The document below represents the reaction of the TB Community,
represented by the WHO Stop TB Department and the Stop TB Partnership,
to the proposed use of the "historical disease allocation model" for the new funding model.

Talking points:

We understand that there is a need to move quickly towards agreement on establishing a viable and fully operational new funding model for the Global Fund. However, the proposal to use a simplistic historical allocation average as the upfront disease allocation approach creates an unfortunate "disease against disease" discussion rather than a constructive and supportive dialogue for these three public health threats.

1. The 16% allocated for TB is based on proposals prepared up to 2010 prior to the availability of critical new tools such as rapid diagnostic tests, and innovative strategic approaches that allow for the efficient scale up of TB care. These changes include new approaches to TB diagnosis and drug susceptibility testing, MDR-TB, TB/HIV and the provision of ART and early case detection with a special focus on vulnerable populations. These new tools and approaches mean that TB budgets must grow in order to enable highly cost-effective interventions to be delivered.

2. The allocation does not recognize the higher degree of success of funded TB projects, only the relative share of approved proposals.

3. **Using other straight-forward methods to determine funding allocation by disease – such as mortality or DALY burden, or global budgeted plan and gaps, TB would receive between 20-34% of the overall available funding** – see table 1 below. These allocation approach options were not discussed or debated in any detail.

4. Maintaining such low-level financing for TB will have a detrimental effect on the achievement of Global Fund strategy targets as well as the international targets set within the Global Plan to Stop TB 2011-2015. More importantly, it will fail to meet national demand to:

   a. Maintain basic levels of quality TB care – for example in parts of Asia where the proposed allocation risks a dramatic decline in the share of financing

   b. Scale up diagnosis and treatment for MDR TB (particularly among the existing pool of untreated patients) – especially in the European and African regions where there are health security implications

   c. Scale up of TB/HIV interventions – including the early provision of ART and faster diagnosis of TB among people with HIV using molecular methods in order to reduce death rates

   d. Extend early case detection, especially in key vulnerable groups and high-risk populations

e.   Ensure more meaningful involvement of communities and civil society in the delivery of TB interventions –as special efforts were only beginning to gain momentum in 2010 and 2011.

Our position therefore is:

- **The approach based on historical disease allocation average is only reasonable as an immediate interim solution (for no more than one year) to be revisited by the Global Fund Board meeting in autumn 2013.**
- **During this interim period we call for an increase of the allocation for TB to at least 20% and the urgent creation of an additional special fund for MDR-TB commodities. This special fund would cover the procurement and stockpiling of second-line drugs and increased access to new diagnostic tools.**
- **We call for the vast majority of collaborative TB/HIV interventions (TB/HIV cases represent 13% of all TB cases), largely a responsibility of HIV programmes, to be supported under HIV grants, with ring-fenced funding within these grants to ensure reasonable budget allocation and improve the performance of HIV interventions in addressing TB.**
- **We commit to support the urgent resource mobilization needs of the Global Fund and all its stakeholders in ensuring greater resources for all three diseases.**

Table 1

	BURDEN			PLAN			GAP*	
	Deaths (2008)	Possible allocation based on deaths	Possible allocation based on DALYs	Major stated outputs in 2015	US $ bn	Possible allocation based on plan costs	US $ bn	Possible allocation based on projected gap for 2015**
HIV	1,758,023	45%	46%	15 million on treatment, etc.	24.0	66%	7.2	59%
TB	**1,327,920**	**34%**	**27%**	**7.2 million cases treated (including 0.3 million MDR), etc.**	**7.3**	**20%**	**2.7**	**22%**
Malaria	826,830	21%	27%	172 million households sprayed, etc.	5.0	14%	2.4	20%

* Based on a conservative estimate of what will be available in 2015 if current (2011) levels of domestic and donor funding are maintained in nominal terms.

** The World Malaria Report 2011 does not report domestic funding available in 2011; as a conservative estimate (one which **over**estimates the gap and therefore the allocation for malaria), we use the 2010 data of 73 countries contained in Annex 2 of the report. The gap (and allocation) for TB is likely **under**estimated, as we exclude Global Plan resource needs for TB/HIV collaborative activities

Sources: World Malaria Report 2011 (including Annex 2); The Global Malaria Action Plan; Global TB Report 2012; Global Plan to Stop TB 2011-2015; UNAIDS Together We Will End Aids, 2012 (based on Investment Framework). WHO estimates of the burden of disease (deaths) are available by World Bank income group here: http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index.html

Background:

1. **What "historical allocation" means for TB**
    a. It represents 16% of the historical levels of investment in the Global Fund portfolio (i.e. for a portfolio of US$ 1 billion it will represent US$ 160 million). This 16% takes into consideration the amounts of funding obtained by TB applications between Round 1-Round 10 and therefore prepared by applicants between 2000-2009. This does not consider the recent Transitional Funding Mechanism results where TB proposals obtained 25% of the overall budget.
    b. The historical level of investment for TB is extremely varied among regions – with some regions having a larger share of overall Global Fund investments for TB. In Asian countries, TB has received more than a third of the regional share of Global Fund investments, and applying a 16% share across all geographic settings will present severe difficulties even for maintaining current efforts in these countries, while inhibiting scale-up in others.
    c. The historical average reflects the thinking, ambitions and available tools up to late 2009. It reflects the approaches prior to several strategic developments in TB: the development and need for scale up of rapid molecular diagnostics, the need to focus on early detection of TB cases, increased focus on key and at-risk populations in order to increase the case detection rate, the urgent need to scale up TB/HIV and MDR-TB interventions (as deliberated by the WHA 2009 and Beijing Ministerial Conference on MDR-TB), inclusion and focus on high-risk groups.

2. **Un – answered questions and risks with the actual model**
    a. It is understood that the model proposed with TB receiving 16% of the funding will be an interim approach. However, will this share apply only to the present uncommitted assets or will it apply to future rounds to be launched in 2013?
    b. We see an important need for a presentation clearly illustrating the methods used for determining allocations and showing how the allocations between bands and within bands will be determined.
    c. After bands are allocated, is competition between the countries within a band expected?
    d. Once the allocation is determined – is it possible that TB financing through review could still succeed in getting more than 16% if proposals are stronger?
    Risks:
    e. This approach creates the premise of a "disease against disease" situation. It creates as well premises for further verticalised approaches in countries as each country will prepare a request for funding (based on their strategy) to address the funding envelope existent for each disease and their respective bands. There seems to be little incentive in the actual model for cross collaboration and to address joint activities in countries, for example with regard to procurement and supply chains, systems for data collection and evaluation, civil society strengthening. TB/HIV interventions – crucial to save the lives of PLHIV – will be compromised, as neither TB nor HIV proposals will push for inclusion of these cross cutting budgets.
    f. Maintaining a 16% trend will move even further away from making up the funding gap as outlined in the Global Plan to Stop TB 2011-2015. This will represent serious

risks in reaching the proposed targets of the Global Fund Strategy 2012-2016, especially around MDR-TB Treatment and ART for people living with HIV and affected by TB. To reach these targets with this model might imply sacrificing basic TB packages and MDR-TB prevention.

g. Global scale up of TB – especially MDR TB – diagnosis and treatment will be stopped. The world will not be responding to the serious MDR-TB health security threat, especially in resource-constrained settings. Even in some BRICS countries that are still receiving GF support there will be a slowdown of the MDR TB response.

h. The Global Fund is the main external donor for TB programmes – Global Fund funding represents more than 80% of the external funding in TB.

i. There are no other significant external/ bi-lateral donors that can step-in to cover the eventual gaps in country plans.

j. We need to be confident that the allocation model applied, even if effective only for a year, will not create special risks, especially for highly vulnerable/dependent countries with large TB burdens (or MDR-TB or TB/HIV burdens). Some lower and middle-income countries - such as in Southeast Asia - will face extreme reductions in potential financing relative to their past GF financing (which was based on "expressed demand")

3. **Other methods that can be used to define allocation among diseases**

   a. The 16% allocation historically is not consistent with:
      i. Real burden of the disease
      ii. Cost-effectiveness considerations
      iii. Low unit cost of TB treatment interventions

   b. Taking into consideration **the burden (nr. of deaths), DALYs, planned costs, funding gaps as indicators/variables used for disease allocations TB should be considered at least at 20% of the funding (between 20-34% of the funding)**

4. **Proposed way forward**

Understanding the need to move forward with the launch of a new funding model and a new funding opportunity,

Understanding that **this interim approach will be applicable just to the present uncommitted assets and do not refer to other new funding to become available in 2013,**

Understanding that **the revision of this interim model will be done by the GF Board in 2013,**

We advocate for an **increased allocation to TB that should be not lower than 20%,**

We advocate for **a special fund for procurement and stockpile of the second line drugs for treatment of MDR TB,**

We advocate for **the vast majority of financing for collaborative TB/HIV interventions, that are a responsibility of the HIV programmes, to be financed via HIV grants,** with ring-fencing in implementation to ensure improving performance of HIV interventions in addressing TB.

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[*]The support of some persons listed reflects their personal views and does not necessarily imply the official endorsement by their agencies or organizations