GF/B11/6

REPORT OF THE TECHNICAL REVIEW PANEL AND THE SECRETARIAT ON ROUND FIVE PROPOSALS

Outline: This paper provides the Board with an overview of the Round 5 proposals process, the Technical Review Panel (TRP) recommendations for funding, key trends observed in Round 5, and lessons learned by the TRP and the Secretariat during the Round. The annexes that support this report are provided on a CD-ROM, and only Annex II (List of components reviewed, classified by category) is attached.

- Annex I: List of proposals reviewed by the TRP, ordered alphabetically
- Annex II: List of components reviewed, classified by category
- Annex III: List of all non-eligible proposals, with justification
- Annex IV: TRP reports for all reviewed components, classified by region
- Annex V: Executive Summaries for all reviewed proposals and full text of all recommended proposals, classified by region

Summary of Decision Points:

1. **The Board is asked to approve for funding the proposals recommended by the TRP in Categories 1 and 2 (as defined below), with the clear understanding that budgets requested are upper ceilings rather than final budgets and the Secretariat should report to the Board the results of the negotiations with the Principal Recipient (PR) on the final budget for acknowledgement (See Annex II).**

   Category 1: Recommended proposals with no or minor clarifications, which should be met within 4 weeks and given the final approval by the TRP Chair and/or Vice-Chair.
   Category 2: Recommended proposals provided clarifications are met within a limited timeframe (6 weeks for the applicant to respond, 3 months and not to exceed 4 months to obtain the final TRP approval should further clarifications be requested). The primary reviewer and secondary reviewer as well as TRP Chair and /or Vice-Chair need to give final approval.
   Category 3: Not recommended in their present form but are encouraged to re-submit.
   Category 4: Rejected.

2. **The Board is asked to note that, as requested by the Board, the TRP graded a sub-set of Category 2 proposals in Category 2B, to allow for a situation in which there are insufficient funds to meet the commitments required to fund all the Category 1 and 2 proposals recommended by the TRP in Round 5.** The TRP defined Category 2B proposals as relatively weak Category 2 proposals, on grounds of technical merit and/or issues of feasibility and likelihood of effective implementation. The TRP took no account of the applicant country's income level, nor of burden of disease nor of any factors other than technical merit and feasibility in grading a proposal as Category 2B.

3. **The TRP is recommending 63 components involving programs in 51[1] countries, for a total value of US$ 1.7 billion over 5 years and US$ 726 million over two years** (Annex II). As in previous rounds, the largest share of funding targets Africa and HIV/AIDS. Round 5 is also characterized by a higher success rate for TB proposals than in previous Rounds, resulting in a higher proportion of total recommended budgets going on TB programmes than in prior Rounds.

4. **The Board is asked to acknowledge the lessons learnt by the Secretariat and the TRP during this process, and to refer the various recommendations contained in this report to the Portfolio Committee for review prior to Board decisions on these recommendations ahead of Round 6.**

[1] This figure does include 2 multi-country proposals (1: Mozambique, South Africa, Swaziland and 2: Solomon Islands and Vanuatu)

Part 1: Overview

1. On March 17th 2005, the Global Fund issued the Fifth Call for Proposals using the revised forms and guidelines approved by the Board. Proposals could be submitted in hard copy, in electronic format using Microsoft Word, and for the first time in Round 5, in PDF Format. This format was introduced with the intention of enhancing data collection and improving analysis of the Round outcome, as well as to facilitate the proposal and grant management process. The application form could be accessed through the Global Fund website (http://www.theglobalfund.org), and was available in English, French and Spanish. The PDF form was made available on a CD-ROM which contained an application that assisted applicants in submitting their proposals in much the same way as the online version. Prior to introducing the system, the Secretariat conducted a rapid survey in Bangladesh, Kenya and South Africa to determine the internet availability access at country level. The Call for Proposals was channeled through a series of networks, including Health, and Foreign Affairs Ministries, the Global Fund website, and main partners through their country offices.
2. The Guidelines for the Fifth Round of Proposals (Guidelines) and Proposal Form (which were approved by the Board) were first revised to allow for further simplification of the process. The Guidelines were streamlined to focus on the key messages and information needed for a sound submission. Eligibility criteria were based on the World Bank classifications of income. Countries classified as Low Income are eligible to request support from the Global Fund. Countries that are Lower Middle Income are eligible to request support but have to meet additional requirements for co-financing arrangements, focusing on poor or vulnerable populations, and moving over time towards greater reliance on domestic resources. Upper-middle income countries are eligible to request support if they face a very high current disease burden and they meet the additional requirements for co-financing arrangements, focusing on poor or vulnerable populations and moving over time towards greater reliance on domestic resources. Lists of eligible countries were attached to the Guidelines.
3. For the first time the Board has introduced a new component on Health System Strengthening to allow countries to include broader system – wide/ cross cutting aspects of system development that demonstrate a clear benefit in the fight against AIDS, Tuberculosis and Malaria. Health System Strengthening component allow countries to target other sectors including education, the workplace and social services.
4. The Guidelines also requested details on Country Coordinating Mechanisms (CCMs), PRs, the country context, targets and indicators and implementation systems such as Monitoring and Evaluation and procurement. The guidelines spell out the scope of proposals, encouraging applicants to apply for both scaling-up of existing programs and new approaches.
5. During the proposal preparation phase, the Secretariat mobilized partners to assist countries in their proposals with special attention to be given to countries that had never benefited from Global Fund Resources. Countries that were covered by international initiatives received specific attention, and the Secretariat ensured that the missions sent by technical partners were briefed prior to their travel to countries so they also were aware of the Global Fund's eligibility criteria as well as the review process.
6. Countries were given 3 months preparation time with a deadline of 10th June, 2005. In total, 168 proposals from 105[2] countries containing 312 components were received. Of these, 90 proposals came from CCMs, the balance were submitted by regional organizations, private sector and NGOs (Fig.1). Of the submitted proposals, 202 components from 105 countries were reviewed by the TRP (Annex I of CD-Rom).
7. The Secretariat set up a team of staff to support countries in the application process, and to answer all problems encountered from both the IT and business sides. This team managed

[2] This figure does include the number of Multi-Country applications

and responded to queries as they came from countries. The Secretariat also put in place a Tracking system to monitor performance in terms of responsiveness to queries. Global Fund eligibility criteria were explained to each applicant requesting/submitting a proposal outside of the CCM. The Secretariat also provided those applicants with the respective CCM contact details.

Part 2: Proposal Receipt and Screening

2.1 Screening Process

1. The Secretariat screening process involved applying screening criteria to ensure transparency and consistency. It focused on the following items:

   a. Source of Proposal:

   For CCM applications, in accordance with the Guidelines, the Secretariat checked the inclusiveness of CCM membership through members' lists, signatures, as well as minutes of meetings. The Secretariat also checked CCMs to ensure that the Board approved Revised Guidelines on the Purpose, Structure and Composition of CCMs and Requirements for Grant Eligibility (Revised CCM Guidelines) had been or was in the process of being implemented.
   - All CCMs are required to show evidence of membership of people living with and/or affected by the diseases;
   - CCM members representing the non-government sectors must be selected by their own sector(s) based on a documented, transparent process, developed within each sector;
   - CCMs are required to put in place and maintain a transparent, documented process to:
     • Solicit and review submissions for possible integration into the proposal;
     • Ensure the input of a broad range of stakeholders, including CCM members and non-members, in the proposal development and oversight process;
     • Nominate the Principal Recipient and oversee program implementation.
   - The Secretariat in the screening process also requested applicants when CCM Chair or Vice Chairs and PR are from same entity that they provide plans on how they were able to mitigate the potentional conflict of interest according with the section 20 of the Revised CCM Guidelines:
   "To avoid conflict of interest, it is recommended that PRs and Chairs or Vice Chairs of CCMs not be the same entity. When the PRs and Chair or Vice Chairs of the CCM are the same entity, **the CCM must have a written plan in place to mitigate against this inherent conflict of interest.** This plan must be documented and made public to ensure the highest levels of transparency and integrity. This plan should include, at a minimum, that the PR, or prospective PR, shall recluse itself from participation at the CCM meeting and shall not be present during deliberations or decisions related to the CCM's monitoring and oversight of the PR, such as decisions related to:
     - the selection of the PR;
     - PR renewal for Phase 2;
     - a substantial reprogramming of grant funds; and
     - those that have a financial impact on the PR, such as contracts with other entities, including sub-recipients."

   For non-CCM applications within a country, again in accordance with the Guidelines, applications were screened against the three exceptional circumstances for submitting outside a CCM.

Finally, for multi-country proposals, an endorsement by the Chair or Vice-Chair of the CCM was required from all the countries targeted in the proposal.

b. Scope of proposal:

Only proposals targeting one or more of the three diseases, or dealing with health systems strengthening, were regarded as eligible. Pure research and pre-investment projects were also screened out.

c. Completeness of Proposal:

The proposal had to be reasonably complete, with all questions covered, including budgets, signatures and attachments.

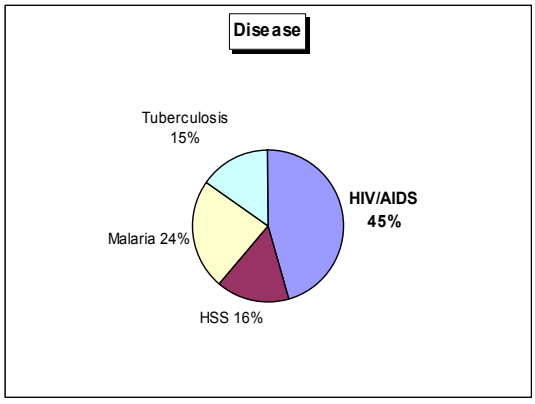
2. The Secretariat maintained an internal high-level Steering Committee which supervised the screening process to ensure that guidelines were followed and that all applicants received fair and consistent treatment.

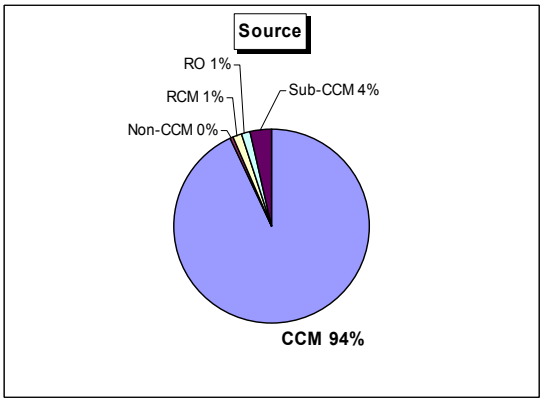
3. The majority of applications came through as electronic documents using Microsoft Word. The Secretariat, with 17 short-term staff, had six weeks to screen received proposals. This time was also used to request from applicants missing information, correct budget inconsistencies and/or obtain further clarifications.

2.2 Outcome of the Screening Process

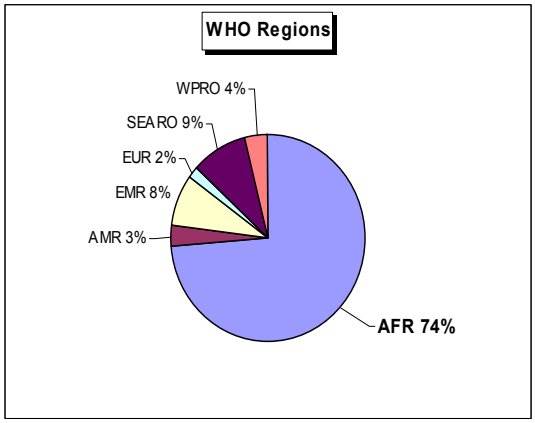
1. Of the 168 proposals received, 70 were screened out by the Secretariat. The screened out proposals were mainly from NGOs or Regional Organizations that did not have CCM endorsements, or did not give any clear and accepted reasons for not applying through CCMs; or had ineligible scope (See Annex III for a list of non–eligible proposals of CD-Rom).
2. A total of 202 components from 105[3] countries were screened as eligible for review by the TRP. The corresponding numbers during Round 4 were 173 components from 96 countries. The breakdown of applications by WHO region, disease and source of application is shown in Figure 1.

Figure 1





[3] This figure does include the number of Multi-Country applications



3. Prior to the TRP review, the Secretariat shared the list of the countries that submitted proposals to the Global Fund with WHO and UNAIDS, and requested these agencies to provide the TRP with updated epidemiological data sheets. These data were provided as requested.
4. The Secretariat also shared the list of the countries that submitted proposals with PEPFAR, World Bank and UNICEF to get their inputs on country contextual information based on their supported programs in country. Information was received from some of these agencies on some, but not all, of the proposals reviewed by the TRP.
5. Feedback from the screening process shows that countries had major difficulties with the PDF forms. Only 5 countries managed to apply through the PDF form.
6. One new country, Tunisia, submitted a proposal for the first time in Round 5.
7. For the first time in Round 5, the Secretariat provided the TRP with detailed information on the progress made by applicant countries on all their existing GFATM grants from prior Rounds.
8. In terms of work process, the Secretariat was able to:
    a. Acknowledge all proposals within one week of the submission deadline,
    b. Screen all proposals in the time allocated, and, where necessary, request further information from applicants,
    c. Quickly inform all ineligible applicants concerning their status, providing them with detailed information on steps they needed to follow to ensure their eligibility for TRP review in future Rounds.

Part 3: The TRP Review Process

1. The TRP met in Geneva from Monday 25th July to Friday 5th August 2005. The panel included 26 members, comprised as follows:

    Jonathan Broomberg (Cross-cutting expert, South Africa, **Chair**)

    Seven AIDS experts : David Burrows (Australia), Peter Godfrey-Faussett (UK), Godfrey Sikipa (Zimbabwe), Papa Salif Sow (Senegal), David Hoos (USA), Nêmora Tregnago Barcellos (Brazil), Kasia Malinowska Sempruch (USA)

    Four malaria experts: Andrei Beljaev (Russian Federation), John Chimumbwa (Zambia), Mark Kofi Amexo (Ghana), Giancarlo Majori (Italy).

Four tuberculosis experts : Lucica Ditiu (Romania), Jacob Kumaresan (India), Pierre Yves Norval (France), Antonio Pio (Argentina)

Ten additional cross-cutting experts : Malcolm Clark (UK) (replaced after 4 days by Yvo Nuyens (Belgium)), Kaarle Olavi Elo (Finland), Leenah Hsu (USA), David Peters (Canada), Glenn Post (USA), Stephanie Simmonds (UK), Michael James Toole (Australia), Josef Decosas (Germany), Andrew McKenzie (South Africa), Martin Alilio (Tanzania).

2. The following table illustrates the tenure of TRP members serving in Round 5:

Joined Round 1	Kasia Malinowska Sempruch (did not serve in Round 4)
Joined Round 2	Jonathan Broomberg, Giancarlo Majori
Joined Round 3	David Hoos (did not serve in Round 4), Peter Godfrey Faussett, John Chimumbwa, Malcolm Clark, Leenah Hsu, Pierre Yves Norval, David Peters
Joined Round 4	Papa Salif Sow, Godfrey Sikipa, Andrei Beljaev, David Burrows, Antonio Pio, Glenn Post, Stephanie Simmonds, Michael James Toole, Kaarle Olavi Elo
Joined Round 5	Nêmora Tregnago Barcellos, Mark Kofi Amexo, Lucica Ditiu, Jacob Kumaresan, Josef Decosas, Andrew McKenzie, Martin Alilio and Yvo Nuyens

As the table illustrates, The TRP is now benefiting from the revised rotation policy which allows members to serve for a maximum of four rounds. This approach has created an appropriate mix of new and experienced members in each Round. In Round 5, 8 members of the panel were serving on the TRP for the first time, a further 9 had served for one prior Round, and the remaining 9 members had served for two or three prior Rounds. Unfortunately, Malcolm Clark, one of the cross cutting experts, had to leave the TRP meeting after four days for personal reasons. The TRP was fortunate to secure the services of Yvo Nuyens, a member of the TRP support group, at very short notice.

3. Prior to and throughout the meeting, the TRP received outstanding logistical and technical assistance from the Secretariat. We would like, in particular, to thank Karmen Bennett, Carl Manlan, Hind Khatib Othman, Hannah Kellogg and Ilze Kalnina, as well as all other Secretariat staff involved in supporting the TRP for their dedicated and professional assistance. The logistical support during Round 5 had clearly benefited from lessons learnt in prior Rounds, ensuring that almost all aspects of the support process were efficient and helpful.

4. WHO, Stop TB, UNAIDS, UNICEF, and Roll Back Malaria provided support to the TRP through initial briefings on the first day of the Round, provision of background reference materials, and stand by experts for consultation if required by TRP members. Further comments on these inputs and support from the agencies are provided below.

5. The TRP benefited substantially in Round 5 from additional background information on applicant countries provided by the Secretariat as well as by the World Bank, WHO and UNAIDS. In this Round, for the first time, reviewers had the benefit of studying the detailed Grant Scorecards for those countries whose prior grants had gone through a Phase 2 review, as well as Grant performance reports completed by Fund portfolio managers where Grant Scorecards were not available. In addition, in some cases, reviewers had the benefit of World Bank Aides Memoire for applicant countries, which proved informative and useful. Fact sheets provided by UNAIDS and WHO were also beneficial to the review process. The

Secretariat materials, in particular, were found to be extremely valuable. Further comment on the background materials are provided below.

6. The TRP reviewed 202 components screened in as eligible by the Secretariat.

7. Around 23 components were reviewed each day. As in Round 4, on the day preceding the review, applications were distributed among 7 working sub-groups comprised of two disease-specific experts (experts on the same disease), and one or two cross-cutting expert(s). Sub-group composition was modified twice during the two weeks of the TRP session to strengthen the consistency of the review process.

8. Each application was thus read by three to four experts. It was extensively reviewed by a disease-specific expert acting as a primary reviewer and a cross-cutting expert, acting as a secondary reviewer. The working sub-groups met every day to discuss the applications and agree on a consensus grading of the proposal. The primary reviewer was also required to draft a preliminary report on the application to be presented in the plenary session.

9. The entire TRP would then meet for 4-5 hours each day in a plenary session to discuss all proposals reviewed on that day. This discussion involved a presentation of the proposal and views of the working sub-group by one of the reviewers, followed by discussion, and subsequent consensus on the final grading of the proposal and final wording of the report. Proposals were graded in one of four categories (1, 2, 3, 4), as requested by the Board. As also requested by the Board, a subset of Category 2 proposals were identified as Category 2B. These are discussed in further detail below. All decisions of the TRP were achieved by consensus. Where consensus was noted to be more difficult to reach, proposals were set down for a further review at the final plenary session on Friday 5th August 2005. 19 proposals (just below 10% of all components reviewed) were set down for further review. In all cases, these proposals were felt to be on the borderline between a Category 2 and a Category 3 proposal, and the TRP believed that a final judgment would benefit from further reflection and discussion.

10. On the last day of the session, the TRP reviewed the 19 proposals identified for further review. Prior to this, the primary and secondary reviewers were requested to revisit the review, and to reconsider their own views prior to presentation to the final plenary session. At the final session, each of these proposals was discussed in detail, and consensus on a final grading was reached in all cases. In addition, the TRP discussed the overall review process and confirmed that it was comfortable with its decisions on all proposals reviewed.

11. As noted above, at the Board's request the TRP graded all proposals on the following basis:

Category 1: Recommended proposals with no or minor clarifications, which should be met within 4 weeks and given the final approval by the TRP Chair and/or Vice-Chair.
Category 2: Recommended proposals provided clarifications are met within a limited timeframe (6 weeks for the applicant to respond, 3 months and not to exceed 4 months to obtain the final TRP approval should further clarifications be requested). The primary reviewer and secondary reviewer as well as TRP Chair and /or Vice-Chair need to give final approval. Category 2B: This category, which is a subset of the Category 2 proposals, was identified at the request of the Board to allow for a situation in which there are insufficient funds to meet the commitments required to fund all the Category 1 and 2 proposals recommended by the TRP in Round 5. The TRP defined Category 2B proposals as relatively

weak Category 2 proposals, on grounds of technical merit and/or issues of feasibility and likelihood of effective implementation. The TRP took no account of the applicant country's income level, nor of burden of disease nor of any factors other than technical merit and feasibility in grading a proposal as Category 2B. In other words, these proposals differ from clear Category 2 proposals only in that they have more technical weaknesses, and/or more questions as to effective implementation, and/or more required clarifications than the clear Category 2 proposals. It is important to note, however, that on balance all of the Category 2B proposals were regarded as recommended for funding, and the TRP believes that the weaknesses and clarifications could be addressed within the timeframes normally provided for Category 2 proposals.
Category 3: Not recommended in their present form but are encouraged to re-submit.
Category 4: Rejected.

12. The entire review process, including the review on the final day, took no account whatsoever of the availability of funds for the Round. The TRP's review was based on relevance, technical merit, feasibility and likelihood of effective implementation.

Part 4: Recommendations to the Board

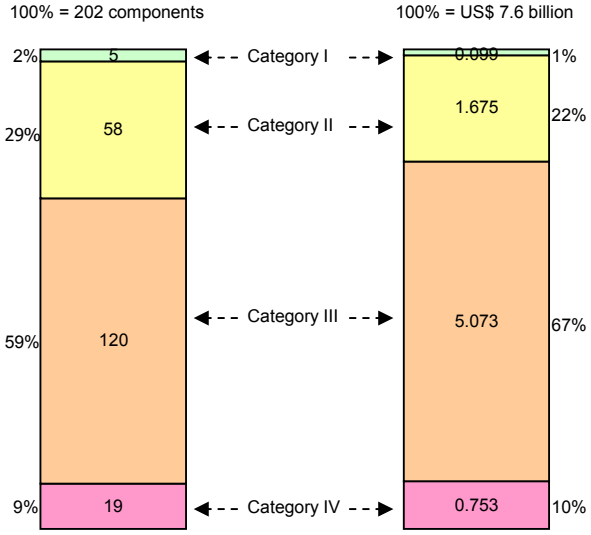
4.1. Overall outcome of the review

1. Figure 2 summarizes the overall breakdown of reviewed components in Round 5. Proposals were grouped into one of the five categories defined above. **63 components in 51[4] countries are recommended in Categories 1 and 2, with 5 components in Category 1 and 58 in Category 2. Of the 58 Category 2 components, 10 were classified in Category 2B. 120 components were graded in Category 3, and 19 components in Category 4**.
In this report, recommended components are defined as all Category 1 and 2 components, including those in Category 2B. Recommended components (n = 63) represent 31% of the reviewed components and 23% (US$ 1,77 bn) of the total budget requested in proposals submitted for review by the TRP in Round 5.

[4] Includes 2 multi-country proposals (1: Mozambique, South Africa, Swaziland and 2: Solomon Islands and Vanuatu)

Figure 2

Round 5: Outcome by TRP category



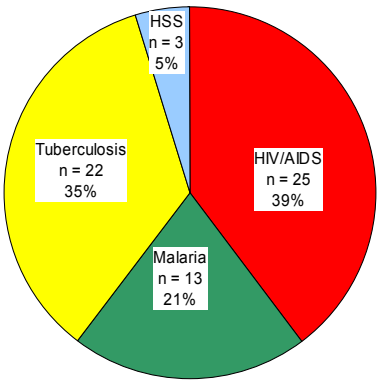
4.2. Recommended proposals

1. Annex II lists components graded in categories 1 and 2 that are recommended by the TRP to the Board for funding in Round 5. Recommended components, (n = 63) correspond to a total initial 2 year budget of US$ 726 M. This Annex also lists the subset of Category 2 components classified by the TRP in Category 2B (n = 10)
2. Annex II further lists components classified in Category 3, i.e. applications that the TRP did not consider strong enough to be recommended for funding in their present form but recommends they be submitted in an improved form in Rounds to come. The Annex also lists components graded in Category 4. These applications are defined as Rejected. In other words, they were not recommended for funding, and the TRP would not encourage their resubmission in any similar format. This is either because the TRP did not consider the proposal to be relevant enough to the objectives of the Fund, or because the proposal was so flawed that it requires complete redevelopment prior to resubmission.
3. Figures 3 and 4 depict the distribution of recommended components and that of the corresponding 2 year budget, by disease category and region. HIV/AIDS components represent 39% of recommended components and 40% of the requested 2 year budget; malaria components represent 21% of recommended components and 27% of the 2 year budget request. TB components represent 35% of recommended components and 27% of the 2 year budget request. Health Systems Strengthening (HSS) components represent 5% of recommended components and 6% of the 2 year budget request. Figure 4 shows that, as with prior Rounds, the largest share of recommended proposals and budget go to African countries, with 51% of recommended proposals and 66% of the recommended two year budget allocated to Africa. These shares are similar to those observed in Round 4, where 49% of proposals and 69% of the total recommended two year budget was awarded to proposals from African countries. Figure 4 also shows the performance of other Regions, which again remains broadly similar to the pattern of Round 4.

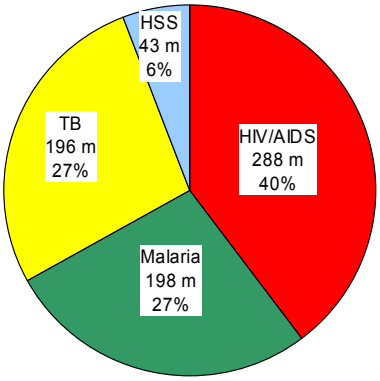
Figure 3

Round 5: Recommended Components By Disease

Total number of components = 63



Total 2-year budget = US$ 726 million



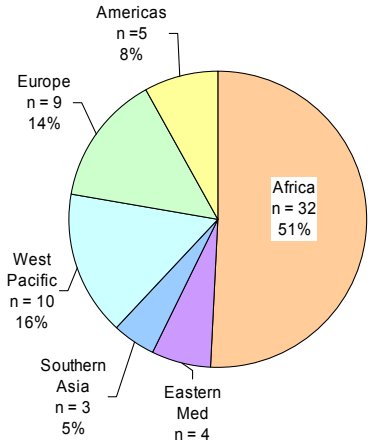
Total 5-year budget for HIV/AIDS: US$ 778 million

Figure 4

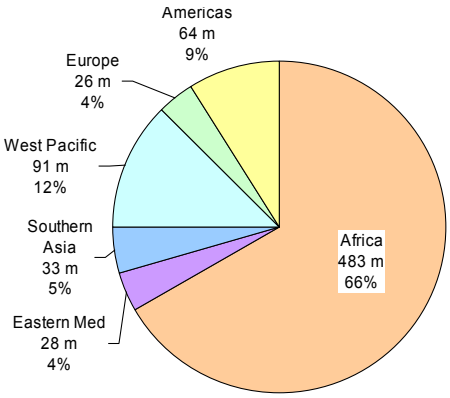
Round 5: Recommended Components by Region

Largest share is towards Africa

Recommended components by region
100%=63 components



Recommended 2-year budget by region
100%=726 Million US$

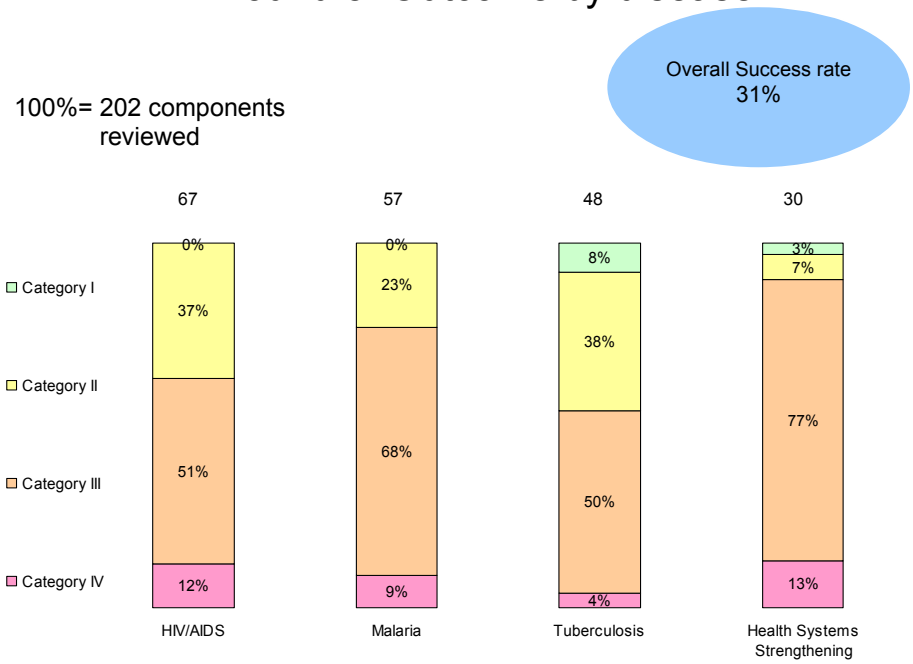


4. Figure 5 below shows the relative success rate by component type in Round 5. The data show that TB proposals enjoyed the highest success rate in Round 5 (46%), due to a noticeable improvement in the quality of TB proposals during this Round. The success rate of HIV/AIDS proposals was 37%, while that of malaria proposals was 23%. In the case of HSS, the low success rate (10%) is of concern to the TRP, and was thoroughly discussed by the TRP. The TRP's views on HSS proposals are discussed in further detail below.

Figure 5

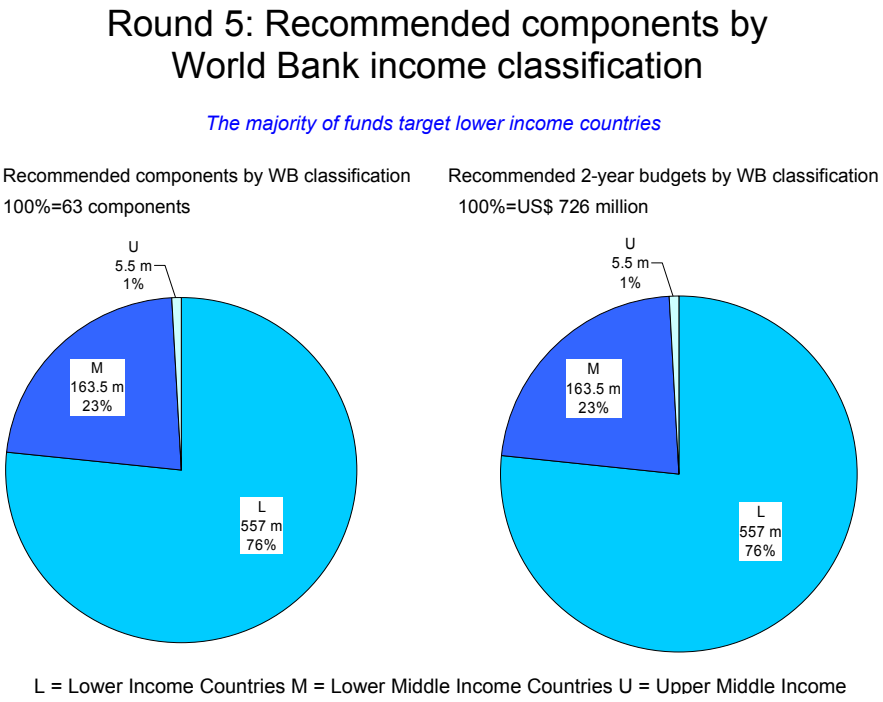
Round 5: Outcome by disease

100%= 202 components reviewed



5. Figure 6 depicts the stratification of recommended components, and of the corresponding 2 year budget, according to the World Bank's classification of income. Countries were classified as Upper Middle Income (UMIC), Lower Middle Income (LMIC) and Low Income (LIC). As in prior Rounds, the majority of funds in recommended proposals are targeting low income countries, with 65% of recommended components and 76% of the total two year budget going to low income countries in Round 5. These are slightly lower than was the case in Round 4, where 80% of recommended proposals and 85% of the total two year budget was allocated to low income countries. The difference in Round 5 is attributable to the greater success of proposals from middle income countries, which account for 33% of recommended components and 23% of the total two year budget, compared to 16% of components and 14% of the two year budget in Round 4.

Figure 6

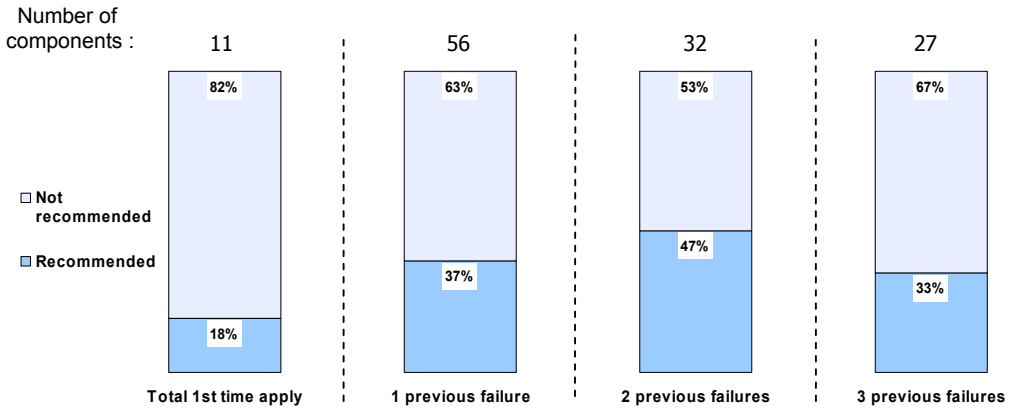


6. Figure 7 shows the relative success rate of new applications (i.e. submitted for the first time to the TRP) as compared with that of proposals re-submitted for the same disease component in Round 5 following Category 3 recommendations in one or more previous Rounds. These data show that the chances of success in an application increase in a linear fashion between those CCMs applying for the first time (18% success rate), those applying after one failed application (37% success rate) and those applying after two failed applications (47% success rate). However, once a CCM has experienced three prior failed applications, the success rate in the fourth application drops to 33%. This pattern is entirely consistent with the pattern observed in Round 4, although the number of proposals which had been rejected for the third time prior to the Round 5 review was much higher in Round 5 than in Round 4 (27 vs. 5). These trends suggest that in general, the quality of proposals improves with re-submission, leading to a higher recommendation rate. This is presumably a result of improved technical support from WHO, UNAIDS and other partners in technical assistance in the proposal development phase, as well as fact that applicants are taking into account the comments provided by the TRP on applications classified in category 3 in prior Rounds. However, there remains a significant sub-set of countries that continue to fail in their applications to the GFATM, and the TRP is concerned at this persistent pattern. In

some of these cases, for reasons the TRP cannot comprehend, the applicants appear to repeatedly ignore the TRP's advice and comments on prior applications. In others, there appears to be an ongoing problem of lack of sufficient technical support of adequate quality for these countries. The TRP would like to make a specific recommendation to the Board that the Secretariat work closely with WHO, UNAIDS and other technical partners to assist this important sub-set of applicants in order to ensure successful applications in Round 6.

Figure 7

Success history and learning* for Round 5 proposals



*** This analysis based entirely on CCM applicants**

4.3. Budgets

1. **The total budget for five years for the recommended components amounts to US$ 1.774 billion.** The budget for recommended components for the first 2 years is US$ 726 million. These figures include those components recommended in Category 2B. The budget for Category 2B components alone is US$ 262 million for the full five years, and US$108 million for the first two years. Figure 8 shows the budget requests for the recommended proposals over the full 5 years. Figure 9 shows the budget requests for the recommended proposals, excluding the Category 2B proposals, over the same time period.

Figure 8

Round 5: Budget requests for recommended proposals

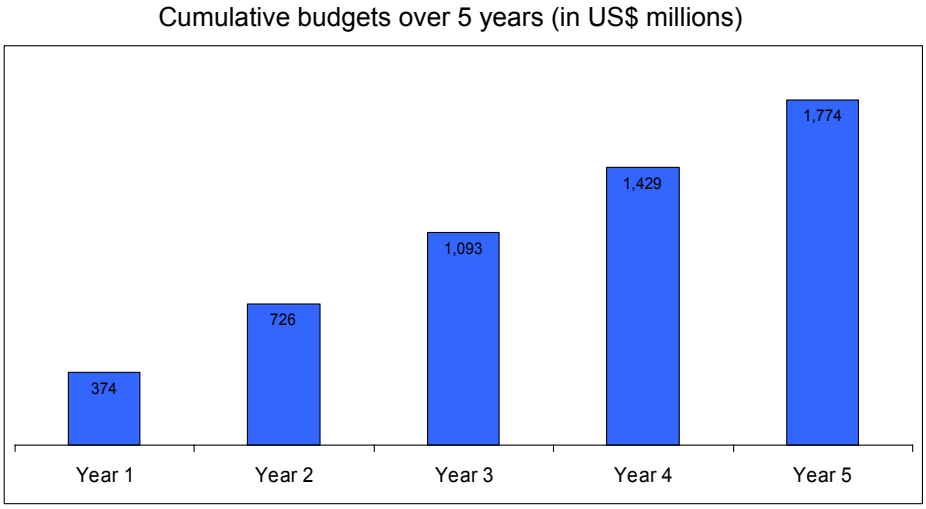
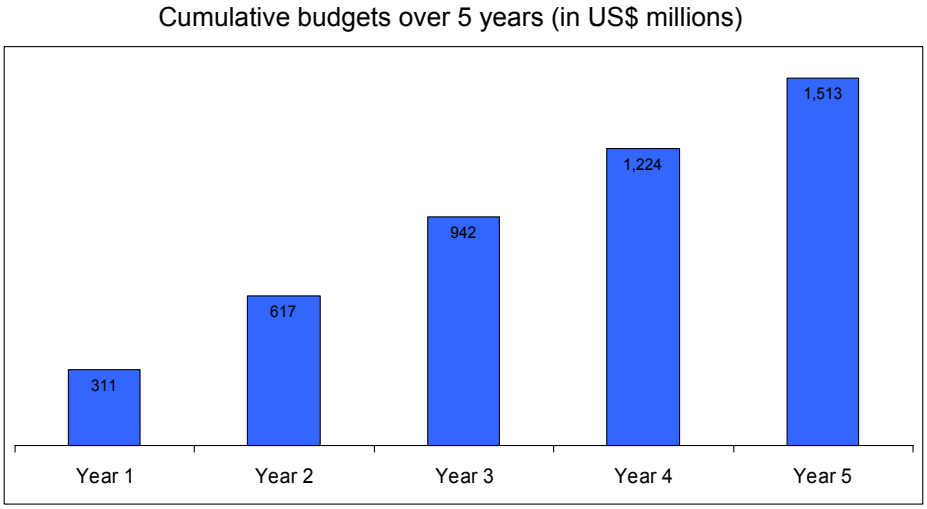


Figure 9

Round 5: Budget Requests for Category 1 and 2 Excluding Category 2B



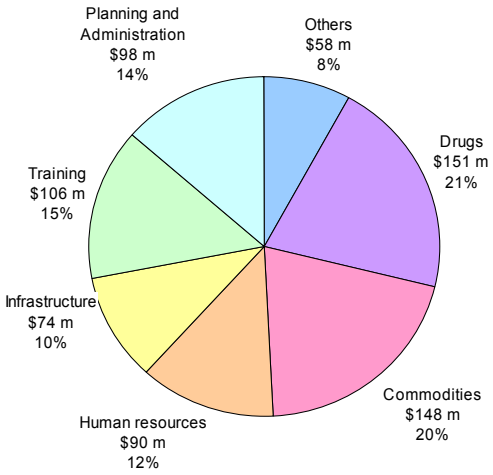
2. Figure 10 shows that 41% of the initial two-year budget is allocated to drugs and commodities, and that human resources (12%) and training (15%) together represent a further 27% of the requested budget for the same period.

Figure 10

Round 5: Budget breakdown for recommended components

Expenditure items for recommended components (in US$ millions)
100%=US$ 726 million (2-year budget)

The budget breakdown shows most funds going to drugs and commodities



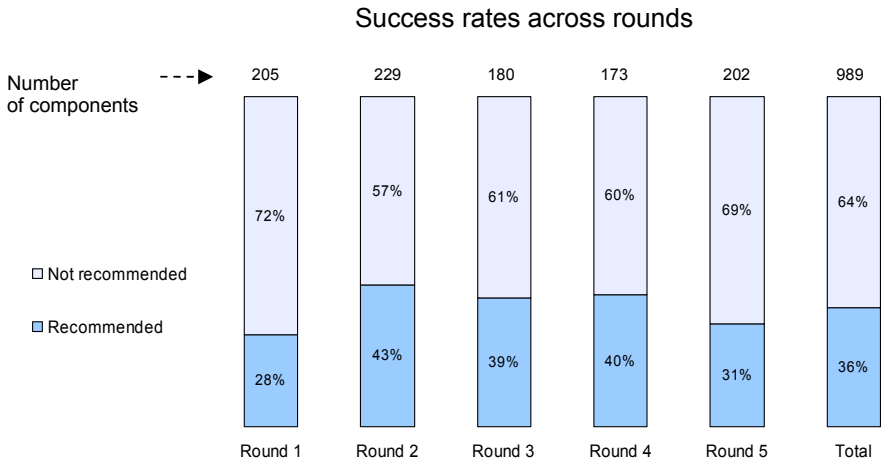
4.4. Comparison of Round 5 with previous Rounds

4.4.1. Overall success rates of proposals

1. Figure 11 shows that the proposals submitted in Round 5 had a lower success rate than the average of the previous four Rounds (31% vs. 40%). The TRP believes that its standards and approach to evaluation of proposals are fully consistent with those of prior Rounds. The only obvious contributing factor to the lower overall success rate in Round 5 was the inclusion of a separate HSS component for the first time in this Round. Eligible HSS components accounted for 14.9% (30/202) of all reviewed components, but these experienced a very low success rate compared to other components (10%, vs. average of 35.3% for the other 3 components). In the absence of the HSS components, the success rate would therefore have been just over 35%. Beyond this factor, the TRP did not identify any meaningful deterioration in the overall quality of proposals, and as noted elsewhere, identified a clear improvement in the quality of TB proposals reviewed in this Round.

Figure 11

Comparison across rounds: success rates



4.4.2. Impact of existing GFATM grants

1. For the first time in Round 5, a large number of applicants already have one or more GFATM grants for the same component, and in many cases, these were Round 3 or Round 4 grants. In addition, the TRP had, again for the first time, the benefit of the detailed Grant Scorecards for countries transitioning from Phase I to Phase II, as well as Fund Portfolio Manager reports and other Secretariat information on the performance of GFATM grants in the applicant countries. The TRP noted the following trends, either alone or in combination, in several of these Round 5 proposals:

1.1 Some proposals were for activities that appeared to be similar to, or to overlap with, the activities under an existing GFATM grant. In many of these cases, however, the Round 5 proposal was found to be very weak in drawing the linkages between the prior grants and the new proposal. The TRP viewed this failure to explain the connections and complementarities (or alternatively, the different focus) between the existing grant/s and the new proposal in a critical light, since it is very difficult to judge the relevance and feasibility of a new proposal without understanding how it relates to existing activities also funded by GFATM. The TRP therefore regarded this as lack of information on the relationship between prior grants and the new proposal as an important technical weakness of the Round 5 proposal.

1.2 Some proposals were from countries that had (often large) Round 3 or 4 grants for the same disease, for which there is still a very limited track record. This is due to the fact that disbursements had only recently begun or had even not yet begun. In these cases, the TRP's major concern was again a technical one – that an existing large grant would already pose a significant challenge the absorptive capacity of the country, and that this would reduce the chances of successful implementation of the proposed Round 5 grant activities. Of course this judgment was made carefully, and on a case-by-case basis, in the context of the other strengths and weaknesses of the proposal, and of other information on the country, where available. In some of these cases, therefore, the TRP took the considered view that it could not justify the awarding of a new grant to a country with an existing early stage grant, often for similar activities, particularly where there were also other significant weaknesses in the existing proposal, as was often the case. However, there were also proposals that the TRP recommended for funding, even where prior grants were still at an early stage, and where the proposed activities were to be partially funded from prior grant funds. These proposals were successful because they explicitly drew the linkages between prior grants and the current proposal, and made specific arguments as to why a new grant was required, how it would add value to the prior grant etc. It is also worth noting that the TRP identified some proposals in which the CCM had not applied in

Round 3 or 4, apparently preferring to wait until there was solid evidence of effective utilization of a Round 1 or Round 2 GFATM grant. The TRP was, naturally, favorably impressed by both the positive track record shown by these countries, and by their considered approach in applying for new GFATM funds.

1.3 Some proposals were from countries with existing GFATM grants from Rounds 1-4, usually for the same component, for which there was evidence of a poor track record on one or more of the prior grants. A poor track record with prior GFATM grants was definitely taken into account by the TRP in its technical judgment about the feasibility and likelihood of effective implementation of the Round 5 grant proposal. This was particularly the case where there was no convincing evidence that the applicant had taken action to improve performance. Poor grant performance was therefore a factor in some of the TRP's decisions not to recommend a Round 5 grant, although it again bears stressing that this was never a factor in isolation, but was considered in the context of the proposal and the country as a whole.

2. It is essential to note that the TRP was at no stage formulaic in its approach to evaluating the impact of existing GFATM grants on decisions to recommend Round 5 proposals. As in all proposals, the TRP is called upon to make a complex and often subtle judgment as to the relevance, feasibility and likelihood of effective implementation of a proposal. Each case was carefully considered on its merits, and in the context of existing GFATM funding within the country. In no case was an application not recommended for funding simply because the country already has a Round 3 or Round 4 grant for the same component. Instead, recommendations against funding were based on a complex set of issues, including problems with the proposal itself, and one (and often more than one) of the factors discussed above in relation to existing grants. The utilization of prior funding was therefore not a disqualifying factor in and of itself, but instead formed an integral element of the TRP's technical judgment on the merit of the proposal.

3. Overall, the TRP takes the firm view that the existence of prior GFATM (or other) grants, and the disbursement history and performance of these the grants cannot be separated from 'technical issues' in considering proposals. Indeed these factors are themselves fundamental to judgments about absorptive capacity, feasibility and likelihood of effective implementation, and are thus themselves intrinsically 'technical issues'.

4. It is arguable that some small number of proposals not recommended for funding in Round 5 might possibly have been recommended for funding in a prior Round, where the proposal would have been considered in the absence of an existing grant/s and/or evidence as to the performance of those grants. But this is a natural development, which the GFATM should anticipate to persist and even to increase in importance as the volume of grants in applicant countries expands. The TRP strongly believes that its approach in taking prior grants into account is completely consistent with the performance-based approach of the GFATM, and that this approach should continue to inform the TRP's judgments in future rounds.

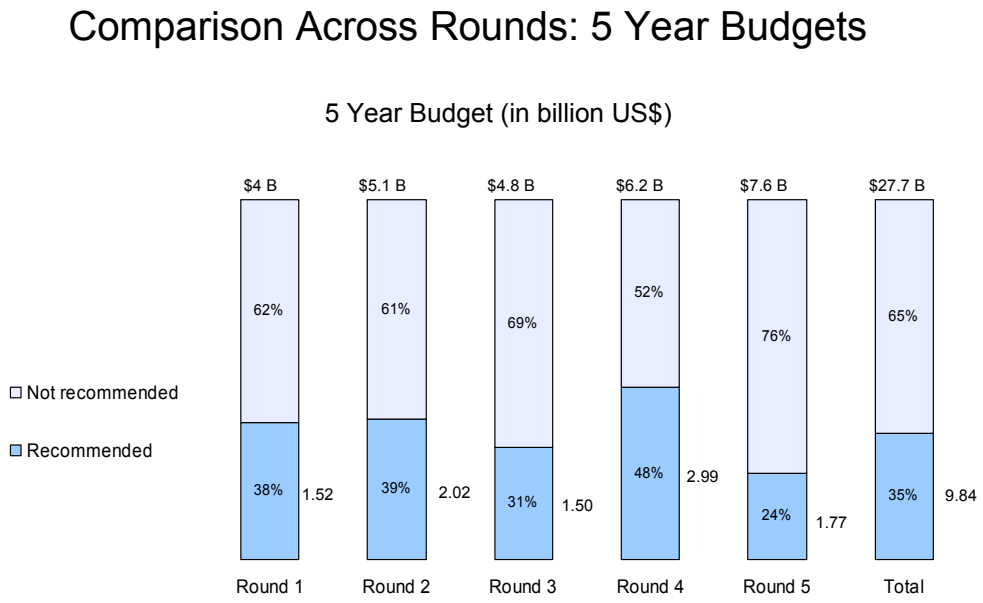
Interestingly, statistical analysis of the results does not show any significant impact of a prior grant or grants on the likelihood of success of an applicant for a Round 5 grant. As the table below shows, having a Round 3 or Round 4 grant did not impact negatively on the success of individual countries in the cases of HIV/AIDS and Malaria components, where the success rate was in fact higher for countries with a prior Round 3 or Round 4 grant than for countries without an existing grant from those Rounds. This is not so the case for TB components, where those with a Round 3 or Round 4 grant had a lower success rate in Round 5 than those without a Round 3 or 4 grant. None of these differences are in fact statistically significant due to small sample sizes, and may therefore be due to chance.

Influence of Prior Grant Status on Success Rates in Round 5			
	No R3 or R4 grant	Any R3 or R4 grant	R3/R4 grant same component

HIV/AIDS	38%	37%	42%
Malaria	25%	22%	26%
TB	59%	39%	50%
All	42%	32%	36%

5. Perhaps most importantly, the TRP feels it important to communicate to applicant countries the importance of taking their own existing grants into account in making subsequent applications to GFATM. Future applications should clearly spell out the linkages between prior grants and the new proposal. In addition, where countries have large existing grants at early stages of implementation, they should earnestly consider deferring applying to GFATM for further funds until there has been more progress with the existing grants. The TRP recommends that clear messaging to this effect be incorporated into Proposal Guidelines for subsequent Rounds.

Figure 12

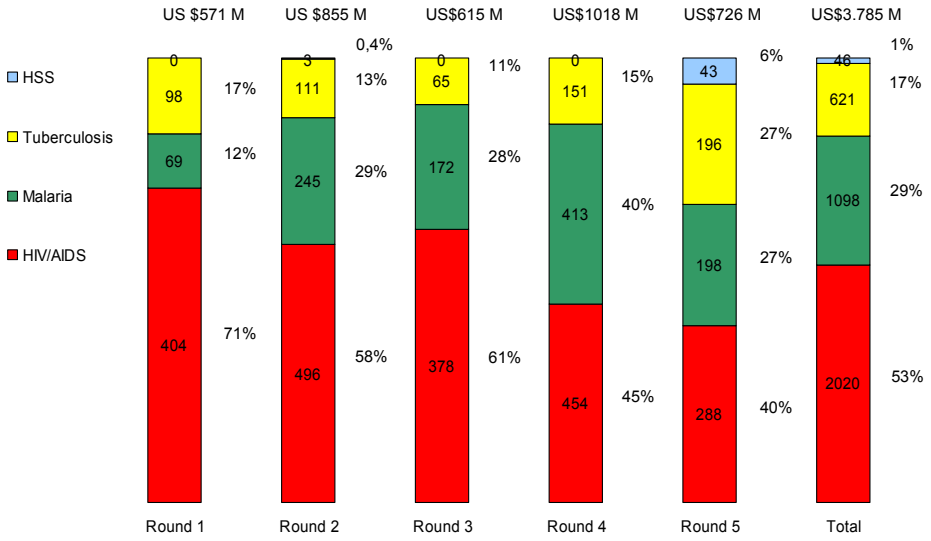


6. Fig. 12 shows that the total five-year budget for recommended proposals in Round 5 (US$ 1,774M) is significantly lower than that of Round 4 (US$ 2.99 B). This difference is largely due to the lower overall success rate in Round 5, discussed above, which resulted in a lower absolute number of approved proposals despite the higher total reviewed (63 approved in Round 5 vs. 72 approved in Round 4). In addition, the average 5 year budget per approved proposal was lower in Round 5 than in Round 4 (US$28.2 million in Round 5 vs. US$41.6 million in Round 4). This latter observation is due to the lower number of applications and recommended components involving substantial scale ups of either ARV programs or malaria control programs, both of which were a significant feature of Round 4.

Figure 13

Comparison across rounds: two-year approved budget by disease component

*Over 50% of funds are going towards HIV/AIDS**

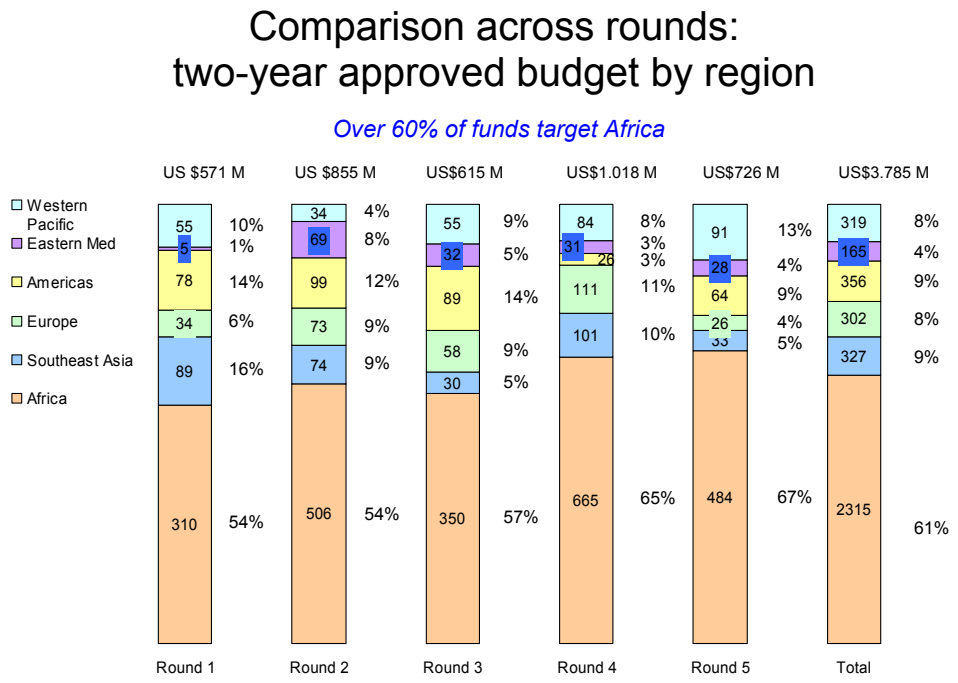


* R1-4 "HIV/TB" grant amounts included in "HIV/AIDS" total. R1-4 "Integrated" grant amounts

7. Figure 13 illustrates the proportion of the total requested two year budget accounted for by each component across all five Rounds. As this demonstrates, HIV/AIDS proposals continue to account for the largest share of the total two year budget, but they account for a lower percentage of the two year budget in Round 5 than the average of the past four rounds (40% in Round 5 vs. 55% in Rounds 1-4). This is explained by the relatively better performance of both TB and malaria proposals in the more recent rounds, as well as by the 6% allocated to HSS proposals in Round 5. Malaria proposals account for 27% of the two year budget, which is the same as the average of the past four Rounds. This is substantially lower than the 40% attributable to malaria in Round 4, which was attributable to the large number of high cost ACT rollout proposals approved in Round 4, of which there were fewer in Round 5. TB components show a substantial increase over the prior Rounds, accounting for 27% of the two year budget in Round 5, which more than double the average of 13% for the prior four Rounds. This is attributable to the higher approval rate of TB components in this Round relative to prior Rounds. The TRP believes that there has been a noticeable improvement in the quality of TB proposals in Round 5 relative to prior Rounds, which explains the higher success rate in this Round. This appears to be due to improved support to applicants from WHO and the Stop TB partnership, as well as other technical partners, and perhaps also to countries taking TRP advice on prior applications into account. On a cumulative basis, Figure 13 shows that HIV/AIDS represents 53% of cumulative two year budgets for all five Rounds, while the corresponding figures for malaria, TB and HSS are 29%, 17% and 1% respectively.

8. Figure 14 shows the distribution of the recommended two year budget by region for Round 5 as well as for the prior Rounds. This shows that 67% of the two year budget in Round 5 was allocated to grants from the Africa region, which is similar to the figure for Round 4 (65%), and higher than the average for the past four Rounds (57.5%). The Western Pacific region also experienced an increase in the share of the total two year budget in Round 5 compared to the average of the past four Rounds (13% in Round 5 vs. 7.75% in past four Rounds). By contrast, the remaining regions all obtained a lower percentage of the total two year budget in this Round compared to the average proportions over the prior four Rounds. In the cases of Southeast Asia and Europe, the proportions are approximately half of the respective averages for the prior four Rounds. The TRP did not identify any obvious causes for these changes in relative proportions allocated to the different regions.

Figure 14



4.5. Summary of Round 5 results

1. 31% of reviewed components were approved in Categories 1 and 2, lower than that of Rounds 2-4 and lower than the average for the past four Rounds. This is mainly due to the lower success rate of HSS proposals
2. Total recommended budget for the Round is US$ 726 million for two years and US$ 1.77 billion for five years. These amounts are both significantly lower than the equivalent amounts for Round 4, due to the lower overall approval rate, smaller number of approved proposals and a lower average budget per approved proposal, with fewer recommended proposals involving large scale ARV and malaria programme roll outs.
3. HIV/AIDS represents 39% of recommended proposals and 40% of the total budget request. Malaria accounts for 21% of recommended proposals and 27% of the total budget request. TB accounts for 35% of recommended proposals and 27% of the total budget request. HSS proposals account for 5% of recommended proposals and 6% of the total budget request.
4. Scaling up of access to antiretroviral drugs remains a significant component of HIV/AIDS proposals, although to a lesser extent than in Round 4. The expected number of new patients accessing treatment through recommended programs ***in Round 5 is 229,000.*** **In Africa approximately 1,293,000 people will have access to ARVs as a result of the cumulative GFATM funding, including Round 5.**
5. Malaria programs had the same success rate as the average for the past four Rounds. The cost of the recommended malaria programs is significantly lower in Round 5 than in Round 4 (US$ 198 M for the first two years in Round 5 vs. US$ 406 M in Round 4) mainly due to fewer large scale ACT roll out proposals in this Round.
6. The doubling of the success rate for TB proposals relative to the average for the past four Rounds was a noteworthy feature of Round 5. This appears to be due to a significant improvement in the quality of TB proposals.

7. Africa represents 67% of recommended funding in Round 5, a similar proportion to previous Rounds. Africa represents 61% of cumulative recommended funding in Rounds 1-5.

8. **Results of Round 5 for five years indicate that approximately 229,000 people will have access to ARVs, 118,500,000 will receive ACT treatment, 17,000,000 will benefit from bed nets, and 1,533,000 will benefit from DOTS and related TB control activities.**

Part 5: Lessons learned and issues for discussion and endorsement by the Board

5.1. Quality and scope of proposals.

1. As in Round 4, Round 5 was characterized by a substantial number of well-written proposals with clear and relevant objectives, reasonable budgets and easy-to-follow work-plans. There were several instances in which proposals that had previously not been recommended for funding were recommended for funding in this Round, indicating that many countries are obtaining support where necessary, and/or are taking into consideration issues raised by the TRP on prior applications.

2. In the view of the TRP, the significant changes to the Proposal Form and Guidelines prior to Round 5 have made a very positive impact on the overall logic, readability and coherence of proposals. The TRP wishes to commend the Board and the Secretariat for these improvements to the Proposal Form and Guidelines, and recommends that these be maintained in their current form, perhaps with some additional changes as suggested below.

3. The TRP was surprised to find that there has not yet been a noticeable trend improvement in the overall quality of proposals reviewed in Round 5 relative to prior Rounds, despite the effect of cumulative experience of several rounds, improved technical support from WHO, UNAIDS and the other technical partners, and the redesigned Proposal Form and Guidelines. Moreover, a significant number of proposals continue to suffer from clearly avoidable weaknesses. Examples of such weaknesses include failure to link the proposal to existing GFATM or other programs, lack of clarity in the strategy and objectives of the proposal, lack of a detailed budget and/or work plan or disconnections between the budget/work plan and the objectives and activities, and unreasonably large or inaccurate budgets. **As noted above, the TRP is concerned by applications which fail to draw the links between the current proposal and existing GFATM funded activities in the country, and although the Proposal Guidelines already emphasize the importance of this point, the TRP recommends that this point be still further emphasized in the Guidelines for Round 6. A similar point applies to links between the proposal and other disease control initiatives in the applicant countries.**

4. The TRP was particularly distressed by the small but important number of countries whose proposals were once again not recommended funding in Round 5, having failed to obtain GFATM funding with similar proposals in two or more prior Rounds. **The TRP recommends that the Secretariat identify this subset of countries and encourages the technical partners to prioritize them for special support in order to address this problem**.

5. The TRP was also concerned by some instances in which countries, for inexplicable reasons, appear to ignore the TRP's advice, often given consistently in two or more prior Rounds, and submit proposals suffering from precisely the same serious defects which prevented them being funded previously. **Once again here it will be important for the Secretariat to identify this subset of countries, and to engage the CCM in discussion in order to avoid these mistakes from being repeated yet again in Round 6.**

6. As noted above, a unique aspect of this Round was the availability of information, from the Secretariat and other sources, on the performance of existing GFATM grants, and in some cases of other funds as well, in the applicant countries. The TRP found this information to be extremely relevant and useful. Where the information on current grants was positive, in that there was evidence of effective utilization of funds, and successful grant performance, this

impacted positively on the TRP's review of the Round 5 proposal. Similarly, where the evidence was less positive, as in either slow disbursement, and/or problems in grant implementation, this evidence tended to impact negatively on the TRP's view of the Round 5 proposal, although such information was never considered in isolation. The TRP's principle concern in interpreting evidence of past performance was with feasibility and absorptive capacity, and in this sense, this approach is entirely consistent with prior approaches of the TRP. The only difference in these cases being that the TRP was now in possession of important information of which it was not previously aware, and/or applicant countries now have sizeable grants which they did not previously have. The TRP also believes that the use of a country's 'track record' in assessing a new proposal is appropriate and entirely consistent with the 'performance based' funding philosophy on which the GFATM is predicated. **The TRP acknowledges the efforts of the GFATM Secretariat in compiling the information available to the TRP on grant performance, and recommends that this approach be continued for subsequent Rounds.**

7. With a few notable exceptions, Round 5 was characterized by fewer applications for large and ambitious scale up programs of antiretroviral therapy. The majority of HIV proposals in this Round were of a more modest nature, perhaps partly as a result of the several large, successful proposals funded in Round 4. The TRP therefore generally did not face the dilemma posed by the very large scale up grants reviewed during Round 4.

8. As in Round 4, the TRP encountered some proposals in this Round which led us to question the current "all or nothing" policy under which an entire proposal may not be recommended for funding if a significant part of it is weak in some respects. As the TRP is, by nature, inclined to give countries the benefit of the doubt, the temptation is always to remove the weaker parts of a proposal, and then to recommend the balance of the proposal for funding. However, after intensive discussion of some specific and complex cases, the TRP decided that, on balance, it would be best to retain the current 'all or nothing' approach. As a result, those proposals with a significant 'weak spot' in an otherwise strong proposal were not recommended for funding. The key reason for this is the concern that once the current approach is changed, there will be no limit to the possibilities of 'cherry-picking' elements out of proposals. This would immeasurably complicate the future work of the TRP, and would also, in our view, lead to poorer judgments in respect of feasibility and effective implementation. It is also the case that introducing a "pick and choose" policy for the TRP would amount to a change in policy for the Fund, involving a shift to becoming more of an agency than a funding mechanism. It is important to stress, in this context, that only proposals where the 'weak spot' was considered material were not recommended for funding.

5.2. Health Systems Strengthening proposals

The low success rate of the HSS proposals reviewed for the first time in Round 5 was noted above. The TRP is concerned by this situation, and debated the causes of this, as well as some possible solutions, in depth during the TRP meeting. The TRP wishes to bring the following observations regarding the HSS proposals to the attention of the Board:

1. The few successful HSS proposals shared many of the typical characteristics of other successful proposals; they were generally focused on a small range of activities, were considered realistic and implementable, and had clearly set out objectives, strategies and activities which were themselves linked to detailed and coherent budgets and work plans. It is noteworthy in this context that one of the five Category 1 proposals in Round 5 was in fact an HSS proposal.

2. The successful proposals each covered quite different aspects of HSS, indicating that the TRP was completely open minded as to the appropriate content of an HSS proposal. For example, one such proposal focused almost entirely on an innovative financing strategy,

while a second focused largely on the human resources aspects of HSS within the applicant country.

3. Many of the unsuccessful proposals demonstrated several of the typical problems of other unsuccessful proposals, including being too broad and ambitious, too vague in their objectives and/or proposed activities, and with poor work plans and/or budgets.

4. In addition to these typical problems, however, the TRP believes that there were specific problems relating to the HSS proposals that contributed to the very low success rate. These include:

   4.1. **The definition of HSS proposals in the Proposal Form and Guidelines was too vague and too broad**, with little guidance to applicants on any specific focus for these proposals. The TRP believes that this was definitely a factor contributing to the large number of broad, vaguely specified and overambitious HSS proposals.

   4.2. **The Proposal Form has been designed for the disease specific components, and is largely unsuitable for the submission of HSS proposals**. For example, the Proposal Form forces many responses which are not relevant to HSS proposals, and requires measurement of impacts that are clearly not appropriate for HSS proposals. Conversely, the Form and Guidelines do not create space for the inclusion of much important information that would assist such proposals. The TRP thus did not have access to critical information on the country's health system, including the existence of SWAps or other financing and donor arrangements, and the detailed human resources situation, all of which are vital to an appropriate assessment of an HSS component.

   4.3. **There has been insufficient consideration given to the impact of inviting separate HSS proposals, while insisting that there be a specific linkage to one or more of the three diseases.** This led to several specific problems identified by the TRP:

      4.3.1. Applicants were not given any specific guidance on what an effective linkage between HSS and a disease component should or could look like. By definition, HSS proposals are broad and general in nature and may not lend themselves to direct and specific linkages with one or more of the three diseases. As a result, in many of the proposals, the linkage between the HSS activities and the diseases was contrived or superficial, and usually not convincing. By contrast, the more convincing proposals made a compelling case for a general, but focused HSS strategy, and argued that this would contribute to the fight against one or more of the diseases in both general and specific ways.

      4.3.2. Applicants were unsure as to whether to include HSS elements only in their HSS proposal, and not in the disease specific proposal, or whether to hedge their bets by including HSS elements in both HSS and disease specific proposals in case only one was successful. It appears that the WHO and perhaps some other agencies specifically advised some countries to include HSS elements in both HSS and disease proposals, as a risk mitigation strategy. This approach had the obvious downside of potential duplication between two successful applications. On the other hand, where countries kept the two proposals entirely separate, the TRP encountered a significant problem in a few cases where the disease component was recommended for funding, but was contingent for successful implementation on resources applied for in an unsuccessful HSS component. **The TRP developed a specific approach here, which was to recommend the successful disease proposal for funding, on condition that the HSS elements required are funded from within the budget of the disease component (in order to be consistent with the principle of not 'cherry picking' elements for funding out of the**

unsuccessful HSS proposals). This is clearly an unsatisfactory and confusing situation that needs to be corrected prior to Round 6.

4.4. **The GFATM System is not currently set up to generate strong HSS proposals, nor to evaluate these effectively.** The TRP is concerned that CCM composition has been built up based on the three diseases, so that many CCMs may lack the expertise to develop (or oversee the development of) strong HSS proposals. Similarly, the GFATM technical partners have developed skills and experience in supporting countries to apply for disease specific proposals, but are still at an early stage in their ability to assist countries to respond effectively to GFATM calls for HSS proposals. It is also not clear that the TRP is itself ideally equipped to evaluate HSS proposals, since evaluating the cross cutting aspects of disease specific proposals and evaluating broad healthcare financing or human resources strategies do not necessarily require the same skills. Co-incidentally, the TRP in Round 5 did have cross cutters with both healthcare financing and human resources skills, but this will require a more systematic TRP selection approach if HSS proposals are to be continued for future Rounds.

5. In summary, while the TRP believes that many of the problems identified in the HSS proposals were typical of other unsuccessful proposals, and may be attributable to lack of experience with this type of proposal, the TRP also believes that the poor quality of these proposals reflects a confusion in the GFATM as to the precise mandate of the Fund in relation to HSS proposals; and that this confusion was reflected in the various problems identified here.

6. **The TRP believes that the Board needs to debate and refine the Fund's mandate in relation to HSS proposals, and should, if possible, clarify all of these issues prior to the Round 6 Call for Proposals. Some key issues and questions which should be debated in this context include:**

   6.1. Whether to retain a separate category of HSS proposals, or to reintegrate these within disease proposals, while making it clear that disease proposals can encompass a broader range of HSS elements than was previously accommodated.
   6.2. Whether or not HSS elements are submitted separately, or within disease proposals, the precise range of HSS elements that GFATM wishes to fund should be carefully defined.
   6.3. Depending on the resolutions achieved on the above issues, other important issues such as appropriate CCM composition, content of Proposal Forms and Guidelines, and TRP composition, will also need to be addressed.

7. While the TRP has debated many of these issues during the Round 5 Review meeting, and certainly has developed thoughts on some of the issues, it naturally does not have ready answers to these difficult and complex questions and problems at this stage. The TRP would however be very willing to work closely with the Secretariat and the Board on these issues, and to assist in any process that is established to resolve these issues prior to Round 6.

5.3. Regional proposals

1. As in Round 4, the TRP once again found that few of the regional proposals were truly able to demonstrate added value beyond what could be carried out within countries themselves. In many cases as well, regional proposals appear to be very expensive, with substantial proportions of the proposed budget allocated to administrative functions, including support for the regional organization/s submitting the proposal. A further problem noted in this Round was that in some cases, 'regions' were constructed opportunistically, by an

organization seeking support from many countries in a region, and cobbling together a proposal with those countries which respond positively. This approach does not lead to natural regional proposals. As a result of these various problems, the success rate of these proposals was low, with only 2 out of 7 (28.5%) reviewed being recommended for funding. It is worth pointing out, however, that where a regional proposal is able to demonstrate added value, these proposals are often strong and innovative, and the TRP is enthusiastic about recommending these few for funding.

2. The TRP therefore recommends to the Board that the Proposal Form and Guidelines for subsequent Rounds should further emphasize that Regional proposals must fully demonstrate added value beyond what can be achieved in individual countries, should be based on natural regions rather than opportunistic collections of countries, and should avoid, wherever possible, inflated budgets with excessive administrative costs.

5.4. Private sector

As in prior Rounds, a relatively small number of all proposals considered In Round 5 involved meangful participation by private companies in the activities proposed for funding. The role of the private sector therefore remains a disappointing aspect of Global Fund proposals over all five Rounds, and will require further attention by the Board and the Secretariat if this is to be adequately addressed.

5.5. Role of prior GFATM grants in future applications

1. As noted in detail above, this was the first Round in which the existence of prior GFATM grants impacted in a meaningful way on the TRP's decisions. In addition to the general point that existing early stage grants raised significant questions about feasibility and absorptive capacity, the TRP identified some other problematic patterns in this Round. In some cases, countries applied to Round 5 for activities that were due to be funded by Phase 2 of a prior grant and indicated that should they be successful in this Round, they would not apply for Phase 2 funding of the prior Round grant. This appears to be an effort to circumvent the performance based funding approach of the GFATM, and the TRP did not recommend any of these proposals for funding for this reason. In other cases, countries had identified that their funding from a prior grant would run out in 2007 or 2008, and applied for funding in Round 5, with a proposed delayed start date in order to dovetail with the prior funding. While these cases were more complex, in some of them the TRP felt that it was inappropriate to tie up scarce GFATM funds for some years, and that these countries should re-apply at a subsequent Round, when they would be able to implement a start date as soon as all conditions were met. These various observations suggest that more detailed guidance is required for countries on the relationship between existing grants and new applications.

2. The TRP therefore recommends to the Board that it develop some specific guidelines on the following issues, and perhaps other related ones, and that these be included in the Proposal Guidelines for Round 6:

2.1 Countries should not apply for funds to replace funding already budgeted in a prior GFATM grant, including in the Phase 2 of such a grant.

2.2 Countries should not apply for grants with a start date delayed more than a defined time period (perhaps 3 months) after signature of the grant agreement.

2.3 Perhaps countries should not apply for a new grant for the same disease for which they have a current grant unless there is already a minimum demonstrated level of implementation of that grant. This could perhaps be defined in terms of either time lapsed since start date, or number of disbursements, or percentage disbursement or

some combination of these. This restriction should apply even where countries are applying for funding for different activities to those funded under the prior grant, since this is not sufficient rationale to recommend further funding when a current grant is at a very early stage (due to concerns regarding absorptive capacity, amongst others). Obviously, where there are compelling reasons to override such an approach, the TRP would consider these, but applicants should in these cases recognize that that they need to provide a clear and persuasive motivation for their approach, which should be considered an exception to a general rule.

5.6 Clarifications by GFATM Secretariat Prior to TRP Review

1. As in prior Rounds, the GFATM Secretariat appears to have worked energetically to assist applicants to ensure that complete applications are received, in order to ensure that they are screened in for review by the TRP. In a substantial proportion of all proposals reviewed, this clarification process appears to have been extensive, with numerous contacts between Secretariat staff and the CCM, in which Secretariat staff either request missing components of the proposal and/or ask questions or request missing information from the proposal. Some typical queries appear to relate to:

- Composition of CCM and absent signatures
- Missing elements of the proposal
- Problems with tables, budgets and work plans

2. While the TRP appreciates the intense and committed work involved in the Secretariat clarification process prior to the TRP review, it has some concerns about this process and about the way in which the resulting information is provided to the TRP. These can be summarized as follows:

2.1 The TRP is concerned that the Secretariat, in some cases, made 'too much' effort to ensure a complete proposal for review. Where a CCM has submitted a very incomplete proposal, this is, in itself, an important indicator of likely success of the grant. This is particularly the case where the TRP is relying only on a 'paper' proposal, without the benefit of detailed country knowledge. If the Secretariat plays too great a role in assisting in completing the proposal form, then this creates the risk that the TRP is reviewing a proposal that does not, in reality, reflect the ability of the country to compile an adequate proposal to GFATM. The TRP is aware that the opposite situation can also be the case, namely that CCMs can simply obtain the services of strong external consultants to write a good proposal that does not reflect the reality of the situation in the applicant country. While this will always be a risk, the TRP believes that the problem of a weak proposal (whether or not assisted by consultants), which is subsequently enhanced through Secretariat assistance, is more of a problem and needs to be considered and addressed.

2.2 The format for presenting clarified information to the TRP in Round 5 was highly problematic. Where such clarifications had taken place, the TRP was provided with often very large volumes of email correspondence, with no intelligent interpretation at all. This resulted in substantial wastage of time and frustration, combing through voluminous email correspondence, which was often duplicated. In most cases, this was not at all helpful, and in fact obstructed the work of the TRP.

3. The TRP recommends that the Board consider the following recommendations in relation to the proposal clarification process that occurs between receipt of proposals and the time of the TRP review:

3.1 The Board should consider a policy whereby a limited number of interactions between the Secretariat and the applicant CCM and/or a limited time period is allowed

for clarifications and submission of missing parts of a proposal. A specific proposal would be that a proposal must be closed for further clarifications and correspondence after the earlier of either 4 communications from the Secretariat or 4 weeks after receipt of the initial proposal in the Secretariat. While these specific parameters are obviously open to debate, the TRP feels strongly about the principle behind this recommendation.

3.2 The Secretariat should not provide the TRP with the entire history of email correspondence between the applicant and the Secretariat. Instead, the whole clarification process should be summarized as briefly as possible, showing only the final results and how these are to be added to the proposal for review by the TRP. For example, where the clarifications have concerned inconsistencies in budget tables, the TRP should see only a revised, final set of tables and should be instructed that these should replace those in the original proposal.

5.7 GFATM Secretariat Screening of Proposals as Eligible for TRP Review

1. Once the clarifications process outlined above is complete, an internal Secretariat panel reviews the proposals for eligibility for TRP review. The TRP has the following observations to make in regard to this screening process and the way its results are communicated to the TRP:

1.1 The Secretariat Panel is currently taking the decision on eligibility in relation to CCM composition and signatures. The TRP accepts that this is the appropriate approach. However, where there have been clarifications or debates on the issue of CCM eligibility, this was not coherently provided to the TRP. Instead, the TRP had to work through extensive email correspondence as noted above.

1.2 The Screening process continued right up to and throughout the duration of the TRP review meeting, with Secretariat staff working with applicant countries to obtain missing components, CCM signatures etc until the penultimate day of the TRP review meeting. The TRP regards this as unfair to those applicants who had less chance for this type of interaction with the Secretariat for whatever reason. It also disrupted planning for TRP reviews, requiring continual reshuffling of proposals scheduled for review on particular days, since outstanding materials were still expected.

1.3 In the TRP's view, some incorrect screening in decisions were made, since many proposals reviewed continued to be incomplete, with significant sections either completely missing or so weak as to suggest that they should not be screened in, in the first place.

2. The TRP recommends that the Board consider the following in relation to the Screening process by the GFATM Secretariat:

2.1 The Secretariat should continue to make judgments on eligibility in relation to CCM composition and signatures. The Secretariat should provide a cover note to each proposal regarding its deliberations and decisions in this regard. This could vary from a simple indication that the CCM meets all criteria, to a more complex note, indicating issues that have arisen and reviewed, and the basis for the Secretariat's decision to screen the proposal in as eligible for review, notwithstanding the various issues concerning the CCM. This will save the TRP substantial time and effort.

2.2 There should be a defined cut-off date for the end of the Screening process, and no proposals should be screened in after that date. This would be consistent with the approach taken on limiting the time and extent of clarifications, as proposed above. At a minimum, the TRP would recommend that all Screening must be completed by the last working day before the TRP review meetings begins.

2.3 The criteria for the Secretariat screening should be more explicit, transparent and in the TRP's view, should also be more rigorous. Where whole sections of a proposal

are either missing or significantly incomplete, and these cannot be addressed through the limited clarification process suggested above, proposals should be screened out. Proposals with these problems never succeed in being recommended for funding, and screening them in results in wastage of TRP review time.

5.8 Provision of Proposal Materials to the TRP

1. For the Round 5 review meeting, the Secretariat provided the TRP with printed copies of each proposal as is customary. In some cases, possibly those which were submitted using the PDF format, parts of the printed copies were hard to read, usually due to dark shading etc. In addition, unlike in previous rounds, the Secretariat did not have on hand a hard copy of all of the attachments submitted with the proposal. These were available electronically, having been scanned in. However, there was no systematic way by which TRP reviewers were made aware of attachments available for each proposal. Reviewers therefore had to make specific requests of the Secretariat staff in order to identify relevant attachments. These comments do not apply to critical attachments such as work plans and budgets, but rather to background documents such as Strategic Plans etc.

2. The TRP recommends the following procedure during Round 6:

2.1 TRP reviewers should be provided with one or more CD Roms containing the full electronic version of proposals for review, as well as all supporting documentation submitted by the country, and background information from the Secretariat, WHO, UNAIDS and other agencies (see below). At the same time, there should be adequate printing facilities, allowing TRP reviewers to print whatever materials they require during the review process.

2.2 Reviewers should also be provided with a hard copy of the main proposal to be reviewed in each case. Prior to duplication, these hard copies should be reviewed for legibility by Secretariat staff and any problems addressed prior to duplication.

5.9 Translation of Proposals

1. Some number of proposals are translated into English prior to the TRP review. This translation is carried out in Geneva. In several cases during Round 5, TRP reviewers felt that an uneven standard of translation of proposals had possibly been prejudicial to the applicants. Specifically, there seem to be several instances where translation of budget and work plan tables was poor, with the translators concentrating on translation of text, but not taking care to transcribe details of numbers into the tables. Where possible, TRP reviewers went back to the original proposals to check for discrepancies between the original proposal and the translated version, and where these were identified, the proposal was not prejudiced in the TRP review.

2. The TRP recommends that the Secretariat make best efforts to ensure a very high standard of translation for future rounds, including insisting that the translators accurately transcribe all budget tables, work plans and other elements, including figures and data, and not only text.

5.10 Background Information provided to the TRP by GFATM Secretariat

1. Information provided by the GFATM Secretariat included:
- Prior TRP review forms where applicants had submitted previously
- Detailed Grant Performance Scorecards, where available

- Summary sheets containing data on existing grants, where there was no Grant Performance Scorecard
- World Bank Aides Memoire on applicant countries, where these were available

2. The Grant Performance scorecards were found to be very helpful. The current version of the Fund Portfolio Manager Report was found to be less useful, partly due to an inadequate design (for which the TRP takes responsibility) and partly due to these reports being incomplete or very superficially compiled in some cases. The World Bank Aides Memoire were only available in a minority of proposals, but were universally found to be very informative and helpful. Due to some logistical problems, there were many cases in which not all of this background information was systematically provided to TRP members with each proposal for review, and TRP members had to spend some time with the support staff requesting the additional information.

3. As in prior Rounds, TRP members had occasion to contact Fund Portfolio Managers with specific questions regarding proposals from countries within their portfolio. The more systematic information provided to the TRP during this Round has reduced the need for this kind of contact. However, there will continue to be occasions where specific issues or questions need to be clarified, and the TRP values and appreciates the input of GFATM staff with detailed knowledge of the situation in applicant countries.

4. The TRP Chair and senior secretariat staff spent a great deal of time correcting and standardizing basic grant related and demographic and economic information inserted by TRP members at the top of the standard review form. It would be more efficient, and lead to a better and more standardized TRP review form, if these elements were completed by the Secretariat prior to the TRP meeting.

5. The TRP would thus recommend the following in relation to information provided by the GFATM Secretariat:

5.1 All available background information, including the items listed above, should be made available to TRP reviewers on a systematic basis, for every proposal reviewed.

5.2 Where detailed Grant Scorecards are not available, a more detailed report than was provided in Round 5 would be very useful. This should provide as much information as possible that is available, and should perhaps be based on the Grant Scorecard as a template. It is important to the TRP that Fund Portfolio Managers take seriously the task of compiling this report.

5.3 Perhaps more effort could be made in obtaining World Bank Aides Memoire for as many applicant countries as are available.

5.4 In addition, the Secretariat should make efforts to obtain country specific reports from the other agencies, where these are available.

5.5 The TRP should continue to have access to Fund Portfolio Managers and Cluster Leaders during the review meeting, in order to address specific questions not covered by the background information.

5.6 The Secretariat should consider providing the TRP with a pre filled in TRP review form for each proposal to be reviewed; information related to the applicant country, size of grant, prior grant history and basic demographic and economic information should ideally be provided in a standardized format. This would allow TRP reviewers to concentrate fully on the substance of the review itself.

5.11 Background Information provided to the TRP by WHO, UNAIDS and other agencies

1. WHO, UNAIDS and the other agencies provided a combination of country fact sheets summarizing latest available information, as well as recent publications for reference by TRP members. The TRP found the Country fact sheets to be highly useful in Round 5, and would like to thank the agencies for their efforts in this regard. TRP disease experts found some, but not all, of the detailed reference publications to be of value. UNAIDS and some of the other agencies also kindly provided contact details for disease experts who were on stand-by to answer questions from TRP members during the two week review process. Whereas the TRP has drawn on this resource in prior Rounds, TRP members utilized this kind offer to a lesser extent during Round 5. On reflection, this was felt to be due to the superior level of detailed background information available to the TRP during this Round.

2. The TRP recommends the following in relation to information provided by the WHO, UNAIDS and other agencies:

2.1 The TRP very much appreciates the updated country fact sheets, and would recommend that they be compiled again in Round 6.

2.2 The TRP will provide specific feedback from its disease experts, to the agencies concerned, on which of the detailed reference publication were and were not found to be helpful. This will hopefully assist in a more focused effort in this regard for Round 6.

2.3 The TRP would appreciate the availability of disease specific expertise that could be called upon from the agencies during the course of the Round 6 review. Given the fact that this was utilized to a lesser during Round 5, it is hoped that this kind of stand by assistance can be offered at no inconvenience to our colleagues in WHO, UNAIDS and the other agencies.

5.12 Briefing meetings with WHO, UNAIDS, UNICEF and other agencies

1. As is customary, the TRP was briefed on the first day of the meeting by the WHO, UNAIDS, UNICEF, the STOP TB partnership and RBM. On this occasion, we experimented with separate briefings for disease experts and the cross cutters, followed by a plenary session. While the TRP sincerely appreciates the efforts of our senior colleagues in the Agencies in making themselves available for these briefings, the experience of the TRP during these briefings was mixed; the cross cutters did not feel that they had benefited in any meaningful way from the WHO briefing on Health Systems Strengthening; on the other hand, the disease experts did feel that the disease specific briefings were helpful in identifying key issues in current thinking and matters that the agencies believed the experts should be aware of during their reviews. In general, the TRP believes that the parallel session approach is superior to a single plenary briefing, since it provides more time for in depth discussion.

2. The TRP acknowledges its own role in ensuring that these briefings meet the needs of TRP reviewers, and will work once again with WHO, UNAIDS and the other partners to improve on these briefings for Round 6. It is also worth noting that the problem with Health Systems strengthening was perhaps attributable mainly to the very broad and amorphous definition of HSS during this Round, which made it hard for the TRP to work with WHO to narrow its briefing to matters of relevance to the TRP in its review.

5.13 Logistical support during the TRP Review Meeting

As noted above, the logistical support provided to the TRP during the Round 5 review meeting was outstanding in all respects. This includes organization and logistics of accommodation of TRP members and meeting rooms, provision of information to TRP members for review, information technology (IT) support and general secretarial support. The TRP wishes to acknowledge the effort of all members of the Secretariat who were involved in the support to the Round 5 review.

5.14 External Review of the TRP

As Board members are aware, the GFATM is currently conducting a review of the TRP and related processes, under the auspices of TERG. The TRP agreed to allow a senior consultant from EuroHealth, which is conducting the review, to observe 3 plenary sessions, as well as to interview members of the TRP individually and in groups during the TRP review meeting. The TRP found the consultant, David Wilkinson, to be highly professional in his approach, and did not experience his presence in the plenary sessions or in interviews to be disruptive in any way. We look forward to the outcome of the review, and hope that the TRP will be able to learn from it as to how to improve the rigor of its processes and outcomes.

5.15. Participation of Secretariat Staff in Plenary Sessions

1. In Round 5, as in prior Rounds, the TRP agreed that GFATM portfolio management staff could observe plenary sessions on the understanding that strict confidentiality will be maintained, and that neither the content of discussions nor decisions taken by the TRP will be disclosed to outside parties. In the past, there have been significant leakages of information from the TRP prior to distribution of the TRP recommendations to the Board, and the need for strict confidentiality was therefore stressed again to Secretariat staff and reinforced by signature of a confidentiality agreement by all staff attending the plenary sessions in Round 5.

2. Unfortunately, these requests and precautions have yet again proved ineffective in Round 5, and there have once again been significant leakages of information to outside parties, concerning both decisions and the content of TRP discussions. The TRP regards these breaches of confidentiality in the most serious light, and fully expects that the Board would take the same view. It is obvious that the TRP as a body, and its individual members are at serious risk of compromise should the content of internal TRP discussions be divulged. Similarly, the TRP's recommendations should remain entirely confidential between the time of the TRP review meeting and the distribution of the TRP recommendations to the Board.

3. The TRP recommends that the GFATM Secretariat identify means of tightening up on the confidentiality of the TRP's recommendations between the time of the end of the Review meeting and the time of submission to the Board.

5.16. TRP Membership and Process

5.16. 1. Renewal of TRP

1. Newly appointed members of the TRP for Round 5 TRP have all performed excellently. This again highlights the value of the improved recruitment process. As noted below, The TRP will require new members for Round 6.

2. As the pool of alternates and members of the Support Group is now quite thin in most areas, the TRP recommends that the Portfolio committee embark on an effort to increase the number of candidates available for selection to the TRP. Past experience has shown that the best candidates are those nominated by senior colleagues in the

various agencies, or by existing TRP members. The TRP would therefore strongly recommend that the Portfolio Committee work actively to secure a large number of nominations from such sources, rather than by advertising for applications in the press, since this latter exercise did not, as a rule, elicit strong candidates.

5.16.2 Chair and Vice-Chair of TRP

1. The TRP has elected Peter Godfrey-Faussett (AIDS Expert, United Kingdom) as its Vice Chair. He will serve as Vice Chair in Round 6, and will thereafter serve as TRP chair for Rounds 7 and 8.
2. **The TRP requests that the Board extends the TRP membership term of Peter Godfrey Faussett from the standard four terms to six terms, since he will already have served four terms when he assumes the Chair of the TRP in Round 7.**

5.16.3. Experts leaving the TRP

1. Kasia Malinowska Sempruch will be leaving the TRP having served four rounds. She will need to be replaced by a new HIV/AIDS expert on the TRP.
2. Giancarlo Majori will be leaving the TRP, having also served four Rounds, and will need to be replaced by a Malaria expert.
3. David Peters has indicated that he will not be available to serve a fourth Round. He will need to be replaced by a cross cutting expert.

4. The TRP would like to acknowledge the outstanding contribution of all three of these departing members, and to thank them most sincerely for their commitment and effort on behalf of the TRP.

5.16.4 Numbers of TRP members in various categories

1. Round 5 was characterized by a higher number of TB and Malaria proposals than reviewed in prior Rounds. While the numbers of TB and Malaria experts on the TRP was sufficient to allow for in depth review of the numbers of proposals in prior Rounds, these experts were put under some strain during Round 5 due to the increased number of proposals. In addition, the inclusion for the first time, of the HSS component, and the need to review 29 of these proposals, placed significant strain on the cross cutting experts, since they had to serve as primary reviewers of the HSS proposals as well as secondary reviewers of the disease specific proposals. The Chair of the TRP served as a back up reviewer for all HSS proposals, but this is not a sustainable solution.

2. The TRP therefore recommends that the Board consider an increase in the size of the TRP by appointing 4 new alternate members (1 alternate in each category), and that the Chair and Vice Chair of the TRP be given the discretion on whether to draft in one or more of these extra alternates to serve for each Round, depending on the number of applications received in each category for the Round in question. The Chair and Vice Chair of the TRP would be required to use the opportunity of appointing extra members of the TRP judiciously, with the aim of retaining the current size of the TRP unless the number and distribution of proposals justifies increased membership.

5.16.5 Need for an expert on Nutrition

1. An increasing number of proposals contain elements requesting funding for nutritional interventions. These require a high level of nutritional expertise. Fortunately, the TRP currently has one member with significant expertise in this area, but this is mere coincidence. The TRP does need to have such expertise within its ranks, and measures should be put in place now to ensure that such expertise is available in the alternate and support pool.

2. **The TRP recommends that, as part of the TRP replenishment process, efforts be made to identify one or more AIDS experts and/or cross cutters with specific nutritional expertise. The Chair and Vice Chair of the TRP should then ensure that in each Round, there is at least one member of the TRP with sufficient expertise in this area.**

5.17 Proposal Form and Guidelines

1. As noted above, the TRP felt that the Proposal Form and Guidelines were improved substantially relative to prior Rounds, and that this made a significant positive impact on the proposals reviewed.
2. **The TRP recommends that the Proposal Form and Guidelines remain in essentially the same format as used for Round 5, but that the following areas be considered for further improvement and emphasis:**
3. **The Guidelines should further emphasize the importance of drawing linkages between the current proposal, and existing GFATM grants (as well as other funding).**
4. **The definition of counterpart financing needs to be further tightened up and a specific, correct mathematical formula provided. Many applicants continue to use various definitions for this, and to provide incorrect ratios due to confusion in the definition and calculation.**
5. **The Guidelines should also provide guidance on the specific conditions under which CCMs may apply for a new grant, when there are already one or more GFATM grants in the country.**
6. **The Proposal Form and Guidelines should request that no completed tables or text boxes be shaded, due to problems with printing.**
7. **The Guidelines should state that GFATM funding will not be allocated for funding of disease programs other than AIDS, TB and Malaria. A few of the Malaria proposals reviewed in Round 5 included requests for funding for anti-helminthics against Filiariasis, to be distributed within Malaria control campaigns. While the TRP recognized the synergies of these approaches from a logistical perspective, there is no scientific evidence that treatment of Filiariasis has any positive impact on malaria morbidity or mortality. Unless there is a specific directive to the TRP from the Board that such interventions should be funded, the TRP will continue to decline such requests, and the Guidelines should be explicit on this.**
8. **Applications for pools of funds for subsequent allocation to multiple recipients: Several proposals in Round 5 suggested the establishment of a small fund, within the country, that would allocate funds to either NGOs, private sector groups or others, to conduct specific activities. While the TRP is supportive of this general concept, it cannot recommend these for funding in the absence of substantial detail on the governance mechanisms, methods of selecting recipients, methods of monitoring recipients etc. The TRP views these proposals much as it views the broader proposal in relation to allocation of funds to PRs and SRs. Thus, future guidelines should specify that where CCMs are proposing the use of pools of funds for later allocation,**

the governance mechanisms and other related issues identified here should be specified in great detail.

9. **Several malaria proposals were noted to lack clarity as to the precise geographical distribution of the malaria problem/s within the applicant country, and as to the relevant control measures to be applied in each geographical zone. The Malaria experts on the TRP therefore recommend that the guidelines for Round 5 require malaria proposals to include a map detailing the geographical distribution of the malaria problem and the corresponding control measures.**

5.18 Publication of strong proposals on GFATM Website

1. In order to assist applicants in developing strong proposals, the TRP suggests that the Board consider a policy of highlighting a few of the very strong proposals on the GFATM website after each Round. This would have the effect of demonstrating proposals that meet all or most of the TRP's criteria, and thus might be a useful adjunct to countries and technical advisors. One approach to this would be to highlight the Category 1 proposals after each Round.

Annex II : List of components reviewed in Round V, classified by category

No.	Proposal ID	Source	Country and World Bank Classification	WHO Region	Component	BUDGET		
						Requested Yr 1	Total 2 Years	Total 5 Years
Category 1						**$25,194,809**	**$43,310,437**	**$98,935,651**
1	38	CCM	Azerbaijan (Lower-middle)	EUR	Tuberculosis	$1,493,514	$3,825,770	$9,516,200
2	77	CCM	Ghana (Low)	AFR	Tuberculosis	$8,987,907	$14,547,546	$31,471,844
3	108	CCM	Guinea (Low)	AFR	Tuberculosis	$2,055,814	$3,391,501	$6,225,144
4	17	CCM	Namibia (Lower-middle)	AFR	Tuberculosis	$4,343,668	$7,222,753	$17,777,383
5	21	CCM	Rwanda (Low)	AFR	HSS	$8,313,906	$14,322,867	$33,945,080
Category 2						**$348,892,938**	**$682,305,751**	**$1,675,566,895**
6	149	CCM	Afghanistan (Low)	EMR	Malaria	$7,825,177	$17,093,334	$32,214,069
7	72	CCM	Albania (Lower-middle)	EUR	HIV/AIDS	$1,224,908	$2,502,858	$4,990,645
8	72	CCM	Albania (Lower-middle)	EUR	Tuberculosis	$480,732	$877,685	$1,442,028
9	183	CCM	Armenia (Lower -Middle)	EUR	Tuberculosis	$2,010,730	$3,898,656	$7,624,135
10	29	CCM	Bangladesh (Low)	SEAR	Tuberculosis	$5,235,919	$10,003,984	$45,977,231
11	107	CCM	Benin (Low)	AFR	HIV/AIDS	$10,199,338	$19,709,054	$51,841,972
12	96	CCM	Bosnia Herzegovina (Lower-middle)	EUR	HIV/AIDS	$2,606,801	$4,832,387	$11,042,257
13	52	CCM	Botswana (upper-middle)	AFR	Tuberculosis	$4,005,231	$5,515,900	$8,956,258
14	129	CCM	Brazil (Lower-middle)	AMR	Tuberculosis	$5,028,280	$11,602,427	$27,240,000
15	73	CCM	Burundi (Low)	AFR	HIV/AIDS	$7,616,818	$13,053,866	$32,353,173
16	36	CCM	Cambodia (Low)	WPR	HIV/AIDS	$8,365,984	$16,292,779	$34,963,654
17	36	CCM	Cambodia (Low)	WPR	HSS	$841,400	$1,841,600	$5,015,741
18	36	CCM	Cambodia (Low)	WPR	Tuberculosis	$1,608,109	$3,268,750	$9,662,024
19	41	CCM	Cameroon (Low)	AFR	HIV/AIDS	$2,635,774	$4,943,590	$12,060,019
20	41	CCM	Cameroon (Low)	AFR	Malaria	$7,205,278	$12,695,885	$21,210,595
21	105	CCM	China (Lower-middle)	WPR	HIV/AIDS	$6,196,600	$12,544,128	$28,902,074
22	105	CCM	China (Lower-middle)	WPR	Tuberculosis	$7,822,000	$17,814,000	$52,889,000
23	105	CCM	China (Lower-middle)	WPR	Malaria	$10,758,696	$20,096,149	$39,410,395
24	83	Non-CCM	Cote D'Ivoire (Low)	AFR	HIV/AIDS	$1,910,193	$3,522,695	$3,522,695
25	106	CCM	Democratic Republic of Congo (Low)	AFR	Tuberculosis	$8,064,136	$17,613,606	$43,716,984
26	71	CCM	East Timor (Low)	SEAR	HIV/AIDS	$2,329,960	$4,304,454	$9,110,302
27	116	CCM	Eritrea (Low)	AFR	HIV/AIDS	$7,197,365	$13,139,010	$33,892,005
28	56	CCM	Ethiopia (Low)	AFR	Malaria	$40,803,871	$64,548,913	$150,066,528
29	137	CCM	Gabon (Upper-Middle)	AFR	Malaria	$1,204,799	$4,013,170	$15,932,460
31	77	CCM	Ghana (Low)	AFR	HIV/AIDS	$13,194,330	$31,630,830	$97,099,610
32	110	CCM	Haiti (Low)	AMR	HIV/AIDS	$9,591,082	$19,205,567	$49,927,069
33	61	CCM	Indonesia (Lower-middle)	SEAR	Tuberculosis	$7,268,936	$18,587,491	$69,434,776
34	30	CCM	Jordan (Lower-middle)	EMR	Tuberculosis	$533,800	$1,072,864	$2,782,864
35	74	CCM	Kenya (Low)	AFR	Tuberculosis	$4,360,602	$7,913,655	$19,917,127
36	104	CCM	Kyrgyzstan (Low)	EMR	Malaria	$933,345	$1,692,390	$3,426,125
37	76	CCM	Lesotho (Low)	AFR	HIV/AIDS	$4,546,708	$10,013,383	$40,346,059
38	53	CCM	Macedonia (Lower-middle)	EUR	Tuberculosis	$925,949	$1,442,489	$3,071,097
39	194	CCM	Malawi (Low)	AFR	HIV/AIDS	$3,175,015	$7,770,655	$19,104,775
40	194	CCM	Malawi (Low)	AFR	HSS	$12,143,782	$26,965,524	$65,429,986
41	109	CCM	Mauritania (Low)	AFR	HIV/AIDS	$3,564,790	$6,584,973	$15,755,931
42	20	CCM	Mongolia (Low)	WPR	HIV/AIDS	$1,085,448	$1,898,775	$4,235,640
43	113	CCM	Montenegro (Lower-middle)	EUR	HIV/AIDS	$963,012	$1,604,606	$2,924,696
57	191	RCM	Mozambique (low), South Africa (lower-mid	AFR	Malaria	$2,204,030	$6,501,141	$21,232,348
44	140	CCM	Niger (Low)	AFR	Malaria	$2,879,546	$5,148,600	$10,491,196
45	140	CCM	Niger (Low)	AFR	Tuberculosis	$4,064,840	$6,326,070	$12,220,815
46	78	CCM	Nigeria (Low)	AFR	HIV/AIDS	$19,753,385	$46,424,283	$180,642,512
47	78	CCM	Nigeria (Low)	AFR	Tuberculosis	$9,905,263	$19,217,311	$53,351,149
49	172	CCM	Peru (Lower-middle)	AMR	HIV/AIDS	$5,752,802	$9,874,896	$12,967,865
50	172	CCM	Peru (Lower-middle)	AMR	Tuberculosis	$13,265,844	$21,017,537	$32,545,545
51	147	CCM	Philippines (Lower-middle)	WPR	HIV/AIDS	$1,319,769	$3,011,919	$6,478,058
52	147	CCM	Philippines (Lower-middle)	WPR	Malaria	$7,161,436	$11,097,529	$14,308,637
53	90	CCM	Republic of Congo (Low)	AFR	HIV/AIDS	$5,513,593	$12,043,407	$45,553,763
54	68	Non-CCM	Russian Federation (Lower-middle)	EUR	HIV/AIDS	$1,757,444	$3,774,826	$12,190,713
55	21	CCM	Rwanda (Low)	AFR	Malaria	$16,412,756	$28,140,772	$39,649,363
56	133	CCM	Sao Tome & Principe (Low)	AFR	HIV/AIDS	$337,015	$584,218	$1,485,190
48	155	RCM	Solomon Islands (Low), Vanuatu (Lower-m	WPR	Malaria	$2,088,573	$3,269,731	$6,623,560
58	213	Sub-CCM	Sudan (Low)	EMR	Tuberculosis	$3,749,017	$8,592,197	$27,568,526
59	19	CCM	Suriname (Lower-middle)	AMR	HIV/AIDS	$1,600,000	$2,600,000	$4,400,000
60	18	CCM	Tajikistan (Low)	EUR	Malaria	$1,425,218	$2,772,001	$5,383,510
30	94	CCM	The Gambia (Low)	AFR	Tuberculosis	$1,744,338	$2,561,327	$5,032,929
61	48	CCM	Zimbabwe (Low)	AFR	HIV/AIDS	$15,996,545	$35,931,159	$62,478,891
62	48	CCM	Zimbabwe (Low)	AFR	Malaria	$9,779,800	$21,217,469	$29,998,400
63	48	CCM	Zimbabwe (Low)	AFR	Tuberculosis	$6,716,826	$10,087,276	$13,471,926
Recommended Proposals					**TOTALS**	**$374,087,747**	**$725,616,188**	**$1,774,502,546**

Category 3						$1,228,665,251	$2,266,242,296	$5,096,656,571
64	149	CCM	Afghanistan (Low)	EMR	HIV/AIDS	$2,192,824	$4,663,653	$10,953,024
65	149	CCM	Afghanistan (Low)	EMR	HSS	$1,040,580	$1,980,090	$4,014,470
66	192	CCM	Angola (Low)	AFR	Malaria	$20,596,862	$39,227,228	$115,827,277
67	38	CCM	Azerbaijan (low middle income)	EUR	Malaria	$1,645,887	$3,179,532	$7,255,952
68	29	CCM	Bangladesh (Low)	SEAR	HIV/AIDS	$3,614,794	$8,135,641	$23,901,394
69	29	CCM	Bangladesh (Low)	SEAR	Malaria	$8,908,324	$18,478,606	$36,993,988
70	103	CCM	Belarus (low middle income)	EUR	Tuberculosis	$6,941,845	$13,239,086	$26,389,516
71	107	CCM	Benin (Low)	AFR	HSS	$3,834,884	$6,560,978	$12,130,576
72	107	CCM	Benin (Low)	AFR	Malaria	$3,383,023	$10,714,920	$52,930,467
73	107	CCM	Benin (Low)	AFR	Tuberculosis	$1,922,754	$3,575,918	$7,793,321
74	96	CCM	Bosnia Herzegovina (low middle income)	EUR	Tuberculosis	$615,710	$1,171,290	$3,157,230
75	47	CCM	Burkina Faso (Low)	AFR	Malaria	$2,700,120	$19,208,881	$27,152,602
76	47	CCM	Burkina Faso (Low)	AFR	HIV/AIDS	$17,637,616	$34,432,357	$71,569,383
77	47	CCM	Burkina Faso (Low)	AFR	HSS	$2,851,720	$5,845,718	$9,170,885
78	73	CCM	Burundi (Low)	AFR	HSS	$1,159,864	$2,370,296	$6,566,203
79	73	CCM	Burundi (Low)	AFR	Malaria	$6,529,400	$12,215,162	$25,401,464
80	36	CCM	Cambodia (Low)	WPR	Malaria	$3,652,267	$5,854,119	$11,824,545
81	25	CCM	Cape Verde (low middle income)	AFR	HIV/AIDS	$2,094,560	$4,313,270	$11,659,200
82	138	CCM	Central African Republic (Low)	AFR	HIV/AIDS	$9,537,181	$22,082,191	$36,632,357
83	138	CCM	Central African Republic (Low)	AFR	Malaria	$4,193,853	$7,598,940	$11,990,390
84	26	CCM	Chad (Low)	AFR	Malaria	$11,046,651	$17,335,833	$36,713,126
85	122	CCM	Colombia (low middle income)	AMR	HIV/AIDS	$4,710,531	$13,338,388	$29,356,545
86	154	CCM	Comoros (Low)	AFR	Malaria	$2,437,690	$4,110,188	$7,727,600
89	67	CCM	Cote D'Ivoire (Low)	AFR	HIV/AIDS	$11,802,856	$26,836,531	$47,022,390
90	67	CCM	Cote D'Ivoire (Low)	AFR	Malaria	$3,949,776	$7,897,631	$20,272,415
95	106	CCM	Democratic Republic of Congo (Low)	AFR	HSS	$11,463,137	$17,947,453	$40,244,494
96	106	CCM	Democratic Republic of Congo (Low)	AFR	Malaria	$11,553,980	$21,184,713	$38,608,576
94	106	CCM	Democratic Republic of Congo (Low)	AFR	HIV/AIDS	$39,244,134	$60,848,374	$142,154,402
91	171	CCM	Djibouti (Low-middle)	EMR	Malaria	$1,238,000	$2,344,000	$5,113,000
92	171	CCM	Djibouti (Low-middle)	EMR	Tuberculosis	$2,913,194	$4,819,773	$10,704,374
93	120	CCM	Dominican Republic (Low-middle)	AMR	Malaria	$2,847,074	$5,368,399	$11,914,220
97	23	CCM	Ecuador (Low-middle)	AMR	Malaria	$3,010,896	$4,097,749	$4,097,749
98	32	CCM	Egypt (Low-middle)	EMR	HIV/AIDS	$1,138,633	$2,185,934	$6,201,772
99	32	CCM	Egypt (Low-middle)	EMR	Tuberculosis	$2,387,910	$4,588,252	$11,085,278
100	118	CCM	El Salvador (Low-middle)	AMR	Malaria	$300,000	$1,100,000	$3,000,000
101	75	CCM	Equatorial Guinea (Low)	AFR	Malaria	$6,813,492	$12,906,111	$25,999,072
102	116	CCM	Eritrea (Low)	AFR	HSS	$4,163,775	$7,697,965	$14,435,485
103	116	CCM	Eritrea (Low)	AFR	Malaria	$6,238,196	$8,844,992	$17,200,208
104	116	CCM	Eritrea (Low)	AFR	Tuberculosis	$799,888	$1,443,404	$3,879,324
105	56	CCM	Ethiopia (Low)	AFR	HIV/AIDS	$9,561,462	$23,145,990	$64,497,352
106	56	CCM	Ethiopia (Low)	AFR	HSS	$89,941,484	$159,999,343	$348,014,355
107	56	CCM	Ethiopia (Low)	AFR	Tuberculosis	$6,298,360	$16,440,576	$69,882,371
108	197	CCM	Georgia (Low-middle)	EUR	HIV/AIDS	$2,245,640	$2,797,640	$4,654,240
109	197	CCM	Georgia (Low-middle)	EUR	HSS	$303,820	$436,320	$814,320
110	77	CCM	Ghana (Low)	AFR	HSS	$7,041,051	$12,552,761	$19,359,341
111	65	CCM	Guatemala (Low-middle)	AMR	Tuberculosis	$3,175,791	$5,826,331	$11,623,999
112	108	CCM	Guinea (Low)	AFR	Malaria	$1,546,679	$3,467,563	$18,987,568
113	159	CCM	India (Low)	SEAR	Malaria	$7,378,045	$14,742,454	$26,448,410
114	159	CCM	India (Low)	SEAR	Tuberculosis	$3,360,000	$7,410,000	$25,020,000
115	61	CCM	Indonesia (Low-middle)	SEAR	HIV/AIDS	$6,362,819	$13,671,879	$26,117,640
116	61	CCM	Indonesia (Low-middle)	SEAR	Malaria	$28,274,347	$43,145,932	$66,543,849
117	178	CCM	Iran (Low-middle)	EMR	Malaria	$5,500,000	$8,500,000	$18,600,000
118	30	CCM	Jordan (Low-middle)	EMR	HIV/AIDS	$1,949,204	$3,588,958	$6,899,718
119	43	CCM	Kazakhstan (Low-middle)	EUR	HIV/AIDS	$1,037,925	$2,000,295	$4,814,539
120	43	CCM	Kazakhstan (Low-middle)	EUR	Tuberculosis	$6,254,293	$8,375,651	$17,558,542
121	74	CCM	Kenya (Low)	AFR	HIV/AIDS	$5,093,344	$8,893,681	$19,796,832
122	74	CCM	Kenya (Low)	AFR	HSS	$5,218,944	$11,179,083	$28,076,553
123	74	CCM	Kenya (Low)	AFR	Malaria	$2,431,600	$4,230,600	$8,427,600
124	195	CCM	Kosovo (Lower-middle)	EUR	HIV/AIDS	$916,019	$1,701,158	$3,687,350
125	104	CCM	Kyrgyzstan (Low)	EMR	Tuberculosis	$4,152,835	$5,309,127	$8,863,698
126	87	CCM	Liberia (Low)	AFR	HIV/AIDS	$6,660,742	$12,394,177	$25,714,627
127	87	CCM	Liberia (Low)	AFR	HSS	$9,259,919	$14,078,615	$17,374,573
128	87	CCM	Liberia (Low)	AFR	Malaria	$9,093,452	$15,015,748	$33,165,706
129	87	CCM	Liberia (Low)	AFR	Tuberculosis	$2,389,679	$4,750,966	$11,949,773
130	100	CCM	Madagascar (Low)	AFR	HIV/AIDS	$4,755,041	$9,512,412	$24,957,422
131	100	CCM	Madagascar (Low)	AFR	HSS	$1,927,505	$4,965,759	$22,599,312
132	100	CCM	Madagascar (Low)	AFR	Malaria	$3,610,220	$7,974,500	$33,470,801
133	100	CCM	Madagascar (Low)	AFR	Tuberculosis	$4,248,611	$8,900,519	$15,249,703
134	111	CCM	Mali (Low)	AFR	HSS	$5,594,359	$7,083,766	$11,600,785
135	111	CCM	Mali (Low)	AFR	Malaria	$7,707,216	$14,862,149	$36,069,482
136	132	CCM	Mozambique (Low)	AFR	HSS	$35,300,000	$72,100,000	$106,600,000
137	132	CCM	Mozambique (Low)	AFR	Malaria	$16,552,180	$32,694,480	$73,121,487
138	17	CCM	Namibia (Low)	AFR	HIV/AIDS	$17,177,265	$31,341,874	$91,950,544
139	17	CCM	Namibia (Low)	AFR	Malaria	$8,966,116	$13,136,240	$21,897,490
140	97	CCM	Nepal (Low)	SEAR	HIV/AIDS	$3,249,718	$7,717,233	$25,788,007
141	97	CCM	Nepal (Low)	SEAR	Malaria	$3,273,707	$5,352,822	$11,372,370
142	97	CCM	Nepal (Low)	SEAR	Tuberculosis	$2,008,298	$3,858,926	$9,481,273
143	140	CCM	Niger (Low)	AFR	HSS	$6,050,220	$7,529,467	$11,474,188
144	78	CCM	Nigeria (Low)	AFR	HSS	$28,765,338	$39,505,341	$64,812,236
145	78	CCM	Nigeria (Low)	AFR	Malaria	$28,987,617	$52,404,797	$179,995,004
148	40	CCM	Pakistan (Low)	EMR	HIV/AIDS	$6,340,070	$13,000,477	$34,989,566
149	40	CCM	Pakistan (Low)	EMR	Malaria	$5,986,615	$11,293,294	$27,059,519
150	40	CCM	Pakistan (Low)	EMR	Tuberculosis	$11,274,942	$15,854,040	$30,308,701
151	27	CCM	Papua New Guinea (Low)	WPR	Tuberculosis	$655,914	$1,975,954	$10,784,888
152	172	CCM	Peru (Lower-middle)	AMR	HSS	$3,437,174	$6,894,200	$17,011,200
153	147	CCM	Philippines (Lower-middle)	WPR	Tuberculosis	$5,755,004	$14,208,812	$45,817,584
87	90	CCM	Republic of Congo (Low)	AFR	Malaria	$10,556,503	$17,664,123	$28,331,791
88	90	CCM	Republic of Congo (Low)	AFR	Tuberculosis	$3,201,591	$4,669,340	$8,138,467
154	21	CCM	Rwanda (Low)	AFR	HIV/AIDS	$20,676,946	$36,053,491	$88,300,796
146	155	RCM	Samoa (Lower-middle), Cook Islands (), Fi	WPR	HIV/AIDS	$1,997,480	$4,251,406	$9,946,332
147	155	RCM	Samoa (Lower-middle), Cook Islands (), Fi	WPR	Tuberculosis	$619,564	$1,466,940	$4,432,060
155	58	CCM	Senegal (Low)	AFR	Tuberculosis	$5,119,146	$8,725,379	$18,336,573
156	201	CCM	Serbia (Lower-middle)	EUR	HIV/AIDS	$2,590,715	$4,755,306	$8,462,528
157	114	Non-CCM	Somalia (Low)	EMR	HSS	$602,540	$1,175,365	$2,832,730
158	114	Non-CCM	Somalia (Low)	EMR	Malaria	$1,052,908	$2,567,445	$14,532,272
159	80	CCM	South Africa (Lower-middle)	AFR	HIV/AIDS	$20,329,000	$45,010,000	$108,289,000
160	80	CCM	South Africa (Lower-middle)	AFR	HSS	$10,928,000	$21,851,000	$42,173,000

161	95	CCM	Sri Lanka (Lower-middle)	SEAR	Malaria	$3,360,822	$4,356,374	$7,290,124
162	95	CCM	Sri Lanka (Lower-middle)	SEAR	Tuberculosis	$855,915	$1,700,680	$4,414,795
163	79	CCM	Sudan (Low)	EMR	HIV/AIDS	$14,734,532	$29,424,335	$112,553,275
164	79	CCM	Sudan (Low)	EMR	Malaria	$12,171,250	$24,019,599	$46,323,995
165	213	Sub-CCM	Sudan (Low)	EMR	HSS	$8,722,153	$25,929,249	$68,455,557
166	79	CCM	Sudan (Low)	EMR	Tuberculosis	$4,019,309	$6,830,013	$15,410,468
167	115	CCM	Tanzania (Low)	AFR	HIV/AIDS	$1,281,564	$9,204,276	$11,932,883
168	115	CCM	Tanzania (Low)	AFR	HSS	$13,146,048	$22,869,642	$34,866,750
169	123	CCM	Tanzania Zanzibar (Low)	AFR	HIV/AIDS	$6,319,553	$12,722,287	$30,817,709
170	176	CCM	Thailand (Low)	SEAR	HIV/AIDS	$2,829,263	$5,920,079	$16,886,287
171	94	CCM	The Gambia (Low)	AFR	HIV/AIDS	$5,982,592	$7,842,275	$14,733,869
172	94	CCM	The Gambia (Low)	AFR	Malaria	$11,441,939	$18,169,122	$40,473,141
173	93	CCM	Tunisia (Lower-middle)	EMR	HIV/AIDS	$5,485,200	$10,007,400	$20,898,000
174	64	CCM	Uganda (Low)	AFR	HIV/AIDS	$798,648	$5,857,397	$17,746,651
175	64	CCM	Uganda (Low)	AFR	HSS	$2,883,333	$5,605,994	$10,942,316
176	64	CCM	Uganda (Low)	AFR	Malaria	$44,915,692	$49,494,235	$90,219,700
177	69	CCM	Vietnam (Low)	WPR	HIV/AIDS	$3,400,000	$6,500,000	$20,000,000
178	69	CCM	Vietnam (Low)	WPR	Tuberculosis	$4,146,735	$7,037,112	$18,718,344
179	136	CCM	Yemen (Low)	EMR	Malaria	$8,260,845	$15,889,956	$41,763,366
180	49	CCM	Zambia (Low)	AFR	HIV/AIDS	$258,404,000	$481,308,000	$1,033,420,000
181	49	CCM	Zambia (Low)	AFR	HSS	$4,246,000	$11,042,000	$34,940,000
182	49	CCM	Zambia (Low)	AFR	Malaria	$14,096,000	$22,147,000	$41,200,000
183	49	CCM	Zambia (Low)	AFR	Tuberculosis	$49,305,000	$98,610,000	$246,525,000
Category 4						**$164,339,764**	**$306,210,534**	**$750,510,205**
184	183	CCM	Armenia (Lower-middle)	EUR	Malaria	$1,082,800	$1,705,100	$2,572,700
185	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	HIV/AIDS	$48,709,605	$66,831,110	$127,046,138
186	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	Malaria	$10,730,000	$16,564,000	$29,779,000
187	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	Tuberculosis	$8,050,000	$12,702,000	$23,507,000
188	32	CCM	Egypt (Lower-middle)	EMR	Malaria	$1,440,000	$2,380,000	$5,000,000
189	159	CCM	India (Low)	SEAR	HIV/AIDS	$30,269,037	$67,620,403	$217,625,981
190	88	CCM	Maldives (Lower-middle)	SEAR	HIV/AIDS	$1,293,913	$2,016,601	$4,184,665
191	40	CCM	Pakistan (Low)	EMR	HSS	$5,316,000	$9,977,880	$26,617,490
192	117	CCM	Paraguay (Lower-middle)	AMR	HIV/AIDS	$2,482,549	$3,941,134	$9,429,262
193	102	RO	Benin (Low), Cote d'Ivoire (Low), Ethiopia (	AFR	HIV/AIDS	$8,656,316	$17,304,394	$44,804,606
194	125	RO	Costa Rica, El Salvador (Lower-middle), G	AMR	HIV/AIDS	$5,183,540	$13,859,280	$30,722,300
195	84	RO	Ghana (Low), Uganda (Low), Zimbabwe (L	AFR	HSS	$8,541,288	$16,363,767	$36,318,213
196	58	CCM	Senegal (Low)	AFR	HSS	$1,510,645	$2,321,013	$3,384,233
197	58	CCM	Senegal (Low)	AFR	Malaria	$6,268,535	$8,251,057	$12,117,141
198	62	RCM	Bangladesh (Low), Bhutan (Low), India (Lo	SEAR	HIV/AIDS	$5,280,000	$15,464,067	$59,842,897
199	95	CCM	Sri Lanka (Lower-middle)	SEAR	HIV/AIDS	$1,713,862	$2,607,594	$5,357,285
200	79	CCM	Sudan (Low)	EMR	HSS	$15,900,000	$42,800,000	$105,860,000
201	196	CCM	Turkey (Lower-middle)	EUR	Malaria	$1,349,740	$2,387,990	$4,784,490
202	196	CCM	Turkey (Lower-middle)	EUR	Tuberculosis	$561,934	$1,113,144	$1,556,804
Total 2 year Recommended Budget:							**$725,616,188**	
Total 5 year Recommended Budget:								**$1,774,502,546**

Annex II : List of components reviewed in Round V, classified by category with 2B

No.	Proposal ID	Source	Country and World Bank Classification	WHO Region	Component	BUDGET		
						Requested Yr 1	Total 2 Years	Total 5 Years
Category 1						**$25,194,809**	**$43,310,437**	**$98,935,651**
1	38	CCM	Azerbaijan (Lower-middle)	EUR	Tuberculosis	$1,493,514	$3,825,770	$9,516,200
2	77	CCM	Ghana (Low)	AFR	Tuberculosis	$8,987,907	$14,547,546	$31,471,844
3	108	CCM	Guinea (Low)	AFR	Tuberculosis	$2,055,814	$3,391,501	$6,225,144
4	17	CCM	Namibia (Lower-middle)	AFR	Tuberculosis	$4,343,668	$7,222,753	$17,777,383
5	21	CCM	Rwanda (Low)	AFR	HSS	$8,313,906	$14,322,867	$33,945,080
Category 2						**$285,447,237**	**$574,147,144**	**$1,413,674,870**
6	149	CCM	Afghanistan (Low)	EMR	Malaria	$7,825,177	$17,093,334	$32,214,069
7	72	CCM	Albania (Lower-middle)	EUR	HIV/AIDS	$1,224,908	$2,502,858	$4,990,645
8	72	CCM	Albania (Lower-middle)	EUR	Tuberculosis	$480,732	$877,685	$1,442,028
9	29	CCM	Bangladesh (Low)	SEAR	Tuberculosis	$5,235,919	$10,003,984	$45,977,231
10	107	CCM	Benin (Low)	AFR	HIV/AIDS	$10,199,338	$19,709,054	$51,841,972
11	96	CCM	Bosnia Herzegovina (Lower-middle)	EUR	HIV/AIDS	$2,606,801	$4,832,387	$11,042,257
12	52	CCM	Botswana (upper-middle)	AFR	Tuberculosis	$4,005,231	$5,515,900	$8,956,258
13	129	CCM	Brazil (Lower-middle)	AMR	Tuberculosis	$5,028,280	$11,602,427	$27,240,000
14	36	CCM	Cambodia (Low)	WPR	HIV/AIDS	$8,365,984	$16,292,779	$34,963,654
15	36	CCM	Cambodia (Low)	WPR	Tuberculosis	$1,608,109	$3,268,750	$9,662,024
16	41	CCM	Cameroon (Low)	AFR	HIV/AIDS	$2,635,774	$4,943,590	$12,060,019
17	41	CCM	Cameroon (Low)	AFR	Malaria	$7,205,278	$12,695,885	$21,210,595
18	105	CCM	China (Lower-middle)	WPR	HIV/AIDS	$6,196,600	$12,544,128	$28,902,074
19	105	CCM	China (Lower-middle)	WPR	Tuberculosis	$7,822,000	$17,814,000	$52,889,000
20	105	CCM	China (Lower-middle)	WPR	Malaria	$10,758,696	$20,096,149	$39,410,395
21	83	Non-CCM	Cote D'Ivoire (Low)	AFR	HIV/AIDS	$1,910,193	$3,522,695	$3,522,695
22	106	CCM	Democratic Republic of Congo (Low)	AFR	Tuberculosis	$8,064,136	$17,613,606	$43,716,984
23	71	CCM	East Timor (Low)	SEAR	HIV/AIDS	$2,329,960	$4,304,454	$9,110,302
24	116	CCM	Eritrea (Low)	AFR	HIV/AIDS	$7,197,365	$13,139,010	$33,892,005
25	137	CCM	Gabon (Upper-Middle)	AFR	Malaria	$1,204,799	$4,013,170	$15,932,460
26	77	CCM	Ghana (Low)	AFR	HIV/AIDS	$13,194,330	$31,630,830	$97,099,610
27	110	CCM	Haiti (Low)	AMR	HIV/AIDS	$9,591,082	$19,205,567	$49,927,069
28	61	CCM	Indonesia (Lower-middle)	SEAR	Tuberculosis	$7,268,936	$18,587,491	$69,434,776
29	30	CCM	Jordan (Lower-middle)	EMR	Tuberculosis	$533,800	$1,072,864	$2,782,864
30	104	CCM	Kyrgyzstan (Low)	EUR	Malaria	$933,345	$1,692,390	$3,426,125
31	76	CCM	Lesotho (Low)	AFR	HIV/AIDS	$4,546,708	$10,013,383	$40,346,059
32	53	CCM	Macedonia (Lower-middle)	EUR	Tuberculosis	$925,949	$1,442,489	$3,071,097
33	194	CCM	Malawi (Low)	AFR	HIV/AIDS	$3,175,015	$7,770,655	$19,104,775
34	194	CCM	Malawi (Low)	AFR	HSS	$12,143,782	$26,965,524	$65,429,986
35	109	CCM	Mauritania (Low)	AFR	HIV/AIDS	$3,564,790	$6,584,973	$15,755,931
36	20	CCM	Mongolia (Low)	WPR	HIV/AIDS	$1,085,448	$1,898,775	$4,235,640
37	113	CCM	Montenegro (Lower-middle)	EUR	HIV/AIDS	$963,012	$1,604,606	$2,924,696
38	140	CCM	Niger (Low)	AFR	Malaria	$2,879,546	$5,148,600	$10,491,196
39	140	CCM	Niger (Low)	AFR	Tuberculosis	$4,064,840	$6,326,070	$12,220,815
40	78	CCM	Nigeria (Low)	AFR	HIV/AIDS	$19,753,385	$46,424,283	$180,642,512
41	78	CCM	Nigeria (Low)	AFR	Tuberculosis	$9,905,263	$19,217,311	$53,351,149
42	172	CCM	Peru (Lower-middle)	AMR	HIV/AIDS	$5,752,802	$9,874,896	$12,967,865
43	172	CCM	Peru (Lower-middle)	AMR	Tuberculosis	$13,265,844	$21,017,537	$32,545,545
44	147	CCM	Philippines (Lower-middle)	WPR	HIV/AIDS	$1,319,769	$3,011,919	$6,478,058
45	147	CCM	Philippines (Lower-middle)	WPR	Malaria	$7,161,436	$11,097,529	$14,308,637
46	90	CCM	Republic of Congo (Low)	AFR	HIV/AIDS	$5,513,593	$12,043,407	$45,553,763
47	21	CCM	Rwanda (Low)	AFR	Malaria	$16,412,756	$28,140,772	$39,649,363
48	213	Sub-CCM	Sudan (Low)	EMR	Tuberculosis	$3,749,017	$8,592,197	$27,568,526
49	19	CCM	Suriname (Lower-middle)	AMR	HIV/AIDS	$1,600,000	$2,600,000	$4,400,000
50	94	CCM	The Gambia (Low)	AFR	Tuberculosis	$1,744,338	$2,561,327	$5,032,929
51	48	CCM	Zimbabwe (Low)	AFR	HIV/AIDS	$15,996,545	$35,931,159	$62,478,891
52	48	CCM	Zimbabwe (Low)	AFR	Malaria	$9,779,800	$21,217,469	$29,998,400
53	48	CCM	Zimbabwe (Low)	AFR	Tuberculosis	$6,716,826	$10,087,276	$13,471,926
Category 2B						**$63,445,701**	**$108,158,607**	**$261,892,025**
54	183	CCM	Armenia (Lower -Middle)	EUR	Tuberculosis	$2,010,730	$3,898,656	$7,624,135
55	73	CCM	Burundi (Low)	AFR	HIV/AIDS	$7,616,818	$13,053,866	$32,353,173
56	36	CCM	Cambodia (Low)	WPR	HSS	$841,400	$1,841,600	$5,015,741
57	56	CCM	Ethiopia (Low)	AFR	Malaria	$40,803,871	$64,548,913	$150,066,528
58	74	CCM	Kenya (Low)	AFR	Tuberculosis	$4,360,602	$7,913,655	$19,917,127
59	191	RCM	Mozambique (low), South Africa (lower-mid	AFR	Malaria	$2,204,030	$6,501,141	$21,232,348
60	68	Non-CCM	Russian Federation (Lower-middle)	EUR	HIV/AIDS	$1,757,444	$3,774,826	$12,190,713
61	133	CCM	Sao Tome & Principe (Low)	AFR	HIV/AIDS	$337,015	$584,218	$1,485,190
62	155	RCM	Solomon Islands (Low), Vanuatu (Lower-m	WPR	Malaria	$2,088,573	$3,269,731	$6,623,560
63	18	CCM	Tajikistan (Low)	EUR	Malaria	$1,425,218	$2,772,001	$5,383,510
Recommended Proposals					**TOTALS**	**$374,087,747**	**$725,616,188**	**$1,774,502,546**

Category 3						$1,228,665,251	$2,266,242,296	$5,096,656,571
64	149	CCM	Afghanistan (Low)	EMR	HIV/AIDS	$2,192,824	$4,663,653	$10,953,024
65	149	CCM	Afghanistan (Low)	EMR	HSS	$1,040,580	$1,980,090	$4,014,470
66	192	CCM	Angola (Low)	AFR	Malaria	$20,596,862	$39,227,228	$115,827,277
67	38	CCM	Azerbaijan (low middle income)	EUR	Malaria	$1,645,887	$3,179,532	$7,255,952
68	29	CCM	Bangladesh (Low)	SEAR	HIV/AIDS	$3,614,794	$8,135,641	$23,901,394
69	29	CCM	Bangladesh (Low)	SEAR	Malaria	$8,908,324	$18,478,606	$36,993,988
70	103	CCM	Belarus (low middle income)	EUR	Tuberculosis	$6,941,845	$13,239,086	$26,389,516
71	107	CCM	Benin (Low)	AFR	HSS	$3,834,884	$6,560,978	$12,130,576
72	107	CCM	Benin (Low)	AFR	Malaria	$3,383,023	$10,714,920	$52,930,467
73	107	CCM	Benin (Low)	AFR	Tuberculosis	$1,922,754	$3,575,918	$7,793,321
74	96	CCM	Bosnia Herzegovina (low middle income)	EUR	Tuberculosis	$615,710	$1,171,290	$3,157,230
75	47	CCM	Burkina Faso (Low)	AFR	Malaria	$2,700,120	$19,208,881	$27,152,602
76	47	CCM	Burkina Faso (Low)	AFR	HIV/AIDS	$17,637,616	$34,432,357	$71,569,383
77	47	CCM	Burkina Faso (Low)	AFR	HSS	$2,851,720	$5,845,718	$9,170,885
78	73	CCM	Burundi (Low)	AFR	HSS	$1,159,864	$2,370,296	$6,566,203
79	73	CCM	Burundi (Low)	AFR	Malaria	$6,529,400	$12,215,162	$25,401,464
80	36	CCM	Cambodia (Low)	WPR	Malaria	$3,652,267	$5,854,119	$11,824,545
81	25	CCM	Cape Verde (low middle income)	AFR	HIV/AIDS	$2,094,560	$4,313,270	$11,659,200
82	138	CCM	Central African Republic (Low)	AFR	HIV/AIDS	$9,537,181	$22,082,191	$36,632,357
83	138	CCM	Central African Republic (Low)	AFR	Malaria	$4,193,853	$7,598,940	$11,990,390
84	26	CCM	Chad (Low)	AFR	Malaria	$11,046,651	$17,335,833	$36,713,126
85	122	CCM	Colombia (low middle income)	AMR	HIV/AIDS	$4,710,531	$13,338,388	$29,356,545
86	154	CCM	Comoros (Low)	AFR	Malaria	$2,437,690	$4,110,188	$7,727,600
89	67	CCM	Cote D'Ivoire (Low)	AFR	HIV/AIDS	$11,802,856	$26,836,531	$47,022,390
90	67	CCM	Cote D'Ivoire (Low)	AFR	Malaria	$3,949,776	$7,897,631	$20,272,415
95	106	CCM	Democratic Republic of Congo (Low)	AFR	HSS	$11,463,137	$17,947,453	$40,244,494
96	106	CCM	Democratic Republic of Congo (Low)	AFR	Malaria	$11,553,980	$21,184,713	$38,608,576
94	106	CCM	Democratic Republic of Congo (Low)	AFR	HIV/AIDS	$39,244,134	$60,848,374	$142,154,402
91	171	CCM	Djibouti (Low-middle)	EMR	Malaria	$1,238,000	$2,344,000	$5,113,000
92	171	CCM	Djibouti (Low-middle)	EMR	Tuberculosis	$2,913,194	$4,819,773	$10,704,374
93	120	CCM	Dominican Republic (Low-middle)	AMR	Malaria	$2,847,074	$5,368,399	$11,914,220
97	23	CCM	Ecuador (Low-middle)	AMR	Malaria	$3,010,896	$4,097,749	$4,097,749
98	32	CCM	Egypt (Low-middle)	EMR	HIV/AIDS	$1,138,633	$2,185,934	$6,201,772
99	32	CCM	Egypt (Low-middle)	EMR	Tuberculosis	$2,387,910	$4,588,252	$11,085,278
100	118	CCM	El Salvador (Low-middle)	AMR	Malaria	$300,000	$1,100,000	$3,000,000
101	75	CCM	Equatorial Guinea (Low)	AFR	Malaria	$6,813,492	$12,906,111	$25,999,072
102	116	CCM	Eritrea (Low)	AFR	HSS	$4,163,775	$7,697,965	$14,435,485
103	116	CCM	Eritrea (Low)	AFR	Malaria	$6,238,196	$8,844,992	$17,200,208
104	116	CCM	Eritrea (Low)	AFR	Tuberculosis	$799,888	$1,443,404	$3,879,324
105	56	CCM	Ethiopia (Low)	AFR	HIV/AIDS	$9,561,462	$23,145,990	$64,497,352
106	56	CCM	Ethiopia (Low)	AFR	HSS	$89,941,484	$159,999,343	$348,014,355
107	56	CCM	Ethiopia (Low)	AFR	Tuberculosis	$6,298,360	$16,440,576	$69,882,371
108	197	CCM	Georgia (Low-middle)	EUR	HIV/AIDS	$2,245,640	$2,797,640	$4,654,240
109	197	CCM	Georgia (Low-middle)	EUR	HSS	$303,820	$436,320	$814,320
110	77	CCM	Ghana (Low)	AFR	HSS	$7,041,051	$12,552,761	$19,359,341
111	65	CCM	Guatemala (Low-middle)	AMR	Tuberculosis	$3,175,791	$5,826,331	$11,623,999
112	108	CCM	Guinea (Low)	AFR	Malaria	$1,546,679	$3,467,563	$18,987,568
113	159	CCM	India (Low)	SEAR	Malaria	$7,378,045	$14,742,454	$26,448,410
114	159	CCM	India (Low)	SEAR	Tuberculosis	$3,360,000	$7,410,000	$25,020,000
115	61	CCM	Indonesia (Low-middle)	SEAR	HIV/AIDS	$6,362,819	$13,671,879	$26,117,640
116	61	CCM	Indonesia (Low-middle)	SEAR	Malaria	$28,274,347	$43,145,932	$66,543,849
117	178	CCM	Iran (Low-middle)	EMR	Malaria	$5,500,000	$8,500,000	$18,600,000
118	30	CCM	Jordan (Low-middle)	EMR	HIV/AIDS	$1,949,204	$3,588,958	$6,899,718
119	43	CCM	Kazakhstan (Low-middle)	EUR	HIV/AIDS	$1,037,925	$2,000,295	$4,814,539
120	43	CCM	Kazakhstan (Low-middle)	EUR	Tuberculosis	$6,254,293	$8,375,651	$17,558,542
121	74	CCM	Kenya (Low)	AFR	HIV/AIDS	$5,093,344	$8,893,681	$19,796,832
122	74	CCM	Kenya (Low)	AFR	HSS	$5,218,944	$11,179,083	$28,076,553
123	74	CCM	Kenya (Low)	AFR	Malaria	$2,431,600	$4,230,600	$8,427,600
124	195	CCM	Kosovo (Lower-middle)	EUR	HIV/AIDS	$916,019	$1,701,158	$3,687,350
125	104	CCM	Kyrgyzstan (Low)	EMR	Tuberculosis	$4,152,835	$5,309,127	$8,863,698
126	87	CCM	Liberia (Low)	AFR	HIV/AIDS	$6,660,742	$12,394,177	$25,714,627
127	87	CCM	Liberia (Low)	AFR	HSS	$9,259,919	$14,078,615	$17,374,573
128	87	CCM	Liberia (Low)	AFR	Malaria	$9,093,452	$15,015,748	$33,165,706
129	87	CCM	Liberia (Low)	AFR	Tuberculosis	$2,389,679	$4,750,966	$11,949,773
130	100	CCM	Madagascar (Low)	AFR	HIV/AIDS	$4,755,041	$9,512,412	$24,957,422
131	100	CCM	Madagascar (Low)	AFR	HSS	$1,927,505	$4,965,759	$22,599,312
132	100	CCM	Madagascar (Low)	AFR	Malaria	$3,610,220	$7,974,500	$33,470,801
133	100	CCM	Madagascar (Low)	AFR	Tuberculosis	$4,248,611	$8,900,519	$15,249,703
134	111	CCM	Mali (Low)	AFR	HSS	$5,594,359	$7,083,766	$11,600,785
135	111	CCM	Mali (Low)	AFR	Malaria	$7,707,216	$14,862,149	$36,069,482
136	132	CCM	Mozambique (Low)	AFR	HSS	$35,300,000	$72,100,000	$106,600,000
137	132	CCM	Mozambique (Low)	AFR	Malaria	$16,552,180	$32,694,480	$73,121,487
138	17	CCM	Namibia (Low)	AFR	HIV/AIDS	$17,177,265	$31,341,874	$91,950,544
139	17	CCM	Namibia (Low)	AFR	Malaria	$8,966,116	$13,136,240	$21,897,490
140	97	CCM	Nepal (Low)	SEAR	HIV/AIDS	$3,249,718	$7,717,233	$25,788,007
141	97	CCM	Nepal (Low)	SEAR	Malaria	$3,273,707	$5,352,822	$11,372,370
142	97	CCM	Nepal (Low)	SEAR	Tuberculosis	$2,008,298	$3,858,926	$9,481,273
143	140	CCM	Niger (Low)	AFR	HSS	$6,050,220	$7,529,467	$11,474,188
144	78	CCM	Nigeria (Low)	AFR	HSS	$28,765,338	$39,505,341	$64,812,236
145	78	CCM	Nigeria (Low)	AFR	Malaria	$28,987,617	$52,404,797	$179,995,004
148	40	CCM	Pakistan (Low)	EMR	HIV/AIDS	$6,340,070	$13,000,477	$34,989,566
149	40	CCM	Pakistan (Low)	EMR	Malaria	$5,986,615	$11,293,294	$27,059,519
150	40	CCM	Pakistan (Low)	EMR	Tuberculosis	$11,274,942	$15,854,040	$30,308,701
151	27	CCM	Papua New Guinea (Low)	WPR	Tuberculosis	$655,914	$1,975,954	$10,784,888
152	172	CCM	Peru (Lower-middle)	AMR	HSS	$3,437,174	$6,894,200	$17,011,200
153	147	CCM	Philippines (Lower-middle)	WPR	Tuberculosis	$5,755,004	$14,208,812	$45,817,584
87	90	CCM	Republic of Congo (Low)	AFR	Malaria	$10,556,503	$17,664,123	$28,331,791
88	90	CCM	Republic of Congo (Low)	AFR	Tuberculosis	$3,201,591	$4,669,340	$8,138,467
154	21	CCM	Rwanda (Low)	AFR	HIV/AIDS	$20,676,946	$36,053,491	$88,300,796
146	155	RCM	Samoa (Lower-middle), Cook Islands (), Fi	WPR	HIV/AIDS	$1,997,480	$4,251,406	$9,946,332
147	155	RCM	Samoa (Lower-middle), Cook Islands (), Fi	WPR	Tuberculosis	$619,564	$1,466,940	$4,432,060
155	58	CCM	Senegal (Low)	AFR	Tuberculosis	$5,119,146	$8,725,379	$18,336,573
156	201	CCM	Serbia (Lower-middle)	EUR	HIV/AIDS	$2,590,715	$4,755,306	$8,462,528
157	114	Non-CCM	Somalia (Low)	EMR	HSS	$602,540	$1,175,365	$2,832,730
158	114	Non-CCM	Somalia (Low)	EMR	Malaria	$1,052,908	$2,567,445	$14,532,272
159	80	CCM	South Africa (Lower-middle)	AFR	HIV/AIDS	$20,329,000	$45,010,000	$108,289,000
160	80	CCM	South Africa (Lower-middle)	AFR	HSS	$10,928,000	$21,851,000	$42,173,000

161	95	CCM	Sri Lanka (Lower-middle)	SEAR	Malaria	$3,360,822	$4,356,374	$7,290,124
162	95	CCM	Sri Lanka (Lower-middle)	SEAR	Tuberculosis	$855,915	$1,700,680	$4,414,795
163	79	CCM	Sudan (Low)	EMR	HIV/AIDS	$14,734,532	$29,424,335	$112,553,275
164	79	CCM	Sudan (Low)	EMR	Malaria	$12,171,250	$24,019,599	$46,323,995
165	213	Sub-CCM	Sudan (Low)	EMR	HSS	$8,722,153	$25,929,249	$68,455,557
166	79	CCM	Sudan (Low)	EMR	Tuberculosis	$4,019,309	$6,830,013	$15,410,468
167	115	CCM	Tanzania (Low)	AFR	HIV/AIDS	$1,281,564	$9,204,276	$11,932,883
168	115	CCM	Tanzania (Low)	AFR	HSS	$13,146,048	$22,869,642	$34,866,750
169	123	CCM	Tanzania Zanzibar (Low)	AFR	HIV/AIDS	$6,319,553	$12,722,287	$30,817,709
170	176	CCM	Thailand (Low)	SEAR	HIV/AIDS	$2,829,263	$5,920,079	$16,886,287
171	94	CCM	The Gambia (Low)	AFR	HIV/AIDS	$5,982,592	$7,842,275	$14,733,869
172	94	CCM	The Gambia (Low)	AFR	Malaria	$11,441,939	$18,169,122	$40,473,141
173	93	CCM	Tunisia (Lower-middle)	EMR	HIV/AIDS	$5,485,200	$10,007,400	$20,898,000
174	64	CCM	Uganda (Low)	AFR	HIV/AIDS	$798,648	$5,857,397	$17,746,651
175	64	CCM	Uganda (Low)	AFR	HSS	$2,883,333	$5,605,994	$10,942,316
176	64	CCM	Uganda (Low)	AFR	Malaria	$44,915,692	$49,494,235	$90,219,700
177	69	CCM	Vietnam (Low)	WPR	HIV/AIDS	$3,400,000	$6,500,000	$20,000,000
178	69	CCM	Vietnam (Low)	WPR	Tuberculosis	$4,146,735	$7,037,112	$18,718,344
179	136	CCM	Yemen (Low)	EMR	Malaria	$8,260,845	$15,889,956	$41,763,366
180	49	CCM	Zambia (Low)	AFR	HIV/AIDS	$258,404,000	$481,308,000	$1,033,420,000
181	49	CCM	Zambia (Low)	AFR	HSS	$4,246,000	$11,042,000	$34,940,000
182	49	CCM	Zambia (Low)	AFR	Malaria	$14,096,000	$22,147,000	$41,200,000
183	49	CCM	Zambia (Low)	AFR	Tuberculosis	$49,305,000	$98,610,000	$246,525,000
Category 4						**$164,339,764**	**$306,210,534**	**$750,510,205**
184	183	CCM	Armenia (Lower-middle)	EUR	Malaria	$1,082,800	$1,705,100	$2,572,700
185	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	HIV/AIDS	$48,709,605	$66,831,110	$127,046,138
186	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	Malaria	$10,730,000	$16,564,000	$29,779,000
187	182	Sub-CCM	Democratic Republic of Congo - Kasai(Low	AFR	Tuberculosis	$8,050,000	$12,702,000	$23,507,000
188	32	CCM	Egypt (Lower-middle)	EMR	Malaria	$1,440,000	$2,380,000	$5,000,000
189	159	CCM	India (Low)	SEAR	HIV/AIDS	$30,269,037	$67,620,403	$217,625,981
190	88	CCM	Maldives (Lower-middle)	SEAR	HIV/AIDS	$1,293,913	$2,016,601	$4,184,665
191	40	CCM	Pakistan (Low)	EMR	HSS	$5,316,000	$9,977,880	$26,617,490
192	117	CCM	Paraguay (Lower-middle)	AMR	HIV/AIDS	$2,482,549	$3,941,134	$9,429,262
193	102	RO	Benin (Low), Cote d'Ivoire (Low), Ethiopia (	AFR	HIV/AIDS	$8,656,316	$17,304,394	$44,804,606
194	125	RO	Costa Rica, El Salvador (Lower-middle), G	AMR	HIV/AIDS	$5,183,540	$13,859,280	$30,722,300
195	84	RO	Ghana (Low), Uganda (Low), Zimbabwe (L	AFR	HSS	$8,541,288	$16,363,767	$36,318,213
196	58	CCM	Senegal (Low)	AFR	HSS	$1,510,645	$2,321,013	$3,384,233
197	58	CCM	Senegal (Low)	AFR	Malaria	$6,268,535	$8,251,057	$12,117,141
198	62	RCM	Bangladesh (Low), Bhutan (Low), India (Lo	SEAR	HIV/AIDS	$5,280,000	$15,464,067	$59,842,897
199	95	CCM	Sri Lanka (Lower-middle)	SEAR	HIV/AIDS	$1,713,862	$2,607,594	$5,357,285
200	79	CCM	Sudan (Low)	EMR	HSS	$15,900,000	$42,800,000	$105,860,000
201	196	CCM	Turkey (Lower-middle)	EUR	Malaria	$1,349,740	$2,387,990	$4,784,490
202	196	CCM	Turkey (Lower-middle)	EUR	Tuberculosis	$561,934	$1,113,144	$1,556,804
Total 2 year Recommended Budget:							**$725,616,188**	
Total 5 year Recommended Budget:								**$1,774,502,546**