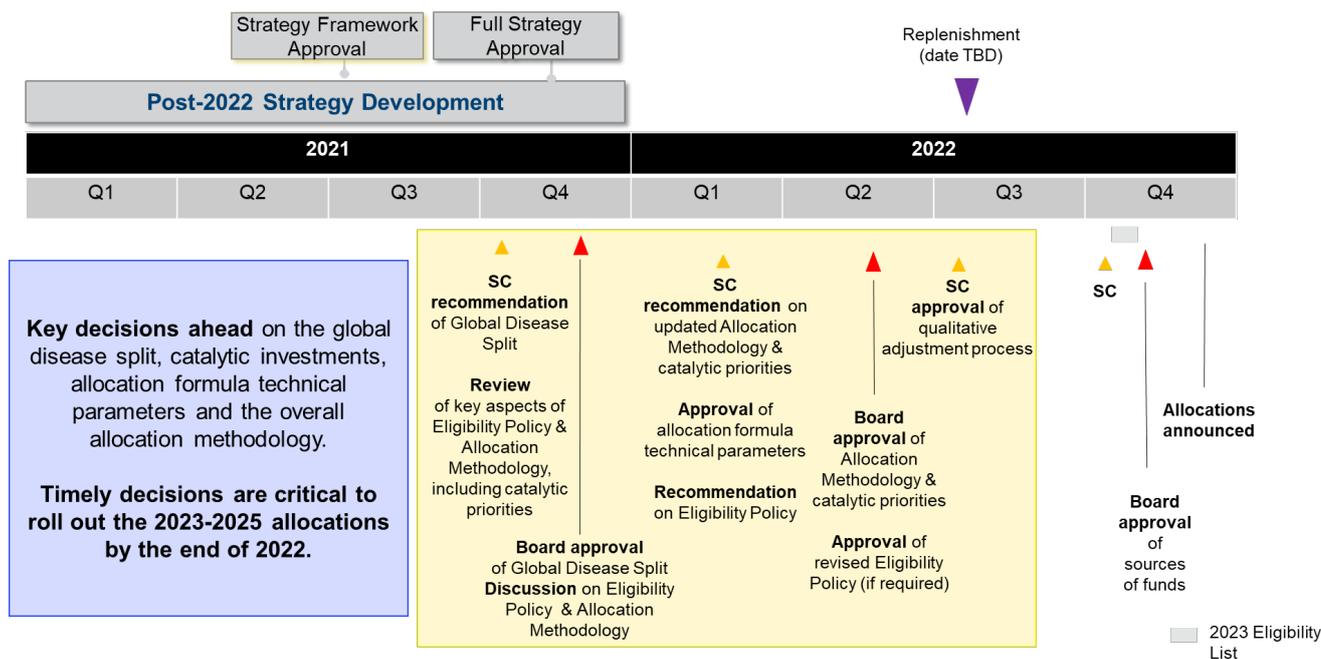
What is required to progress the proposal?

33. The Board is requested to decide between the options put forward by the SC for the global disease split in November 2021. The Board will approve the overall allocation methodology in May 2022. In November 2022, based on the 7th replenishment outcome the Board will approve the amount of funds available for country allocations. If Option 1 is chosen by the Board, this amount would determine the applicable global disease split for the 2023-2025 allocations. If Option 2 is chosen by the Board, the status quo disease split will apply regardless of available funding.

What would be the impact of delaying or rejecting the decision to progress?

34. Between now and May 2022, a series of key decisions are scheduled for the global disease split, catalytic investments, the technical parameters of the allocation formula and the overall allocation methodology (see chart below). Given the very tight timeline and sequencing of decisions on the 2023-2025 allocation methodology, a delay in the Board decision on the global disease split would have a knock-on effect, delaying preparations to inform subsequent decisions. The impact would be significant, as this would jeopardize the timely finalization and communication of the 2023-2025 allocations, scheduled for the end of 2022.

Figure 2: Timeline of Review of 2023-2025 Eligibility and Allocation Policies



Recommendation

The Strategy Committee did not reach consensus on a single option for the global disease split and therefore recommends to the Board to decide between the options presented in Annexes 1 and 2.

Annexes

The following items can be found in Annex:

- Annex 1: Option 1 for GF/B46/DP04: Revise the global disease split based on available funding
- Annex 2: Option 2 for GF/B46/DP04: Maintain the current global disease split
- Annex 3: Summary of previous Committee Input
- Annex 4: Relevant Past Board Decisions
- Annex 5: Links to Relevant Past Documents & Reference Materials
- Annex 6: Analysis of Global Disease Split Options

Annex 1 – Option 1 for GF/B46/DP04: Revise the global disease split based on available funding

Decision Point: GF/B46/DP04: Global Disease Split for the 2023-2025 Allocation Methodology

Based on its review of the Secretariat’s analysis and recommendations on the global disease split for the 2023-2025 allocation period, and the Strategy Committee’s related deliberations, the Board:

1. Acknowledges that the total amount of funds available for country allocation (including approved sources of funds for country allocation and any additional funds approved as available for country allocation) will be decided by the Board in November 2022, based on the recommendation of the Audit and Finance Committee following announced replenishments results from the 7th Replenishment;
2. Approves that the apportionment of available country allocation funds across disease components (“Global Disease Split”) for the 2023-2025 allocation period will be determined by the total amount of available funds for country allocation for the 2023-2025 allocation period approved by the Board;
3. Acknowledging the increased share of deaths from tuberculosis among the three diseases, approves the following Global Disease Split for the 2023-2025 allocation period, which increases funding for tuberculosis while preserving funding and potential for scale-up for HIV and malaria:
 - a. Any available funds for country allocation up to and including US\$ 11 billion will be apportioned as follows: 50% for HIV/AIDS, 18% for tuberculosis, and 32% for malaria; and
 - b. Any additional available funds for country allocation above US\$ 11 billion will be apportioned as follows:
 - i. 45% of such funds will be apportioned to HIV/AIDS;
 - ii. 25% of such funds will be apportioned to tuberculosis; and
 - iii. 30% of such funds will be apportioned to malaria.

4. Requests the Secretariat and relevant Board committees to continue to explore other options for mobilizing additional resources for tuberculosis and maximizing the impact of funds invested in tuberculosis programs.

Budgetary implications (included in, or additional to, OPEX budget): None.

Annex 2 – Option 2 for GF/B46/DP04: Maintain the current global disease split

Decision Point: GF/B46/DP04: Global Disease Split for the 2023-2025 Allocation Methodology

1. Based on its review of the Secretariat’s analysis and recommendations on the global disease split for the 2023-2025 allocation period, and the Strategy Committee’s related deliberations, the Board:
 - a. Agrees that while additional resources are urgently required to address the increased share of deaths from tuberculosis, changing the global disease split may jeopardize HIV and malaria programs as well as funding for the lowest income countries; and
 - b. Agrees that tools other than the global disease split would be more effective in increasing funding for tuberculosis.
2. Accordingly, the Board agrees to maintain the current global disease split for the 2023-2025 allocation period, such that any available funds for country allocation will be apportioned as follows: 50% for HIV/AIDS, 18% for tuberculosis, and 32% for malaria; and
3. The Board requests the Secretariat and relevant Board committees to continue to explore other options for mobilizing additional resources for tuberculosis and maximizing the impact of funds invested in tuberculosis programs.

Budgetary implications (included in, or additional to, OPEX budget): None.

Annex 3 – Summary of Committee Input

Extracts from the draft Chair’s Notes of the 17th Strategy Committee Meeting

Eligibility and Allocation, Part 1: Global Disease Split

Presentation

- The Secretariat presented additional analysis that the SC had requested in July and options for the global disease split. Based on the findings on burden, funding landscape, absorption, and the impact of COVID-19, the Secretariat showed that there was evidence supporting the directionality of an increase to the TB share. To determine the degree of change, options were evaluated based on how well each option meets the following criteria: (1) target a greater share of funding to TB that is impactful and aligns better with burden; (2) mitigate the impact on HIV/AIDS and malaria allocations; (3) ensure ability to scale-up in high-burden countries; and (4) protect allocations in low-income countries and for the most vulnerable populations.
- The Secretariat-recommended option would maintain the current split (HIV 50%, TB 18%, malaria 32%) for when the total funding available for country allocations is US\$ 11 billion or less. Starting at above US\$ 11 billion, the split of HIV 45%, TB 25% and malaria 30% would apply to additional amounts above US\$ 11 billion. This option provides a smooth progression to scale-up TB with greater increases at higher funding levels, and it avoids severely impacting HIV and malaria. The US\$ 11 billion threshold was recommended to ensure that there could still be a minimum of scale-up in high burden HIV and malaria countries at funding levels similar to 2020-2022.
- Other options were considered, such as changing the global disease split regardless of the funding envelope and ways to provide a steeper increase for TB. These options would provide less protection for HIV and malaria allocations and generate greater shifts away from low-income countries. The status quo option was not recommended by the Secretariat because it is a missed opportunity to better align funding to burden and provide a meaningful increase for TB allocations.
- The Secretariat noted that delays in reaching a decision on the disease split would have cascading effects leading to delays in rolling out country allocations and catalytic investments. The global disease split is one of many policy levers, but these are not mutually exclusive, and it is likely that many policy levers would need to be activated to address critical needs in TB.

SC Discussion

- The SC Chair acknowledged the complexity and challenges of this decision and indicated that most constituencies had converged on the directionality of change, but there were differing views on how to address TB needs. The SC agreed that more funding was needed for tuberculosis, given the evidence of TB’s increased share of mortality since the global disease split was determined. There was also consensus on the principles proposed by the Secretariat in assessing the degree of change, especially the need to protect allocations where there is the least ability to pay and where there is high burden and vulnerable populations. The SC noted the economic and health system

disruptions caused by the COVID-19 pandemic which have negatively impacted programs in all three diseases.

- Constituent views differed on how to balance between enacting a meaningful increase of funding for TB and protecting low-income countries and progress made in HIV/AIDS and malaria programs. Many constituents supported the Secretariat-proposed option as striking the right balance, while some expressed that the increase for TB was too marginal at similar levels of funding as the 2020-2022 allocation period. Alternative proposals were put forward to accelerate the pace of funding increase for TB, but these options were not advanced as these resulted in steeper decreases to low-income and high burden HIV and malaria countries.
- Some inquired about ways to offset decreases in low-income compared to status quo split through other parameters of the allocation methodology, specifically the Country Economic Capacity (CEC) curve and the weighting of disease burden metrics. Others considered the global disease split as too blunt of an instrument to address TB mortality and requested the Secretariat to provide options on the use of other policy levers, including catalytic investments, innovative finance and domestic resource mobilization. It was acknowledged that the global disease split is only one policy lever, and that the combined effect of all policies including partnerships, broader health system issues and how the funds are implemented at country level must be taken into account. Two constituencies expressed concerns on the regional outcomes of a change in disease split and sought clarification on whether the split would be reviewed in subsequent allocation periods.

Secretariat Response

- Addressing the concerns around low-income and regional outcomes, the Secretariat clarified that the allocation methodology would continue to prioritize allocations for high burden and low income countries. Therefore, even with a change in disease split as proposed by the Secretariat, allocations in low income countries and Sub-Saharan Africa would still increase significantly, at a more than proportionate rate than the overall funding envelope. In a US\$ 13 billion scenario for example, Sub-Saharan Africa allocations would increase by US\$ 456 million from 2020-2022 allocations, which is US\$50 million less than if the current split was maintained. Low-income country allocations would increase by US\$ 152 million, which is US\$ 20 million less than status quo split.
- The Secretariat did not recommend adjusting the CEC curve to compensate for reductions in low-income. Modelling the effects of changing the curve, the Secretariat found that there would be unintended consequences, particularly for HIV allocations where there is heavy reliance on Global Fund financing for key population programs. Upper middle income countries (UMIC's) would be doubly affected due to the reduction of HIV share and the reduction in the CEC factor.
- The Secretariat reviewed the effects on allocations by income if there was a change to the weighting of MDR-TB within the methodology's burden parameters, and if mortality instead of incidence was the primary burden metric. This initial analysis found that such changes would have very limited effect in overall allocations in low income countries. It was noted that burden indicators should reflect the epidemiological context and would continue to be reviewed in consultation with technical partners.
- Options for using other policy levers were presented per SC request, showing how co-financing, innovative finance, program split and other levers impact funding for disease programs. The

Secretariat noted that the replenishment will have the greatest impact on funds for all diseases, and in addition, domestic resources and other donors are critical actors in the push to increase TB funds. The Secretariat confirmed that the global disease split would be reviewed every three years as it is a part of the allocation methodology.

Action Points

- The SC concluded that TB needs should be urgently addressed, that HIV/AIDS and malaria programs and low-income countries should be protected, and that other policy levers could mobilize additional resources for TB with partner collaboration. Although there was some convergence towards recommending the Secretariat-proposed option, the SC did not reach an agreement. It concluded that more time was needed to allow for constituency consultations and potential refinements to the options proposed – enabling a Board decision building on SC conclusions to date.
- The SC recommended Decision Point GF/SC17/DP07, requesting the Board to consider two options: (1) the Secretariat’s proposal of a change in the global disease split depending on total funding available for country allocations; and (2) maintaining the current split.

Extract from the Report of the 16th Strategy Committee Meeting

Eligibility and Allocation

Secretariat presentation

20. The SC Vice Chair highlighted the overall timelines for the review of the Eligibility Policy and the 2023-2025 Allocation Methodology, reminding the Committee that that the decision on the global disease split will come earlier than in previous cycles in order to enable timely progress on other key decisions, including catalytic investments and the allocation formula. The SC will be requested to make a recommendation on the global disease split at its 17th Meeting (October 2021) to the Board (November 2021).

21. The Secretariat reiterated the purpose of the two policies – to determine which country components may be eligible for an allocation (Eligibility Policy) and to determine how much funding countries may receive, as well as how much funding is set aside for catalytic investments (Allocation Methodology). Decisions on how funding is operationalized at the country level is outside the scope of these two policies. It was also noted that while discussions around the Post2022 Strategy have not concluded, the guidance provided by the Board to date has suggested that RSSH investments be designed to deliver the Global Fund’s HIV, TB and Malaria goals and

that regarding Pandemic Preparedness and Response (PPR) the Global Fund should be more intentional in building PPR capabilities and aiming to strengthen the impact of HIV, TB and malaria programs and build system resilience and sustainability.

22. The Secretariat acknowledged that there have been requests from several constituencies for an independent review of the global disease split like the one conducted in 2013. It was clarified that the rationale for why the Secretariat does not recommend an independent review is that there is limited comparability across the diseases; the results of the analyses could be different based on the methodology and assumptions used; and the Global Fund is in a different place this time, with a need

to maintain essential lifesaving services that are currently funded. In addition, the Secretariat pointed out that the analysis provided to the SC built on the approaches of two of the three institutions from the 2013 review, namely a comparison of Disability-adjusted life years (DALYs) and consideration of the global funding needed for each disease.

23. The Secretariat noted that since the 15th SC meeting, the Secretariat has engaged with technical partners from HIV, TB, malaria and RSSH to put forward the evidence and considerations for the global disease split review. The Secretariat provided an overview of the analyses conducted on the global disease split which considered the latest evidence from the three diseases, the effect of changing the split on country allocations, and other policy levers that affect the overall distribution of funding. HIV, TB and Malaria partners made separate presentations on the available evidence supporting the need to invest in each of the three diseases and the potential losses due to not investing more.

24. The Secretariat emphasized that although the global disease split determines the overall split of resources across the components in the Allocation Methodology, it is just one of many mechanisms (e.g. country revisions to indicative allocations, catalytic investments etc.) that affect the final distribution of funds across the three diseases.

25. The Secretariat posed three questions and options for SC input: around the directionality of change in the overall share of funds (i.e. whether to increase in the share of Global Fund resources for TB), the degree of change to be considered in the global disease split, and the options – both within and beyond the global disease split – to increase investments for one component while ensuring impact of other programs.

SC Discussion

26. On the specific questions posed by the Secretariat, the SC provided the following feedback:

i. Directionality: Several SC members expressed an opinion that evidence supported an increase in the Global Fund's share of funding towards TB, however there was not a consensus position nor was there agreement on where the funds would come from. It was also noted that both HIV and malaria have significant gaps and needs.

ii. Degree: On the degree of change, some SC members noted that the degree of change to directing more resources, if any, to TB should be limited, with the caveat that the shift of resources should not affect those countries with the least ability to pay or impact populations most vulnerable to HIV and malaria.

iii. Options: There were divergent views among SC members with respect to the change in the global disease split and/or use of other policy levers. Some members expressed concerns with the impact of a shift of resources from HIV or/and malaria to TB, while others expressed concerns with the potential impacts of not allocating more resources to TB. Some SC members requested further evidence and analyses to inform their position on the different options, but the specific evidence needed remained an issue for follow-on input and discussions.

27. Some SC members deferred their constituency positions on the three questions to a later date.

28. A number of issues were raised on the implementation of funds, including for human rights, gender, health systems strengthening, community systems and PPR. Additional discussion at a future SC session was requested to understand how the operationalization of the next cycle of grants will reflect the Post-2022 Strategy.

29. In response to requests to present further detailed evidence and analyses on global disease split at the next session, some SC members noted that further clarity should be provided to the Secretariat on the specific data and analyses being sought.

30. Regarding RSSH, a number of SC members noted the importance of ensuring that in the next cycle these investments are increased. Some SC members noted the connection between the amount of funds allocated and quality of the implementation of RSSH and CSS interventions and highlighted recent TERG and TRP reviews on the issue. However, there was not agreement with respect to a separate RSSH allocation and the Board's strategic views on a primary focus on HTM were noted.

Secretariat Response

31. The Secretariat thanked the SC members for their input and noted that further analyses will be brought to the next SC Meeting with the aim of enabling the SC to provide a recommendation to the Board on the global disease split. Specifically, the Secretariat will prepare more scenarios on limited changes to the global disease split providing an increased share of funding for TB, while limiting decreases for HIV and malaria. The analysis will include the effect on the allocations of countries with the lowest ability to pay.

32. Regarding a separate RSSH allocation, the Secretariat reiterated that as the Board's strategic guidance on a primary focus on HTM was clear, a separate RSSH allocation is not recommended as part of the global disease split. There is however a need to increase the quality of RSSH investments at country-level. The Secretariat noted that given the importance of country context for RSSH investments, an RSSH allocation cannot be determined upfront in meaningful way that acknowledges the different contexts in which the Global Fund operates. The Secretariat also noted that any funding for a separate RSSH allocation would come from HIV, TB and Malaria and that there are other areas such as funding request modalities, guidance and technical partner support that are more appropriate to ensuring increased impact and investment in this area.

33. On the separate discussion regarding policy levers for implementation and operationalization guidance, the Secretariat will discuss with SC Leadership to find suitable time to address these issues, either at the 17th or 18th SC Meeting.

Action Point

- The SC members were requested following the meeting to provide in writing any specific asks for additional data and analyses they would like the Secretariat to prepare for the 17th SC Meeting in order to inform the recommendation on the global disease split.

Annex 4 – Relevant Past Board Decisions

Past Board Decisions can be found on the online Board Decisions Database found here:

<https://www.theglobalfund.org/en/board/decisions/>

Relevant past Decision Point	Summary and Impact
GF/B41/DP02: Allocation Methodology for the 2020-2022 Allocation Period (May 2019) ⁸	Based on the recommendation of the Strategy Committee, the Board approved an updated allocation methodology for the 2020-2022 allocation period. The global disease split remained unchanged from the 2017-2019 allocation period.
GF/B35/DP10: Allocation Methodology 2017-2019 (April 2016) ⁹	Based on the recommendation of the Strategy Committee, the Board approved an allocation methodology for the 2017-2019 allocation period. The global disease split remained unchanged from the 2014-2016 allocation period.
GF/B29/EDP11: Revising the distribution of funding by disease in the new funding model allocation methodology (October 2013) ¹⁰	The Board approved an initial apportionment of available resources across the three diseases as follows: 50% HIV/AIDS, 18% tuberculosis, and 32% malaria.

⁸ https://www.theglobalfund.org/media/8536/bm41_02-allocation-methodology_report_en.pdf

⁹ <https://www.theglobalfund.org/board-decisions/b35-dp10/>

¹⁰ <https://www.theglobalfund.org/board-decisions/b29-edp11/>

Annex 5 – Relevant Past Documents & Reference Materials

- https://tgf.sharepoint.com/sites/ESOBAA1/GFBC/StrategyCommitteeSC/SC%20Meetings/16th%20SC%20Meeting%205-6%20July%202021/Meeting%20documents/GF_SC16_11_SC%20Report.pdf
- https://tgf.sharepoint.com/sites/ESOBAA1/GFBC/StrategyCommitteeSC/SC%20Meetings/16th%20SC%20Meeting%205-6%20July%202021/Meeting%20documents/SC_16_03%20Eligibility%20and%20Allocation%20Review.pdf
- https://www.theglobalfund.org/media/8536/bm41_02-allocation-methodology_report_en.pdf
- <https://www.theglobalfund.org/board-decisions/b35-dp10/>
- <https://www.theglobalfund.org/board-decisions/b29-edp11/>

Annex 6 – Analysis of Options for the Global Disease Split

Figure 3: Change in funding by disease from 2020-2022 allocation cycle at different funding amounts in the status quo and Secretariat-recommended options

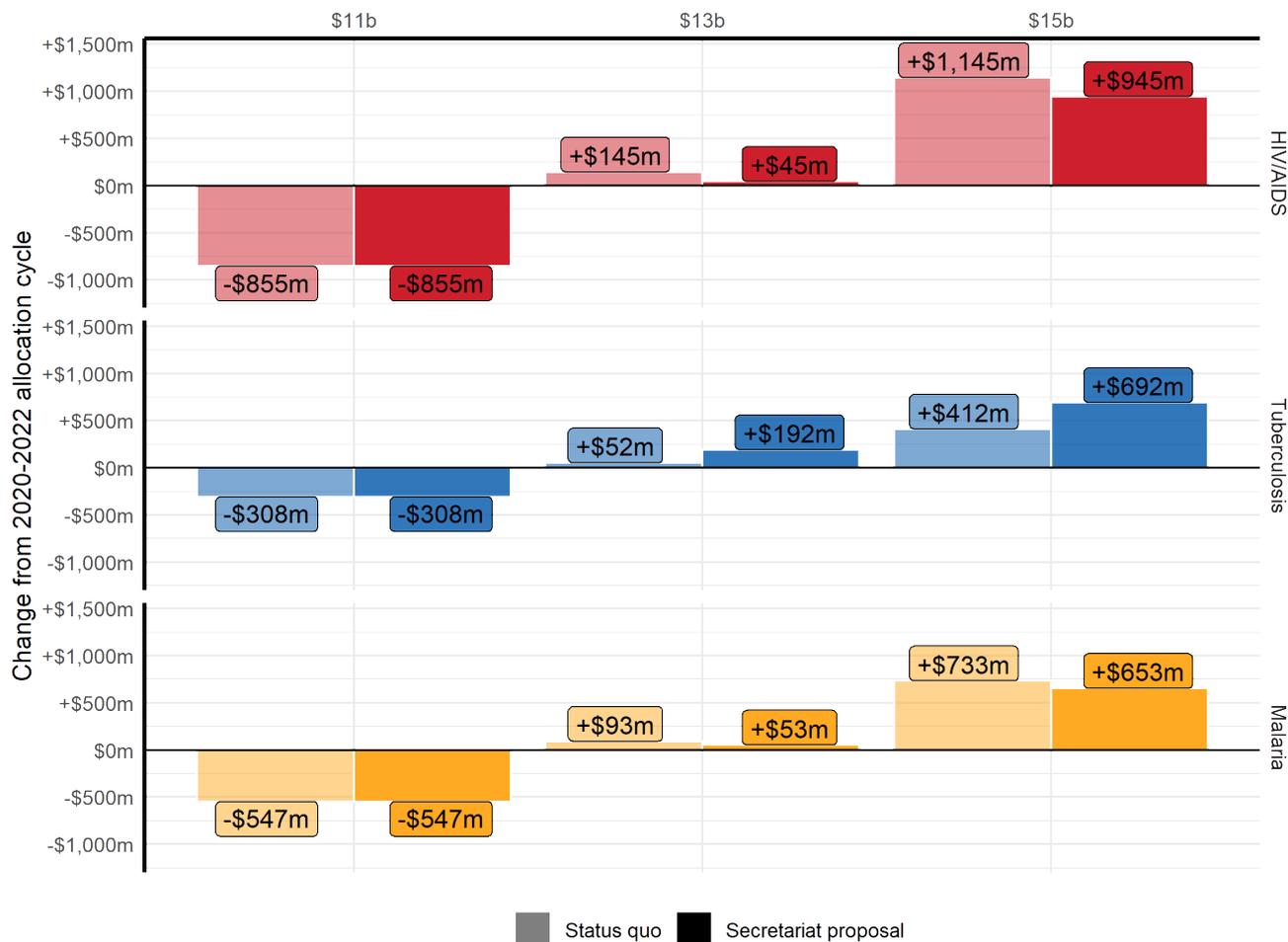


Figure 4: Allocations by income group under different funding amounts in the status quo and Secretariat-recommended options

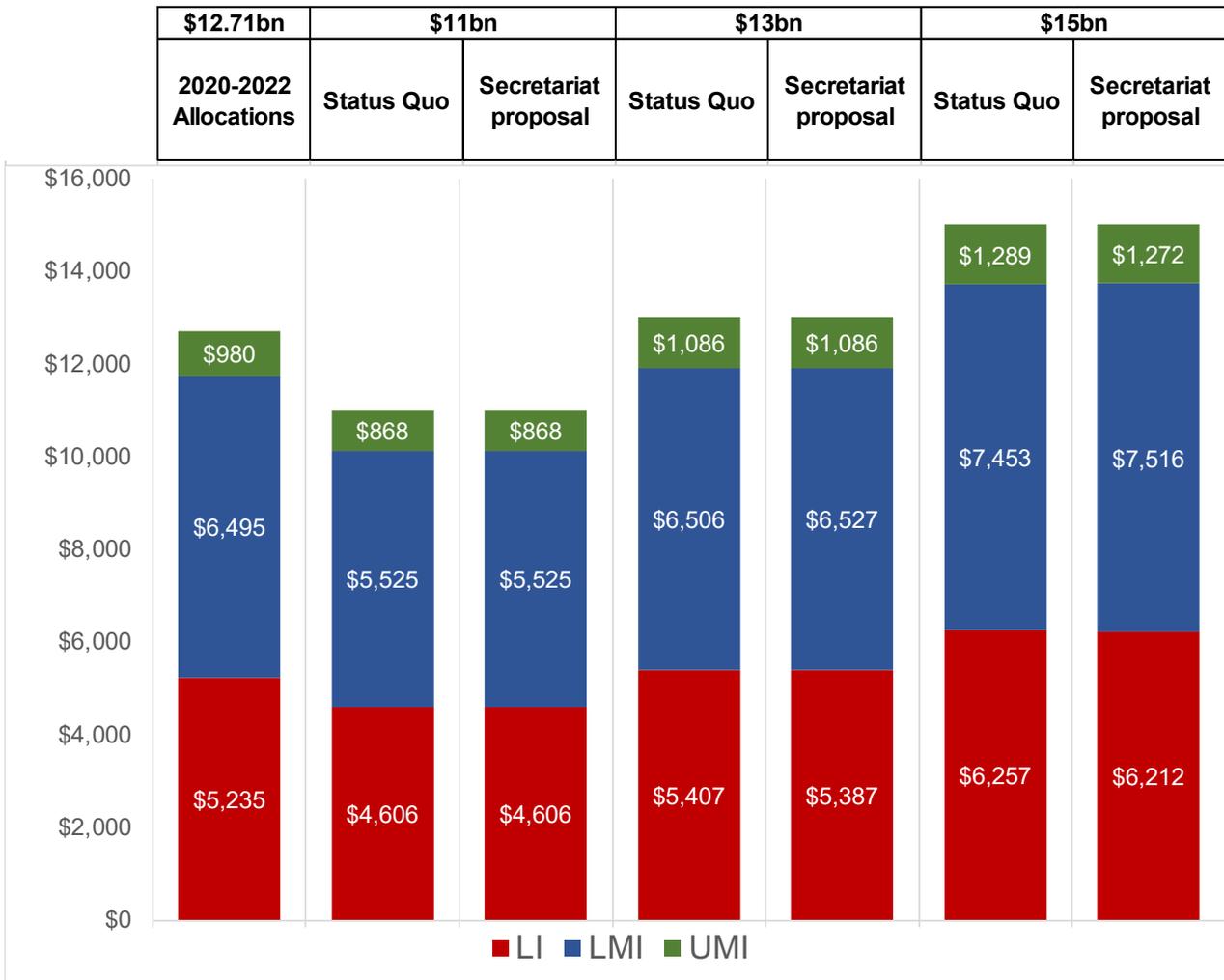
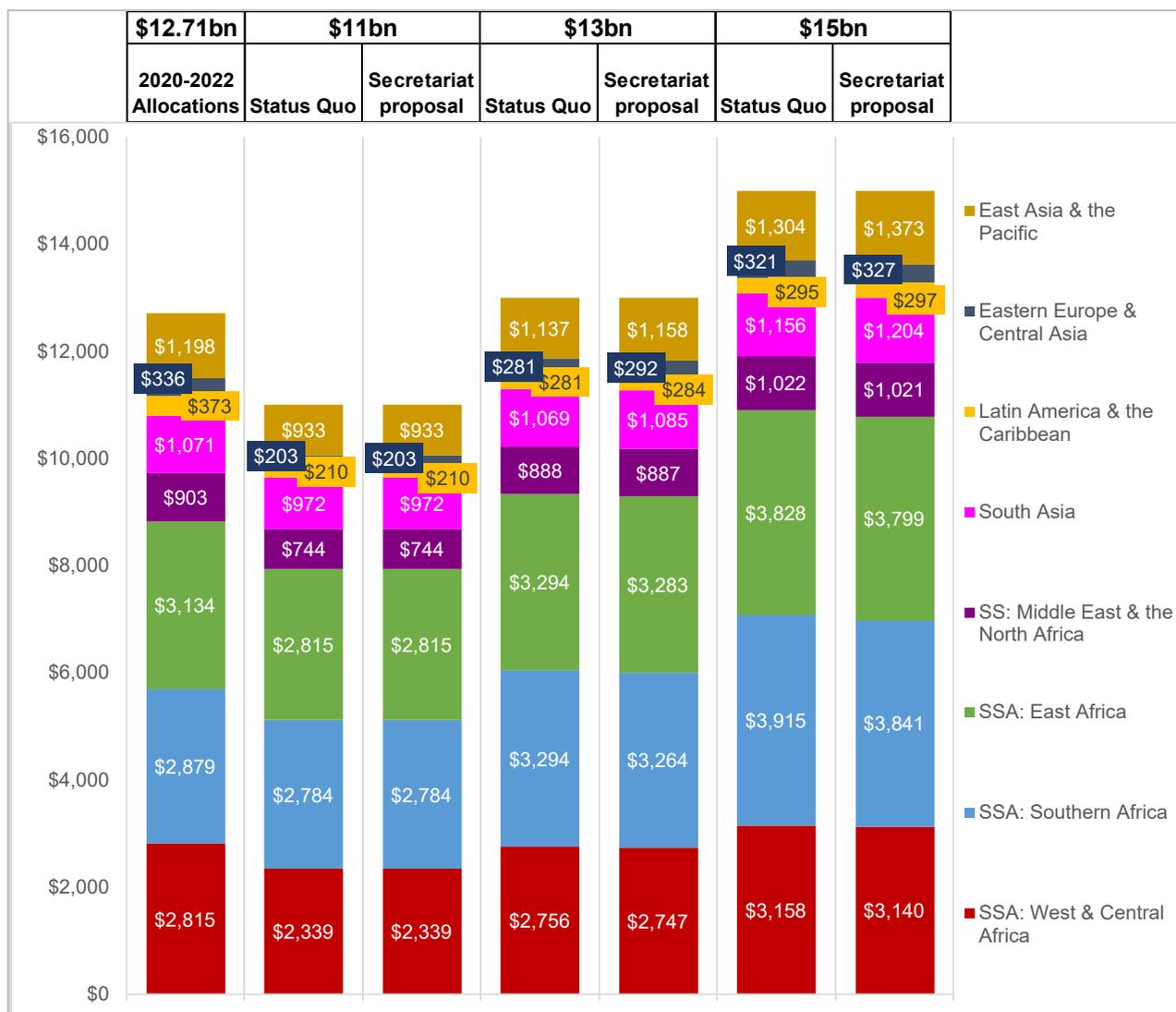


Figure 5: Allocations by region under different funding amounts in the status quo and Secretariat-recommended options



Note: The scenario results presented in this Annex show formula-derived amounts, based on latest input data and formula parameters for the 2020-2022 allocation period. They do not account for qualitative adjustments. The scenario results are therefore subject to change.