Description of the Grant Cycle 8 Allocation Methodology

(covering the 2026-2028 allocation period)

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The allocation methodology[1] consists of two parts: country allocations and catalytic investments. Country allocations are the Global Fund's main source of funding to drive impact. For Grant Cycle 8 (GC8), the Global Fund Board approved a total of US$10.783 billion for country allocations. Catalytic investments aim to complement country allocations by driving focus to priority areas that are underinvested or cannot be achieved through country allocations alone. The Board approved US$ 260 million for catalytic investments for GC8.[2]

Country Allocations

The Global Fund's Eligibility Policy identifies countries that may receive an allocation for each disease. Eligibility to receive a Global Fund allocation does not guarantee an allocation.[3] Allocations are determined through the allocation methodology, which is approved by the Board.

[1] https://www.theglobalfund.org/kb/board-decisions/b52/b52-dp05/
[2] https://www.theglobalfund.org/kb/board-decisions/b54/b54-dp03/. Excludes private sector contributions. Further information on catalytic investments for GC8 can be found on the Sources of Funding page: https://resources.theglobalfund.org/en/grant-life-cycle/sources
[3] For example, in accordance with the Board-approved allocation methodology, the Global Fund may decide not to provide an allocation to a country component where there is no existing grant(s), where there has never been a Global Fund grant, or where a country component has successfully transitioned and/or where commitments have been made to ensure domestic financing of the program. In all cases, individual country context will be considered as part of allocation decisions.

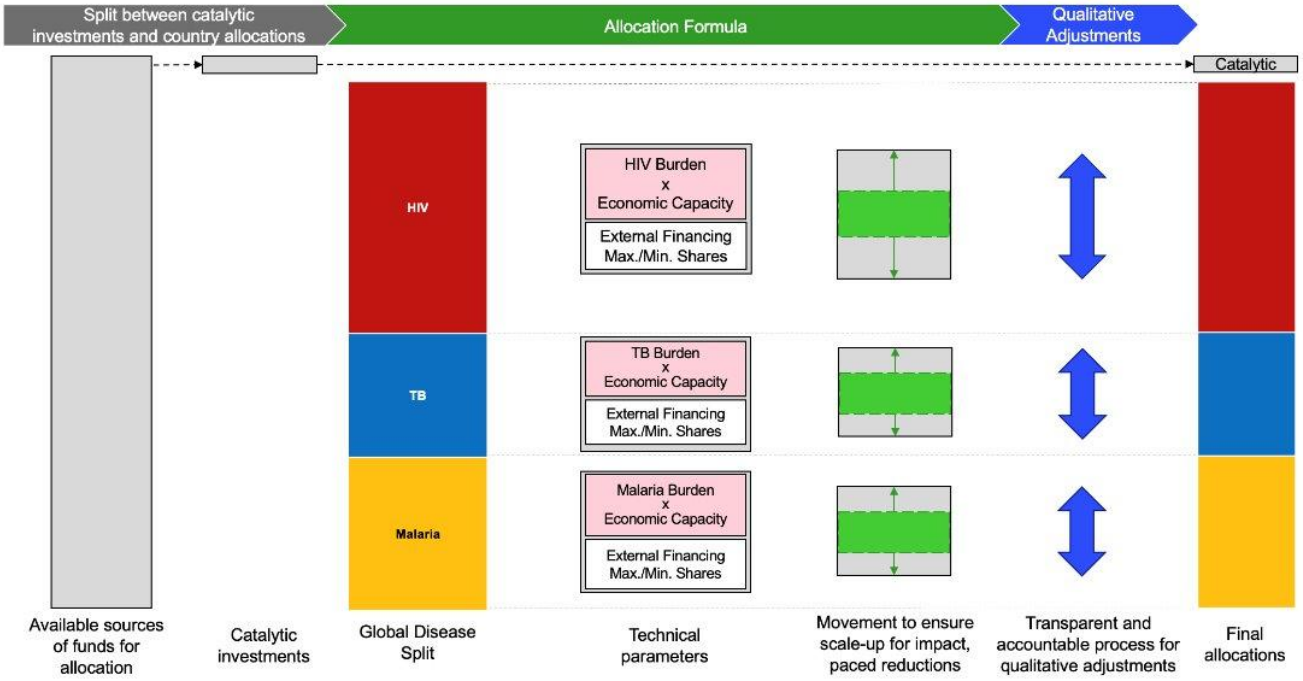

Figure 1: Overview of the GC8 Allocation Methodology

Allocation Formula

Global disease split

To produce country allocations, the allocation formula first divides the total funds available for country allocation by the Board-approved global disease split which is as follows:

i. Amounts up to and including US$12 billion:
   a. HIV/AIDS: 49.6%;
   b. Tuberculosis: 18.6%;
   c. Malaria: 31.8%.

ii. Amounts above US$12 billion and up to including US$17 billion will be apportioned according to a linear extrapolation between the split detailed under (i) above and the split detailed under (iii) below.

iii. Amounts above US$17 billion:
   a. HIV/AIDS: 40%;
   b. Tuberculosis: 25%;
   c. Malaria: 35%.

The global disease split determines the total amount of funding available per disease for the allocation formula.

Technical Parameters

After the funds are divided based on the global disease split, disease specific technical parameters are applied within each disease envelope. This step distributes funding to each country primarily in line with its disease burden as a share of the total disease burden of all Global Fund eligible countries. It also accounts for country economic capacity, to give more weight to countries with lower capacity to fund responses to the three diseases and build resilient and sustainable systems for health (RSSH). As part of sustainability considerations and GC8 shifts, the Allocation Methodology was updated for GC8 to further prioritize Global Fund allocations for the lowest income and highest burden settings, where country-level disease burden acutely affects global progress and domestic resources are highly limited.

For each eligible country, the formula first determines its share of total disease burden[4] among all eligible countries. The disease burden share is multiplied by the country's economic capacity[5] and the share is recalculated accordingly. This share, applied to total disease funding, produces an allocation amount called the "raw allocation." Figure 2 illustrates how a country's raw malaria allocation is calculated:

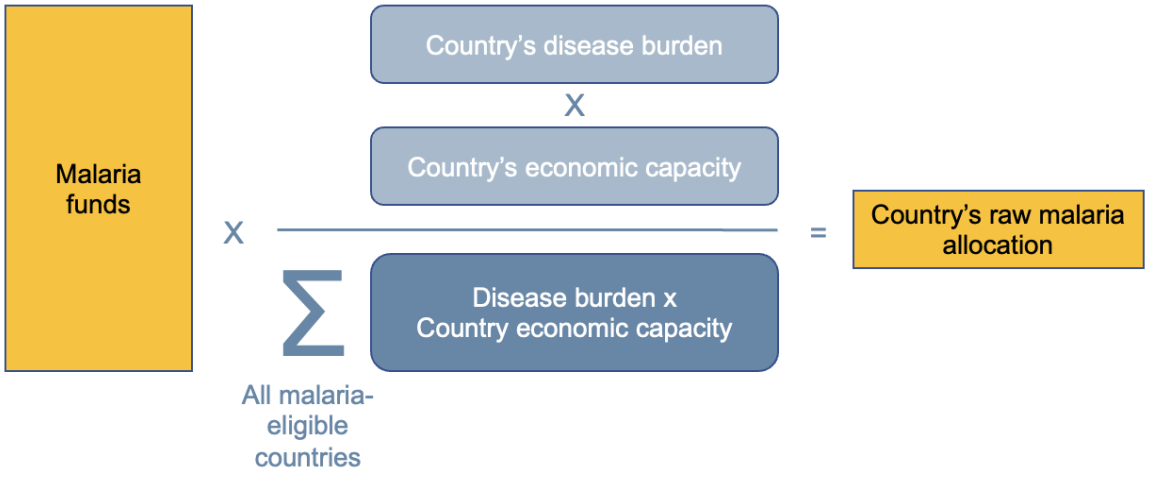

Figure 2: Example of calculating a country's raw malaria allocation

The country's raw allocation for the disease is then adjusted to ensure alignment with:

[4] Disease burden for GC8 is measured by: for HIV: the number of people living with HIV (latest available data); for TB: TB incidence + 10*MDR-TB incidence (latest available data); for malaria: [0.05 * mean malaria incidence rate]+[0.05 * mean malaria mortality rate] + [mean number of malaria cases, adjusted for population growth]+[mean number of malaria deaths adjusted for population growth]. Adjustment for population growth is given by multiplication by [population at risk, latest available year] / [mean population at risk]. Each indicator is normalized except population at risk. Data is mean of 2000-2004 except in 5 WHO-identified countries where latest 5-year average is used. The disease burden indicators are calculated using latest available data from UNAIDS (for HIV) and WHO (for TB and malaria).

[5] Country economic capacity (CEC) values are between 1 and 0. CEC values are measured by a smooth curve, which decreases as Gross National Income (GNI) per capita increases. For those countries with the lowest GNI per capita, their CEC value is 1. The CEC value remains at 1 until just after the lower middle income threshold, where the CEC value starts to decrease as GNI per capita increases. This means that if there were two countries with the same disease burden, but one has a much higher GNI per capita than the other, the country with the higher GNI per capita would get calculated a lower raw allocation than the one with the much lower GNI per capita. The CEC indicator uses latest GNI per capita data from the World Bank.

- A minimum share policy (not less than US$500,000 per disease component) to ensure the allocation is significant enough to produce viable results;[6]
- A maximum share policy (disease allocations are limited to a maximum of 10% of total available disease funding, and country allocations are limited to 7.5% of total funding) to ensure the allocation is not overly concentrated in a few countries;
- Other external financing projections to help align with the distribution of total external resources for the disease.[7]

Scale-up and paced funding reductions

The scale-up and paced funding reduction step aims to provide more predictable funding by adjusting the initial calculated allocations relative to the previous Global Fund funding cycles. This step prevents steep drops in funding for countries with decreasing allocations. The total adjustment is limited to 7.5% of total funding available for country allocations, ensuring increases in allocations are protected and decreases in allocation can be managed. The scale-up and paced reduction step is the final step in establishing the formula-derived allocation for each eligible country disease program.

Qualitative Adjustments

As the final step of the allocation methodology, the formula-derived amounts are refined through a qualitative adjustment process approved by the Global Fund Board's Strategy Committee. The qualitative adjustment process aims to maximize the impact of Global Fund resources by accounting for key epidemiological, programmatic and country contextual factors that are important to determine country allocations, but either cannot be considered formulaically or are not fully represented in the allocation formula. The process is carried out under the oversight of the Strategy Committee and takes place in two stages:

- Stage 1: Stage 1 adjusts for epidemiological factors that are not reflected in the disease burden indicator of the allocation formula. Stage 1 does not guarantee an upwards or downwards adjustment, nor does it determine which program areas are funded from the allocations. Stage 1 provides the starting point for Stage 2 considerations. Based on the recommendations of technical partners, the Stage 1 adjustment is applied for HIV only to account for the unique epidemiologic factors and programmatic costs related to key and vulnerable populations.

- Stage 2: Adjustment of HIV, TB and malaria allocations to account for other contextual factors and to further maximize the impact of Global Fund resources. This holistic adjustment is determined by a Secretariat panel with consideration of all

[6] Subject to assessment through the qualitative adjustment process of the impact that could be achieved, contribution towards achieving strategic objectives, and ability to efficiently manage such programs with differentiated and simplified grant management processes.
[7] Projections for other external financing are discounted by 50% for data quality and can influence country allocations by only up to 25%.

relevant contextual factors. These factors include disease program coverage gaps, economic capacity and sustainability, transition and co-financing considerations, costs associated with delivering program services in challenging operating environments, programmatic performance, risk environment, absorption, and the cost of continuing previously supported Global Fund essential programming. Acknowledging the unique malaria funding challenges in GC8, the Board approved a maximum flexibility of 2% of total funds that may be moved across diseases during the GC8 QA process to address critical malaria program gaps in lower income contexts.[8] The Secretariat used 1% of total funds in the qualitative adjustments process to limit funding reductions for malaria allocations in lower income countries. All changes made in the qualitative adjustments process are transparently reported to the Strategy Committee, while the Board receives a report of component changes greater than US$5 million and 15%.

This process results in final allocations communicated to the country in the allocation letter. During funding request development, countries have the flexibility to revise the funding split between disease programs and programs that build RSSH. The program funding split is subject to Global Fund review.

[8] https://www.theglobalfund.org/kb/board-decisions/b53/b53-edp22/