Thirtieth Board Meeting
Geneva, Switzerland, 7-8 November 2013

GF/B30/6

Revision 1, Attachment 1

THE GLOBAL FUND ELIGIBILITY AND COUNTERPART FINANCING POLICY

Adopted under Decision Point GF/B30/DP5

PART 1: OVERVIEW

1. As outlined in the Framework Document[1], the Global Fund's criteria for eligibility for funding should take into account a number of factors such as disease burden, political commitment, the involvement of an inclusive Country Coordinating Mechanism and the poverty situation[2] of the country[3] in which activities will be implemented.
2. This document sets out an integrated Eligibility and Counterpart Financing[4] policy (the "Policy"). It is designed to ensure that available resources are allocated to countries and regions with the highest disease burden and least ability to bring financial resources to address these health problems, while giving due priority to communities and subpopulations at high risk of disease.
3. This Policy applies to all funding opportunities and establishes criteria to identify components eligible to receive funding allocations,[5] and sets requirements and restrictions on how funds may be accessed.

PART 2: ELIGIBILITY

4. Eligibility criteria are established to identify which countries may qualify to apply for funding from the Global Fund, and under which conditions. Eligibility determinations will be based on compliance with Country Coordinating Mechanism (CCM) minimum eligibility requirements and such other eligibility requirements as described in this Policy. Applications must also demonstrate compliance with Counterpart Financing requirements (Part 3 of this Policy).
5. **CCM Minimum Eligibility Requirements:** All applicants must comply with the CCM minimum eligibility requirements approved by the Board and as amended from time to time[6].
6. **Timing:** Eligibility determinations will be made on a yearly basis following the publication of income level classifications (see Paragraph 7 of this policy) and provision of official disease burden data by key partners[7]. These determinations will be effective from 1 January to 31 December of the following calendar year subject to the following provisions:
    a. Countries or components that become eligible during an allocation period may receive an allocation, subject to the availability of funding, only after being newly eligible for two consecutive eligibility determinations.
    b. Countries or components that become ineligible during an allocation period before accessing their funding will not forfeit their allocation. However, the Secretariat may adjust the level of funding and require specific time-bound actions for transitioning to other sources of financing.
7. **Income Level:** The income level eligibility of a country submitting an application shall be based on a country's income classification as determined by the Global Fund. The Secretariat will make the determination of income classification following the publication of the World Bank (Atlas Method) Income Classifications in July of each year (or

[1] The Framework Document of the Global Fund (January 2002)
[2] Income level measured by appropriate economic indicators, such as the World Bank, Atlas Method.
[3] References in this document to "country" refer to "economy" as classified by the World Bank.
[4] Formerly referred to as 'cost-sharing' criteria in previous Board decisions.
[5] Under the funding model adopted at the Twenty-Eighth Board Meeting (GF/B28/DP4), all eligible country components are calculated three-year indicative funding amounts for each allocation period, based on an allocation methodology that utilizes indicators approved by the Strategy, Investment, and Impact Committee.
[6] GF/B16/DP19, GF/B20/DP12 and as amended by GF/SIIC08/DP4.
[7] Disease burden data is the latest available official data provided by the headquarters of the following key partners per disease: HIV and AIDS: UNAIDS and WHO; Tuberculosis: WHO; Malaria: WHO.

following the month of publication if different from July). With respect to income classification, eligibility shall be determined considering the following:

a. Low income countries (LICs) shall be eligible without specific restriction.

b. Lower middle income countries (LMICs) shall be split into two income groups using as a cut-off the midpoint[8] of the range of GNI per capita for LMICs as reported by the World Bank. Countries at the midpoint or below the midpoint shall, for the purposes of this Policy, be described as "Lower LMICs" and those above the midpoint as "Upper LMICs". All LMICs must comply with requirements regarding the focus of applications (see Paragraph 16 of this Policy).

c. Upper middle income countries (UMICs) will be evaluated for eligibility based upon their respective disease burden (see Paragraph 8 of this Policy). In addition, all UMICs must comply with the requirements regarding the focus of applications (see Paragraph 17 of this Policy).

d. UMICs designated under the 'small island economy' exception to the International Development Association lending requirements, are eligible to apply for funding from the Global Fund, regardless of national disease burden.

e. UMICs that are members of the Group of 20 (G-20) countries are not eligible for new or renewal of existing funding unless they have an 'extreme' disease burden. However, countries excluded from applying for funding under this provision may be eligible to apply for HIV/AIDS funding if they meet the criteria described in Paragraph 12 of this Policy (i.e., the NGO Rule).

f. High income countries (HICs) shall be ineligible to apply for funding through a single country application.

g. Members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) are ineligible to apply for funding.

8. **Disease Burden:** All LICs and LMICs shall be eligible to apply for funding for HIV and AIDS, tuberculosis, malaria[9], and/or Cross-cutting Health Systems Strengthening. Subject to Paragraph 7.d. of this Policy, UMICs shall only be eligible to apply for funding for the disease(s) in which their reported disease burden[10] is measured as 'High', 'Severe' or 'Extreme' as reported in the matrix included in Annex C to this Policy, and as may be amended from time to time. UMICs which are eligible to apply for funding on account of having a 'Severe' or 'Extreme' disease burden, but not those with 'High' disease burden, shall be eligible to apply separately for Cross-cutting HSS funding.

9. Recognizing the diversity of country situations, eligible UMICs with a 'high' disease burden and eligible 'Small Island Economy' exception countries to the International Development Association lending eligibility requirements[11] with a 'low' or 'moderate' disease burden will only be eligible to receive a pre-defined maximum amount of funding[12].

10. Notwithstanding Paragraphs 7.a. through 7.g. above, countries that are certified as 'malaria-free' by WHO or are on the WHO's 'Supplementary List' of countries where

[8] The 'midpoint' is defined as the average between the lower and the upper bound GNI per capita of the LMIC category.

[9] Countries certified as malaria-free by WHO or on the WHO's Supplementary List of Countries are not eligible for funding (as per paragraph 10 of this policy).

[10] As reported by official data provided by the headquarters of the following partners: UNAIDS and WHO for HIV and AIDS, and WHO for tuberculosis and malaria.

[11] As found at the International Development Association website.

[12] These maximum amounts will be defined prior to the commencement of each allocation period as part of the allocation methodology assessed by the Strategy, Investment and Impact Committee.

malaria never existed or disappeared, regardless of their income level, are not eligible to apply for malaria funding.

11. A Regional or multi-country application shall only be eligible for funding where the majority (at least 51 percent) of countries included in the application would be eligible to submit their own request for funding for that same disease through a single-country application. Furthermore, a regional or multi-country application must meet the specific requirements for submitting a regional application.

12. **NGO Rule for HIV/AIDS:** UMICs not listed on the OECD's DAC list of ODA recipients[13] are eligible to apply for HIV and AIDS funding only if the following conditions are met:

    a. Such country has a reported disease burden of 'High', 'Severe' or 'Extreme';

    b. The application is submitted and the program will be managed by a non-governmental organization (NGO) within the country in which activities would be implemented;

    c. The government of such country shall not directly receive any funding;

    d. Requests are submitted as a non-CCM or other valid application;

    e. Such funding requests must meet the focus of application requirements set forth in Paragraph 17 of this Policy and must demonstrate that they target key services, as supported by evidence and the country's epidemiology; and

    f. Applicants must provide confirmation that the services requested in the application are not being provided due to political barriers.

13. **Eligibility Transitions:** Subject to paragraph 7 e. through g., countries or components funded under an existing grant that become ineligible may receive funding for up to one additional allocation period immediately following their change in eligibility (Transition Funding). The Secretariat, based on country context and existing portfolio considerations, will determine the appropriate period and amount of funding.

14. Notwithstanding paragraph 7 e. through g., a grace-period of one allocation period will be provided to those countries with an existing HIV grant that meet the criteria in paragraph 12 and become ineligible due to changes in income level.

15. **LIC Application Focus:** All LICs may submit applications for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS deemed appropriate to the populations being served, without restriction on the scope of the application, but subject to Technical Review Panel (TRP) review.

16. **LMIC Application Focus:** All Lower and Upper LMICs may submit applications for HIV and AIDS, tuberculosis, malaria and/or Cross-cutting HSS but must focus at least 50 percent of the interventions on Special Groups and/or Interventions[14]. Compliance with this criterion will be determined at the time of the TRP review.

17. **UMIC Application Focus:** If eligible, according to disease burden as set out in Paragraph 8 above, UMICs must focus 100 percent of the interventions on Special Groups and/or Interventions. Compliance with this criterion will be determined at the time of the TRP review.

[13] The Development Assistance Committee (DAC) of the Organisation for Economic Co-operation and Development publishes a list of countries eligible for Official Development Assistance (ODA).

[14] Special Groups and/or Interventions are 'underserved and most-at-risk populations' and/or 'highest impact interventions within a defined epidemiological context' as further defined in Annex A.

PART3: COUNTERPART FINANCING

18. Counterpart Financing requirements will apply to all countries applying for funding to the Global Fund.

19. Regional, multi-country and non-CCM proposals are not required to meet the Counterpart Financing requirements described in this Policy.

20. **Minimum Threshold:** Applicants must demonstrate compliance of the national government of the country which is the subject of an application with the minimum threshold for Counterpart Financing. Counterpart Financing threshold is defined as the minimum level of the government's contribution[15] to the national disease program, as a share of total government and Global Fund financing[16] for that disease. To comply with this requirement, the applicant must either demonstrate that its respective national government has met the minimum threshold at the application stage, or, if the country's share is below the minimum threshold for Counterpart Financing, it must provide a justification and present an action plan as to how it intends to move towards it as part of the proposal application (see Paragraph 25 of this Policy).

21. The minimum threshold for Counterpart Financing shall be 5 percent for LICs, 20 percent for Lower LMICs, 40 percent for Upper LMICs, and 60 percent for UMICs[17]. UMICs will be encouraged to increase their Counterpart Financing contribution to above 90 percent during the duration of grant implementation to facilitate graduation out of Global Fund financing.

22. **Increased Government Contribution:** Over the course of implementation of grants funded by the Global Fund within any given country, the government of that country must increase the absolute value of their contribution to the national disease program and health sector each year. In monitoring compliance (see Paragraphs 25 and 26 of this Policy), extenuating circumstances can be submitted by the applicant for consideration along with clear action plans to meet Counterpart Financing requirements.

23. **Expenditure Data:** Applicants will be required to report government expenditure to key partners[18] using existing measurement mechanisms each year. The numbers, once validated, will be used to assess progress.

24. An applicant should include provision for up to US$ 50,000 (per disease) to support costing studies if needed and/or requested by the Global Fund and/or the TRP. The Global Fund will invest through partners on an annual basis[19] using existing measurement mechanisms to make the health and disease expenditure data publicly available for proposal development.

25. **Compliance:** At the time of application submission, applicants will be required to report on Counterpart Financing percentages and trends of their respective national governments. A justification and action plan must be provided as part of the application submission if Counterpart Financing is below the minimum threshold (see Paragraph 20 of this Policy).

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[15] The measure for a government's contribution is the annual average of that government's spending in the past two years and current government budget for the relevant disease program. Government expenditure is ideally measured as all government spending on the disease program, excluding external assistance other than loans.

[16] The measure for Global Fund financing is the annual average of all categories of financing requested and provided through other existing Global Fund grants for that disease, for the implementation period of the new application.

[17] The minimum Counterpart Financing threshold for Cross-cutting HSS proposals shall be set at the same levels as for disease proposals and is measured in the same way. Counterpart Financing in the context of Cross-cutting HSS proposals is the total of the government's contribution to all national disease programs (HIV and AIDS, tuberculosis and/or malaria as applicable to a country) which either have existing Global Fund support or a funding request under consideration. Global Fund financing is the total of existing and requested funding for the applicable diseases and HSS.

[18] Key partners include WHO and UNAIDS, among others.

[19] Amount should be based on an annual estimate from partners for the provision of disease and health expenditure data.

26. Review of the state of compliance with Counterpart Financing requirements will be a material part of all funding requests and conducted by the Secretariat.

27. **Transitions in Income Category:** If a country transitions from one income category to another during a grant period, its minimum threshold will not be reassessed until it applies for funding again.

28. Countries nearing income level category transition will be encouraged to increase their Counterpart Financing contribution with the aim of reaching the next Counterpart Financing threshold in time for their next application for funding.

29. An Early Warning system will be developed and implemented by the Secretariat to identify countries likely to be transitioning to another income level category in the next three years.

Definitions of 'Underserved and Most-At-Risk Populations' and 'Highest-Impact Interventions within a Defined Epidemiological Context'

Underserved and most-at-risk populations:

Subpopulations, within a defined and recognized epidemiological context:

1) That have significantly higher levels of risk, mortality and/or morbidity;
2) Whose access to or uptake of relevant services is significantly lower than the rest of the population.

Note: HIV, TB and malaria applications may include embedded HSS elements. The above definition is intended to capture HSS interventions that benefit 'underserved and most-at-risk populations'.

Highest impact interventions within a defined epidemiological context:

Evidence-based interventions that:

1) Address emerging threats to the broader disease response; and/or
2) Lift barriers to the broader disease response and/or create conditions for improved service delivery; and/or
3) Enable roll-out of new technologies that represent global best practice; AND
4) Are not funded adequately

Note: HIV, TB and malaria applications may include embedded HSS elements. The above definition is intended to capture 'highest impact HSS interventions' that may be part of a disease application.

Cross-cutting HSS interventions addressing needs of underserved populations:

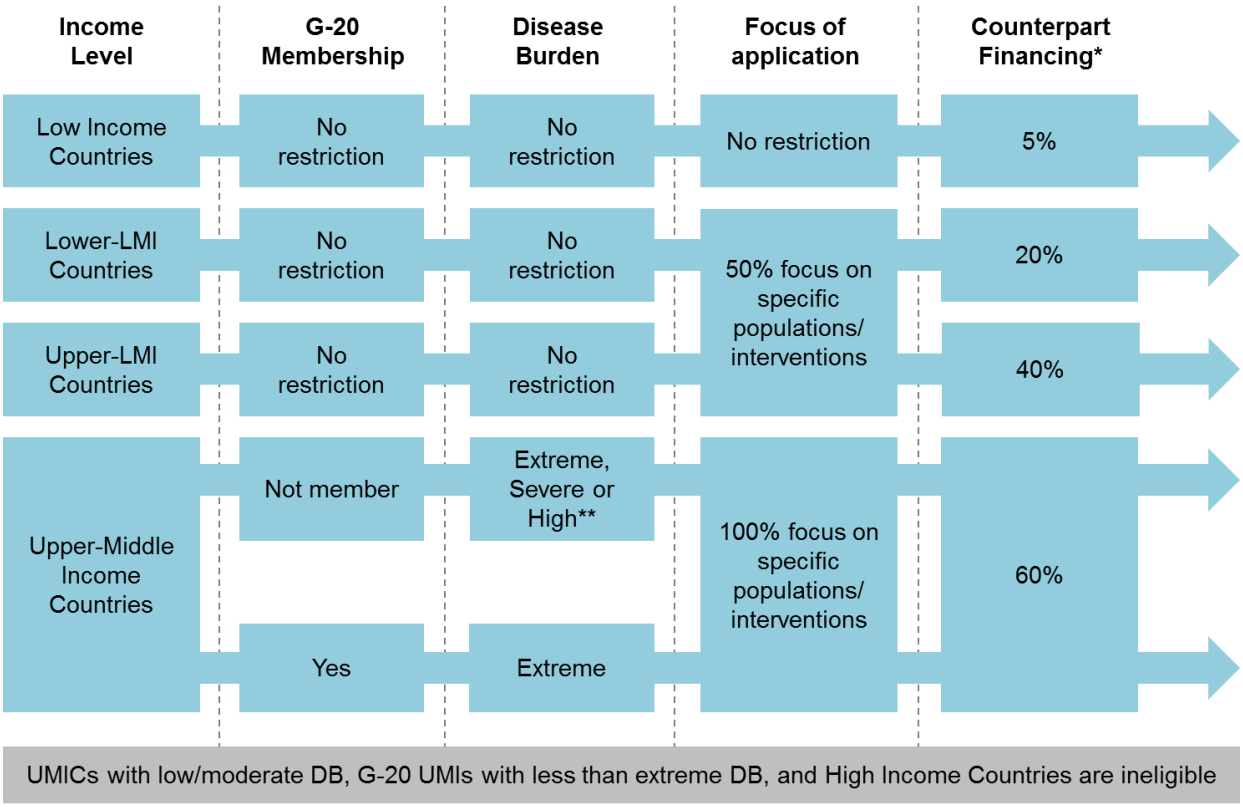
Health systems and community systems strengthening interventions that, within the country context, improve program outcomes for underserved populations in two or more of the diseases by:

1) Improving equitable coverage and uptake addressing any, and preferably all, of:
    - Availability of services
    - Access to services
    - Utilization of services
    - Quality of services

AND

2) Are not funded adequately

Flow chart showing the Eligibility Criteria and required application focus



** Minimum threshold: this is the minimum government contribution to the national disease program, as a share of the total of the government and Global Fund financing for that disease.*
*** Small Island Economies are eligible if they have a low or moderate disease burden.*

Disease Burden Indicators

	HIV*	TB*	MALARIA* ‡
Category	*HIV prevalence in population and/or at-risk populations*	*Combination of TB notification rate per 100,000 population (all forms including relapses); and add WHO list of high burden countries (TB, TB/HIV or MDR-TB burden)*	*Combination of mortality per 1000 at risk of malaria; morbidity rate per 1000 at risk; and contribution to global deaths attributable to malaria.*
Extreme	HIV national prevalence ≥ 10%	TB notification rate per 100,000 ≥ 300 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥2 **OR** Contribution to global deaths ≥2.5%
Severe	HIV national prevalence ≥ 2% and < 10%	TB notification rate per 100,000 of ≥ 100§ **OR** TB notification rate ≥ 50 and < 100 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75§ and morbidity rate ≥ 10 **OR** Contribution to global deaths ≥ 1%§ **OR** country with documented artemisinin resistance
High	HIV national prevalence ≥ 1% and < 2% **OR** MARP† prevalence ≥ 5%	TB notification rate per 100,000 of ≥ 50 and < 100 **OR** TB notification rate per 100,000 ≥ 20 and < 50 and high TB, TB/HIV or MDR-TB burden country	Mortality rate ≥ 0.75 and morbidity rate < 10 **OR** mortality rate ≥ 0.1 and < 0.75 regardless of morbidity rate **OR** contribution to global deaths ≥ 0.25% and < 1%
Moderate	HIV national prevalence ≥ 0.5% and < 1% **OR** MARP prevalence ≥ 2.5% and < 5%	TB notification rate per 100,000 of ≥ 20 and < 50 **OR** TB notification rate per 100,000 < 20 and high TB, TB/HIV or MDR-TB burden country	Mortality rate < 0.1 and morbidity rate ≥ 1 **OR** contribution to global deaths ≥ 0.01% and < 0.25%
Low	HIV national prevalence < 0.5% and MARP prevalence < 2.5% **OR** no data	TB notification rate per 100,000 of < 20 **OR** no data	Mortality rate < 0.1 and morbidity rate < 1 **OR** contribution < 0.01% **OR** no data

* Data sources: HIV and AIDS: UNAIDS and WHO. If data are available for most-at-risk populations (MARPs), the highest prevalence will be taken into account. Tuberculosis: WHO. Malaria: WHO

† MARP: Most-at-risk population

‡ The Secretariat will use malaria data for earlier years (2000) as recommended by WHO. In the case that an application is submitted from a sub-national applicant the Global Fund will use incidence and mortality rates for those specific areas (and the contribution of those areas to the global burden).

§ And not covered by the criteria for the Extreme category.