# REPORT OF THE SECRETARIAT AND THE TECHNICAL REVIEW PANEL ON ROUND 3 PROPOSALS

**Outline:** This paper has been written as a joint Secretariat-TRP report. It aims to provide the Board with an overview of the Round 2 proposals process, the TRP recommendations for funding as well as lessons learned. Several annexes support this report and are provided in a CD-ROM, only Annex II is attached here.

- 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

**<u>Summary of Decision Points:</u>**

1. The Board is asked to approve for funding proposals recommended by the Technical Review Panel, and according to the categories listed 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 on the final budget for acknowledgement. (See Annex II).

   - <u>Category 1:</u> 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.
   - <u>Category 2:</u> 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 Co-Chair need to give final approval.
   - <u>Category 3:</u> Not recommended in their present form but are encouraged to re-submit.
   - <u>Category 4:</u> Not recommended for funding.

2. The Board is asked to acknowledge the lessons learnt of the Secretariat and the TRP during this process and to allow adequate measures to be taken to improve Round 4.

## Part 1: OVERVIEW

1. On March 12th, 2003, the Global Fund issued the third Call for Proposals using the revised forms and guidelines. This was channelled through a series of networks, including Health and Foreign Affairs Ministries, the Global Fund web-site, as well as the main partners and their country offices.

2. The proposal guidelines and forms have been revised with new eligibility criteria that are 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 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.

3. The guidelines also request detail on 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 programmes and new approaches.

4. During the proposal preparation phase the Secretariat mobilised partners to assist countries in their proposals with special attention to be given to countries that had never benefited from Global Fund Resources. The Executive Director circulated the list of countries twice rejected in previous proposal rounds to WHO and UNAIDS asking them to give these countries special attention.

5. Countries were given a total of 3 months preparation time with a deadline of May 31, 2003. In total, 170 proposals representing 240 components were received by the Secretariat from 112 countries. Of these 100 were CCM applications, the balance coming from Regional Organizations and NGOs. Of the submitted proposals, 180 components from 114 proposals were submitted to the TRP.(Annex I)

6. The TRP is recommending 70 components in 50 countries[1], for a total value of USD 1.5 billion over 5 years and USD 620 million over two years for funding. Similarly to Rounds 1 and 2, the largest share of funding targets Africa and HIV/AIDS.(Annex II)

## Part 2: PROPOSAL RECEIPT AND SCREENING

### 2.1 Screening process

[1] In addition, one regional proposal (CARICOM) is being recommended which covers Antigua and Barbuda, Bahamas, Belize, Barbados, Dominica, Dominican Republic, Grenada, Haiti, Jamaica, Montserrat, St. Lucia, St. Kitts and Nevi, St. Vincent and the Grenadines, Trinidad and Tobago and Surinam.

1. The Secretariat screening process involved applying screening criteria to ensure transparency and consistency. It focused on the following items:
   - Source of Proposal: The revised guidelines define which type of applicant is eligible. For CCM applications, the Secretariat checked the inclusiveness of their membership through members' list, signatures, as well as minutes of meetings. For non-CCM applications within a country, applications were screened against the three exceptional circumstances for submitting outside a CCM, as stipulated in the guidelines:

     i). countries without legitimate Governments,
     ii). countries in conflict or facing natural disasters,
     iii). countries that suppress or have not established partnerships with civil society and NGOs.

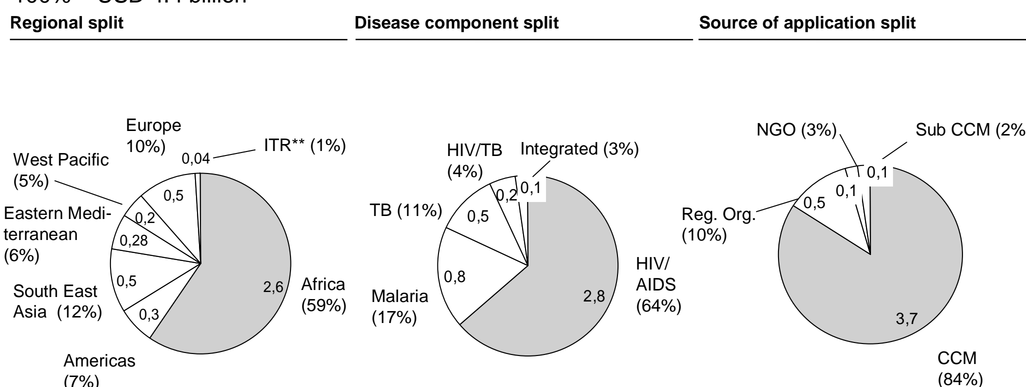
     Finally, for multi-country proposals, an endorsement by the Chair or Vice-Chair of the CCM was required from all the countries targeted in the proposal.
   - Scope of proposal: Only proposals targeting one or more of the three diseases are eligible. Pure research and pre-investment projects were also screened out.
   - Completeness of Proposal: The proposal must be reasonably complete, with all questions covered, including budgets, signatures and attachments.
2. The Secretariat has established an internal high level Steering Committee which supervises the screening process to ensure that guidelines are followed and that all applicants are receiving fair and consistent treatment.
3. Through its database, the Secretariat was able to capture key proposal information such as detailed budgets with expenditures break-down and partner allocations by component. The Secretariat, with nine full time interim staff, had five weeks to screen received proposals and to communicate with countries for further clarifications.

### 2.2 Outcome of the screening process

1. Of the 170 proposals received, 50 were screened out by the Secretariat and 6 proposals were late and not processed. 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; 4 were from ineligible sources (See Annex III for a list of non–eligible proposals).

2. A total of 180 components from 114 proposals were screened as eligible for review by the TRP. The regional, disease and source of application splits are shown in Figure 1.

**Figure 1**




*USD 1.8 billion requested for first 2 years
** ITR = Inter-Regional (combination of African and Caribbean states)

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 to update their epidemiological data sheets.

4. Feedback from the screening process shows, in general, no improvement in the quality of proposals submitted in Round 3 over Round 2, as evidenced by:

   a. Applicants submitting proposals for components rejected in the last two Rounds after minimal updating of specific sections.
   b. Multi-country proposals being resubmitted as the same proposals rated as category 4 by the TRP in Round 2.

5. However, 20 new countries submitted proposals for the first time or after being rejected in Round 1 and for the first time, an inter-regional proposal from Africa and the Caribbean was received.

6. 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. Inform quickly 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 the coming Rounds.

**Part 3: THE REVIEW PROCESS**

1. The TRP met in Geneva from Monday July 21 to Friday August 1, 2003. The panel included 26 members: Michel D. Kazatchkine (AIDS expert, France, Chair), Alex Coutinho (AIDS expert, Uganda, vice-Chair), 5 additional AIDS experts: Peter Godfrey-Faussett (UK), Hakima Himmich (Morocco), David Hoos (USA), Kasia Malinowska-Sempruch (Poland), Suniti Solomon (India); 4 malaria experts: John Chimumbwa (Zambia), Mary Ettling (USA), Giancarlo Majori (Italy), Jane E. Miller (UK); 4 tuberculosis experts: Rosmini Day (Indonesia), Paula Fujiwara (USA), Fabio Luelmo (Argentina), Pierre Yves Norval (France); 11 cross-cutting experts: Jonathan Broomberg (South Africa), Malcom Clark (UK), Daniel Denolf (Belgium**),** Sarah Gordon (Guyana), Wilfred Griekspoor (Netherlands), Leenah Hsu (USA), Danguole Jankauskiene (Latvia), Wiput Phoolcharoen (Thailand), David Peters (Canada), Rima Shretta (Kenya), Richard Skolnik (USA).
2. Fourteen members of this panel had not participated in the first or second round of review (John Chimumbwa, Malcom Clark, Rosmini Day, Daniel Denolf, Mary Ettling, Peter Godfrey-Faussett, David Hoos, Leenah Hsu, Danguole Jankauskiene, Pierre-Yves Norval, David Peters, Wiput Phoolcharoen, Rima Shretta, Suniti Solomon). Four members had been on the panel since Round 2 (Jonathan Broomberg, Hakima Himmich, Giancarlo Majori, Richard Skolnik) and eight members of the panel had been on the TRP since Round 1 (Alex Coutinho, Paula Fujiwara, Sarah Gordon, Wilfred Griekspoor, Michel Kazatchkine, Fabio Luelmo, Kasia Malinowska-Sempruch, Jane Miller).
3. Throughout the meeting, the TRP was assisted by the Secretariat led by Hind Othman. Experts from UNAIDS and WHO could easily be reached throughout the two weeks of work of the TRP.
4. The TRP reviewed a total of 180 components screened by the Secretariat out of 240 components. There was no data check by UNAIDS and WHO prior to the TRP review, as it had been the case in Round 2. UNAIDS and WHO however provided the TRP with updated epidemiological data sheets on each of the three diseases.
5. Around 20 components were reviewed each day. On the day preceding the review, applications were distributed among 4 working subgroups comprised of 5 to 6 TRP members (including 1 or 2 AIDS expert(s), 1 TB expert, 1 malaria expert and 2 or 3 cross-cutting experts). Sub-group composition was modified twice during the 2 weeks to strengthen the consistency of the review process.

6. Each application was extensively reviewed by a disease-specific expert acting as a primary reviewer and a cross-cutting expert, acting as secondary reviewer, and was also read by all other experts within the sub-group. Working subgroups met everyday for approximately 3 hours in the afternoon to discuss the applications and agree on a provisional grading of the proposal. The subgroup was also presented with a preliminary draft of the report by the primary and secondary reviewers.
7. The entire TRP would then meet for 3 to 5 hours in a plenary session each day to agree on the final grading of the proposal and final wording of the report. Proposals were graded into 1 of 4 categories, as requested by the Board. No vote was taken as all decisions of the TRP were achieved by consensus.
8. On the last day of the meeting, the TRP reviewed the grades that had been agreed upon during the prior 2 weeks. There was a general consensus of the group on the judgments made. Only 3 % of the scores were revisited (i.e. proposals initially graded as 2 or 3 switched to 3 or 2), after extensive discussions. The proportion of components classified in categories 1 and 2 each day (i.e. the relative success rate) did not differ significantly throughout the 2 weeks of the review process.

## Part 4: RECOMMENDATIONS TO THE BOARD

### 4.1. Overall outcome of the review

1. Proposals were grouped into one of four categories:
    - **Category 1** : Recommended proposals with no or minor clarification, which should easily be answered within 4 weeks and given the final approval by the TRP Chair and co-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 final TRP approval should further clarifications be requested). The primary reviewer, secondary reviewer as well as TRP Chair and/or co-Chair need to give final approval.
        i. Following the Board's decision in June 2003, the TRP further grouped successful proposals of category 2 into two sub-categories 2A and 2B, based on merit. Applications classified into sub-category 2B were those, which among the proposals graded in category 2, are requiring a larger amount of clarifications. Sub-categorization into 2A and 2B took place on the last day of the TRP meeting as the panel was reconsidering all applications graded in categories 2 and 3 during the two weeks of review. Approximately two-thirds of components were graded 2A and one-third in sub-category 2B.

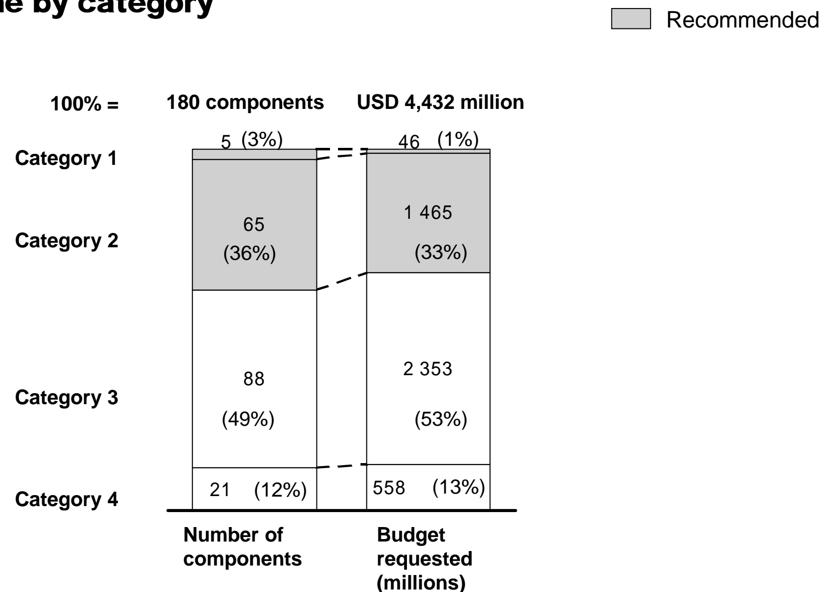
ii. Grading proposals in category 2 into sub-categories 2A and 2B had been considered by the Board to address a potential large gap between available funds for Round 3 and the first two-year budgets requested in recommended proposals.

iii. In view of the results of Round 3, however, the PMPC considered in its meeting of September 9, 2003 to recommend to the Board to approve all TRP recommended proposals in categories 1,2A and 2B.

- **Category 3:** Not recommended in their present form but are encouraged to re-submit.
- **Category 4:** Not recommended for funding.

2. Figure 2 summarizes the overall results of the review process in Round 3, which were proportionally similar to Round 2. Components graded in category 1 represented 3 % of the reviewed components; category 2 represented 36 %, category 3 represented 49 % and category 4 represented 12 %.

**Figure 2**




- Annex II lists the applications graded in categories 1 and 2 (2A + 2 B) that are recommended by the TRP to the Board for funding in Round 3.
- Annex II further lists the applications 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 considered

relevant), recommending that they be submitted in an improved format in Rounds to come.

3. Of the 70 components recommended from 50 countries, the regional and disease distribution of recommended Round 3 corresponds to the relative burden of disease by region and disease category as shown in figures 3 and 4.

**Figure 3**

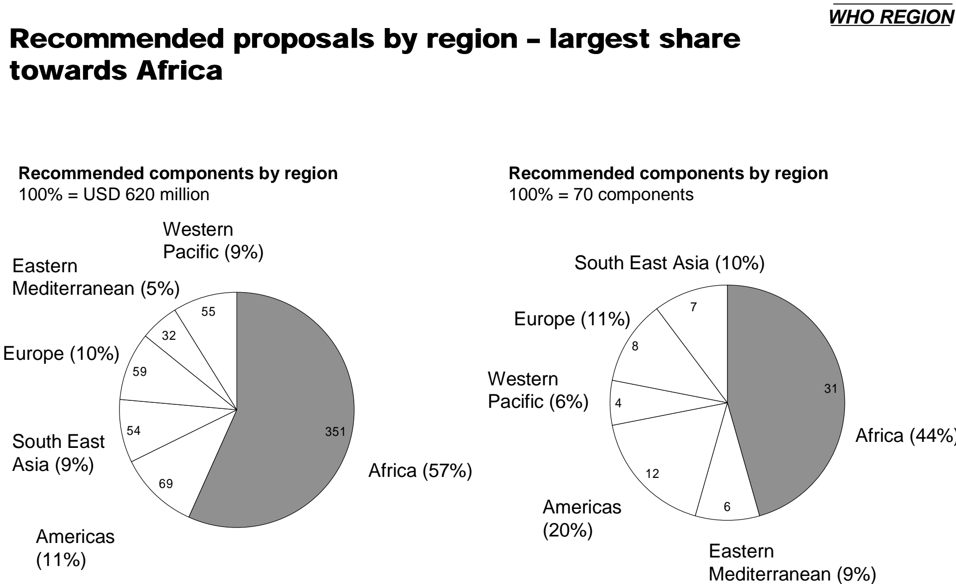
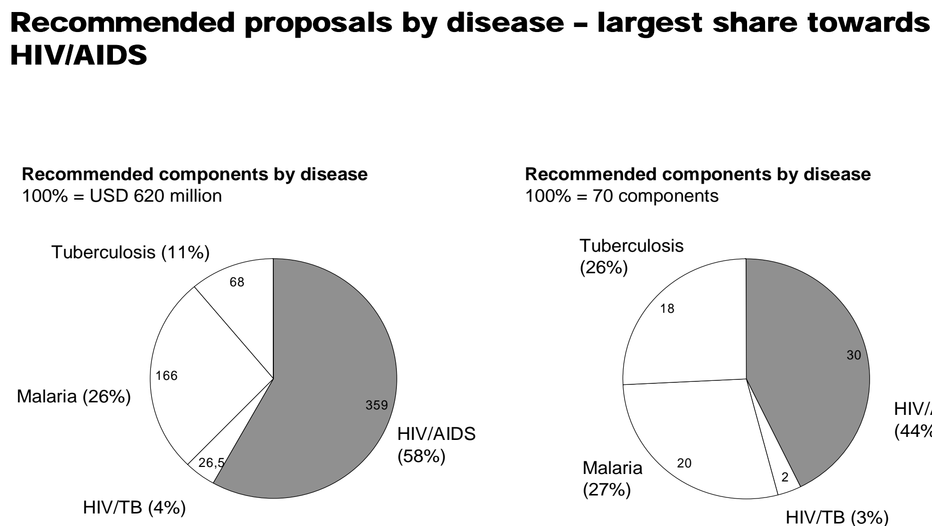
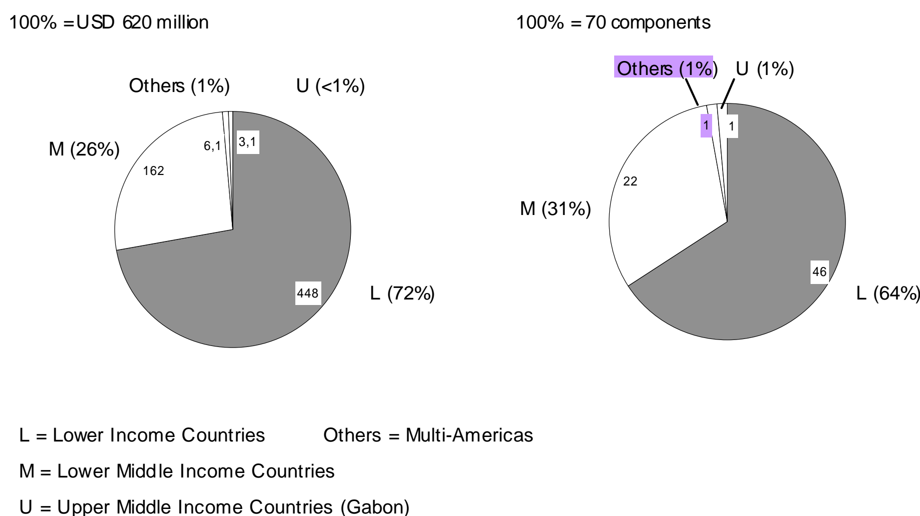



**Figure 4**



## Figure 5

**The majority of funds target Lower Income countries (World Bank classification)**




L = Lower Income Countries Others = Multi-Americas

M = Lower Middle Income Countries

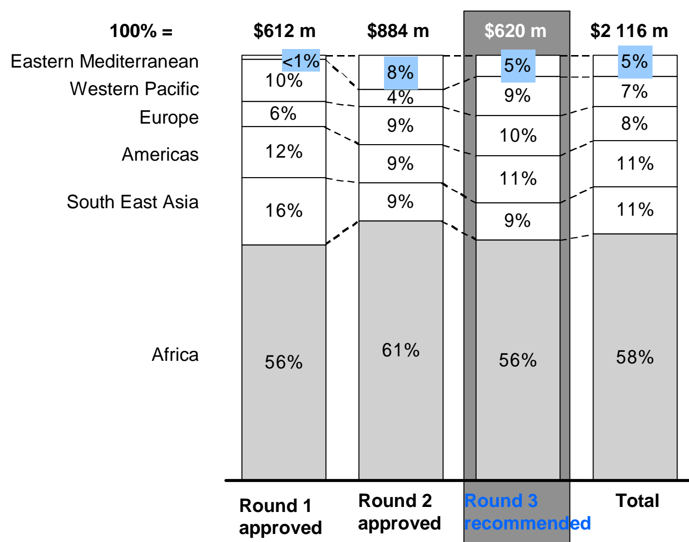
U = Upper Middle Income Countries (Gabon)

4. Interestingly, comparing Rounds 1 and 2 approvals with Round 3 recommendations shows relative consistency between the dollars spent by region in Figure 6 and a smoothing of expenditures by disease in Figure 7 below.

## Figure 6

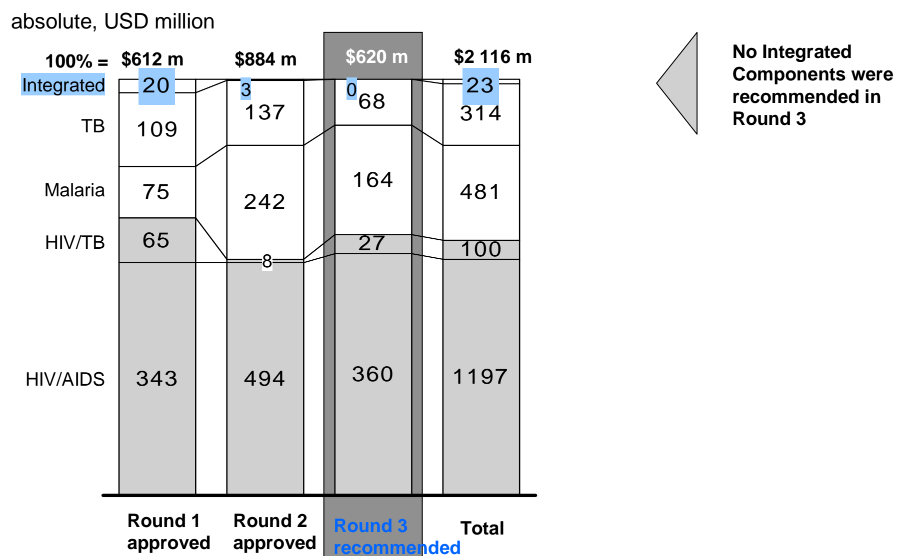
**Consolidated Round 1, Round 2 and Round 3 view by region**

%, USD million



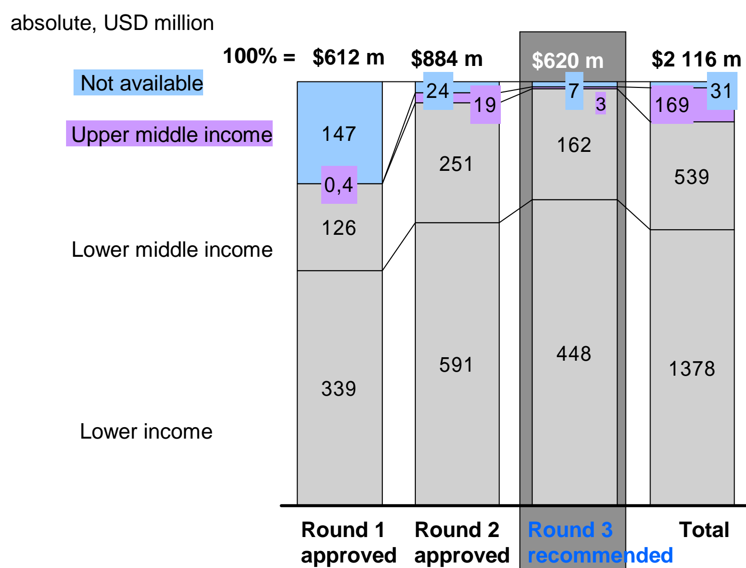
## Figures 7

**Comparison between Round 1, Round 2 and Round 3 view by disease**




5. Figure 8 depicts the stratification of proposals approved in Rounds 1 and 2 and recommended in Round 3, according to the World Bank's classifications of income. Countries were classified as Upper Middle Income (UMIC), Lower Middle Income (LMIC) and Low Income (LIC). UMIC expenditures in absolute dollars declined from Round 1, however, LMIC and LIC remained relatively consistent.

## Figure 8




6. Figures 9, 10 and 11 depict the relative success rate of applications in Round 3 according to disease category, region and income. The success rate for HIV/AIDS, Malaria and TB are similar. The HIV/TB success rate is lower, probably due to smaller, less technically supported country applications.

## Figure 9

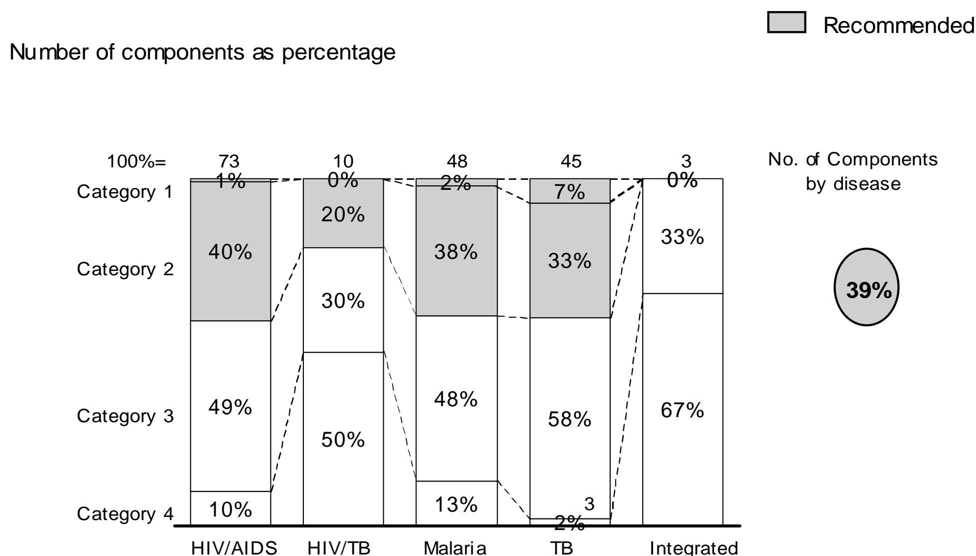


**Figure 10**

The success rate for countries classified by income show low and lower middle-income countries having higher success rates. This may be due to increased technical support during the proposal preparation process.

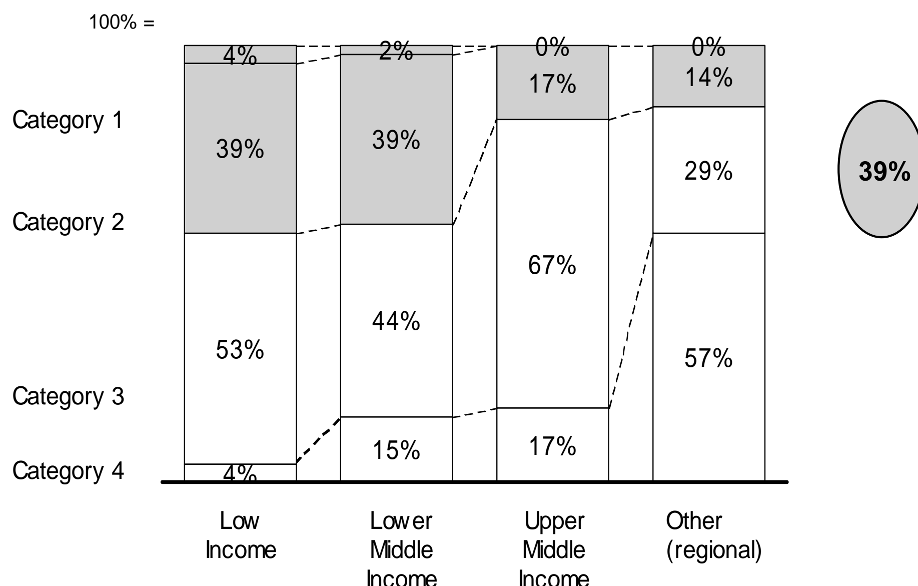
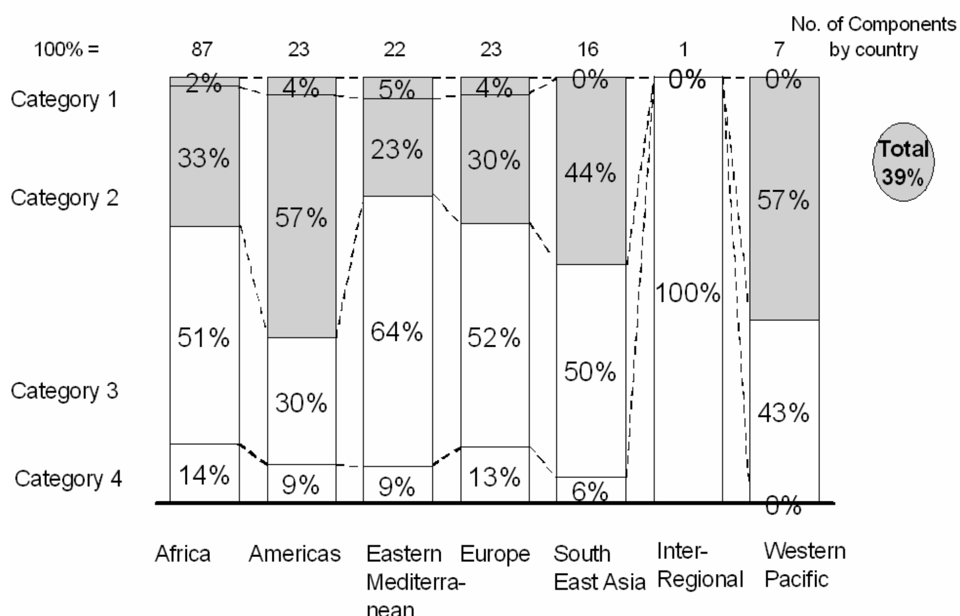
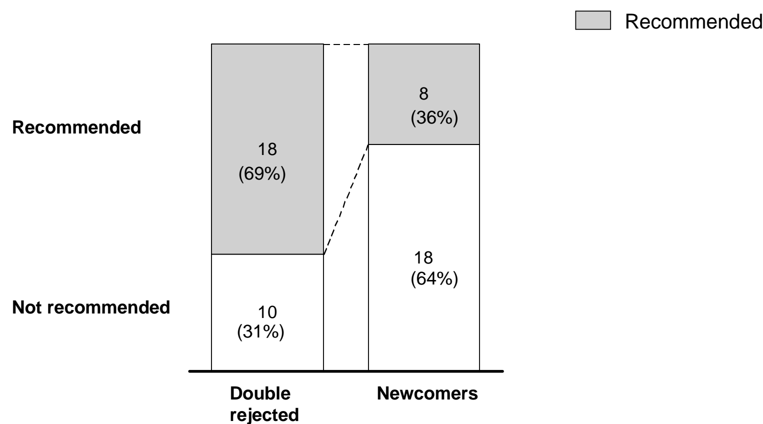



**Figure 11**



7. Figure 12 shows the impact on success rates for those applicants previously rejected who received direct assistance from WHO/UNAIDS. The double rejected applicants who obtained assistance had a 70% higher success rate than new applicants. This data supports the work initiated by the Secretariat early on in engaging partners in the proposal development phase.

**Figure 12**




8. Table 2 lists the new applicants (i.e. submitted for the first time to the TRP) and the new components that were rejected in previous rounds.

**Table 2**

**New countries**

| Country | Component | Country | Component |
|---|---|---|---|
| Algeria | HIV | Guyana | HIV/AIDS |
| Angola | Malaria | Guyana | Malaria |
| Belarus | HIV/AIDS | Jamaica | HIV/AIDS |
| Belize | HIV/AIDS | Liberia | Malaria |
| Bolivia | HIV/AIDS | Macedonia | HIV/AIDS |
| Bolivia | TB | Niger | HIV/AIDS |
| Bolivia | Malaria | Niger | Malaria |
| Cameroon | HIV/AIDS | Papua New Guinea | Malaria |
| Cameroon | TB | Paraguay | TB |
| Cameroon | Malaria | Philippines | HIV/AIDS |
| Gambia | HIV/AIDS | Russian Federation | HIV/AIDS |
| Gambia | Malaria | Russian Federation | TB |
| Guatemala | HIV/AIDS | Serbia | TB |
| Guinea-Bissau | TB | Tajikistan | TB |

**Countries previously funded with new components this round**

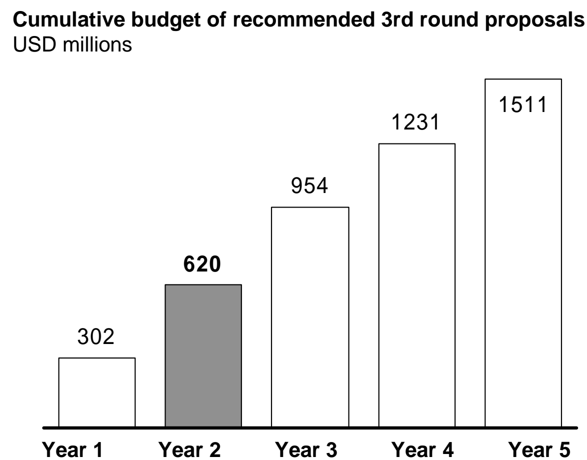
| Country | Component | Country | Component |
|---|---|---|---|
| Bangladesh | TB | Korea DPR | Malaria |
| Chad | HIV/AIDS | Myanmar | Malaria |
| Chad | Malaria | Rwanda | HIV/AIDS |
| Comores | HIV/AIDS | Rwanda | Malaria |
| Congo (DRC) | HIV/AIDS | Somalia | TB |
| Congo (DRC) | Malaria | South Africa | HIV/AIDS |
| Dominican Republic | TB | Sudan | HIV/AIDS |
| East Timor | TB | Swaziland | TB |
| Eritrea | HIV/AIDS | Tanzania | HIV/TB |
| Gabon | HIV/AIDS | Tanzania-Zanzibar | TB |
| Georgia | Malaria | Togo | Malaria |
| Haiti | Malaria | Togo | TB |
| Haiti | TB | Uzbekistan | HIV/AIDS |
| India | HIV/TB | Vietnam | Malaria |
| Ivory Coast | TB | | |

## 4.2. Successful proposals

1. Figure 13 shows the cumulative budgets being requested for recommended Round 3 proposals for categories 1 and 2.

**Figure 13**

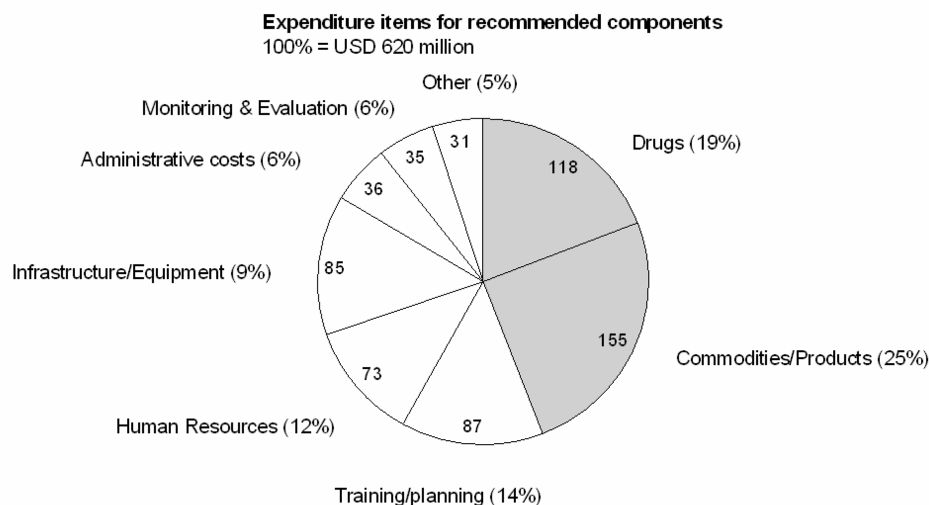
**Budget requests for recommended proposals**




2. Figure 14 shows the proportion of the first two-year budgets requested in recommended proposals for drugs and commodities. This is similar to the previous 2 rounds in which 50%-55% was also spent on drugs and commodities.

**Figure 14**

**Budget breakdown shows most funds going to Drugs and Commodities** ($273m of $620m recommended)



## Part 5: LESSONS LEARNED AND ISSUES FOR DISCUSSION AND ENDORSEMENT BY THE BOARD

### 5.1. Quality of proposals

1. The TRP assesses the overall quality of submitted applications as being no better in Round 3 than in Round 2. However, the TRP does acknowledge that a number of applications that had been graded in category 3 in previous Rounds have significantly improved in quality in Round 3 (see Fig. 8). Yet, some applications still failed after one or two previous submissions to the Fund.
2. The TRP draws the attention of the Board to the fact that the current classification definitions result in the clustering of most applications in categories 2 and 3 (representing 88 % of the components in Round 3). By having the words “strongly encourage” in the definition of Category 3, the TRP felt that Category 3 countries felt compelled to resubmit in the consecutive Round. **To allow for greater distinction between categories 2 and 3 the TRP recommends to the Board to slightly modify the definition of category 3 by deleting the word “strongly”.**
3. HIV/TB applications had a lower rate of success in Round 3 than in previous Rounds (Figure 9). One of the reasons may be that they often originated from small countries that have received less attention from multilateral organizations. **The TRP suggests that specialized agencies, including STOP TB, give specific attention to this issue.**
4. With regard to HIV/AIDS, the TRP noted that the requests for antiretroviral treatment were often disproportionately low with regard to the urgency and extent of need and to the expectations of affected populations. **The TRP suggests that a stronger language be used regarding scaling up of antiretroviral treatment in the guidelines and that partners working with countries in proposal development address this issue.**

### 5.2. Eligibility

1. The TRP agrees that the Secretariat has full responsibility to assess the eligibility of applications submitted to the Global Fund. Yet**, the TRP asks the Board to consider that the Internal Appeal Mechanism also include the screened out proposals.**
2. **For applications that the Secretariat would consider equivocal regarding eligibility, it is suggested that they be given to the TRP for further review as has been the case so far.**
3. Based on its experience of the first three rounds, **the TRP suggests that the PMPC and the Board reconsider the current guidelines for NGOs to apply to the Fund outside a CCM. The TRP draws the attention of the Board to the need for a clear definition of what “endorsement by a CCM” means.**

- The TRP further draws the attention of the Board to the specific dilemma it faced with South Africa's CCM presenting several "endorsed" NGO–originating components outside of a comprehensive consolidated and integrated strategic work-plan of which these would be part. The TRP wishes to draw the attention of the Board to the limits of the CCM model for large federal-type countries such as South Africa, India and Russia.

5. Countries eligible to apply to the Fund are countries classified as "Low Income, Lower Middle Income and Upper Middle Income" by the World Bank. Countries classified as "Lower Middle and Upper Middle" income had to meet the requirements of co-financing and their proposals had to focus on vulnerable populations and give evidence that they are moving over time towards greater reliance on domestic resources. Lists of countries in each classification are provided in Annex 1C of the Guidelines for proposals. **The TRP requests that the Board provide more detailed guidelines on "co-financing", as it is difficult to assess this item with the information available in the proposals submitted in Round 3.**
6. The TRP draws the attention of the Board to the case of the multi-country proposal originating from the Eastern Caribbean where only one of nine countries applying was in the eligible group of countries as defined above. The TRP questioned the eligibility of the proposal. **In this case and others, if the TRP questions the eligibility of a proposal, it is suggested that the TRP grades the application for its merit and presents it to the Board, as a separate category for discussion and determination on eligibility prior to approval.**
7. **The TRP also asks the Board to define an eligibility policy with regard to the conditions under which countries that have already been successful with one or several components may submit a new application for the same component**.

### 5.3 Proposal guidelines and forms

#### 5.3.1 Proposal guidelines

The TRP requests that the PMPC and the Board develop and improve proposal guidelines including:

1. **Defining better the co-financing processes of applications from lower middle and upper middle income countries;**
2. **Specifying the process of endorsement by CCM by requesting more than just a letter of endorsement either from the Chair or Vice-Chair of the CCM.**
3. **Specifying that multi-country proposals must fit and complement individual country programs and priorities;**
4. **Regarding applications on social support to orphans, guidelines should highlight that support for orphans should**

**include addressing the prevention and treatment of HIV for orphans as well.**

#### 5.3.2 Proposal form.

The TRP suggests that the proposal form:

1. **Give more emphasis on the need for joint HIV/TB activities, i.e. more emphasis on TB–related issues in proposals on HIV/AIDS and more emphasis on HIV/AIDS in applications dealing with TB;**
2. **Be improved to give better guidance on the preparation of the detailed work plan and budget;**
3. **Provide a better view of additionality ( i.e. asking applicants to clearly report the ongoing funded programs in the country, such as World Bank or bilateral donor-funded projects, (as well as programs that have been accepted for funding from other sources but have not yet started ) and how these complement or overlap with the proposal that is submitted to the Fund.**
4. **Request more explicit information on procurement and distribution, including:**
    - **Are structures in place?**
    - **Is external assistance needed?**
    - **How is the quality of drugs assessed?**
    - **What are the costs of assays for monitoring of treatment?**
    - **What are the cost of drugs?**
5. **Request that information be provided on how human capacity to implement the program will be developed over time.**
6. **Request that the suggested modalities for the selection of the NGOs and other sub recipients be described.**

### 5.4. TRP process

#### 5.4.1. TRP rotation policy

1. The current policy on TRP renewal, as approved by the Board, is that after Round 3, one third of TRP members will be rotated off the TRP after each round, with members expected to serve for 3 rounds before being rotated off. The necessity of a regular rotation and renewal of the TRP is clear. However, after reflecting on the TRP experience over three rounds, we believe that the current policy has some important disadvantages, and **therefore request that the PMPC and the Board consider amending**

**the current policy on TRP renewal to a 4 round term with 25 % of members being rotated off after each round.**

2. The key issues to consider related to this recommendation are as follows:

    a. Risk of a weak TRP for Round 4: As the Board is aware, the relatively large renewal and expansion of the TRP for Round 3 (TRP 3), resulted in 50% of TRP members serving for the first time (13/26), with a further four members having served for only one prior round and eight members for two prior rounds. We are concerned that if the current rotation policy is continued, TRP 4 will have a high proportion of members with limited experience on the TRP.

       The table below illustrates the current rotation process; approximately 90% of TRP 4 members will have either no or only 1 round of prior experience. We believe that the quality of decision making of the TRP would be improved by the presence of a significant proportion of members with more experience of the process. Under the current rotation policy, we therefore believe that there is some risk that TRP 4 will be weaker than would be the case with a higher proportion of more experienced members. This problem may be aggravated by the likely fact that some members from Rounds 2 and 3 who would still be eligible to serve in round 4 may not be able to do so.

    b. Stability and functioning of TRP beyond round 4: Even beyond the specific considerations of TRP 4, we believe that a 25 % rotation policy will, over time, lead to a better balance between new and experienced members, resulting in a stable and productive TRP with a higher consistency of decision making.

**Table reflecting 25% and 30% rotation of TRP members**

| **TRP Experience** | **30% Rotation Policy**<br>**No. of members as % of total** | **25% Rotation Policy**<br>**No. of members as % of total** |
|---|---|---|
| No prior experience | 9 (36%) | 6 (24%) |
| One round | 13 (52%) | 13 (52%) |
| Two rounds | 3 (12%) | 4 (16%) |
| Three rounds | 0 | 2 (8%) |

* Assumes rotation occurs on a first in first out basis, and that all members from prior rounds who are eligible for TRP 4 are able to serve.

The table above also shows the distribution of TRP 4 members resulting from a 25 % rotation policy with a 4-term maximum limit. TRP composition with a 25% rotation policy is somewhat more balanced, with 76% of members having one or no prior rounds of experience versus 88%

c. Term of Office of TRP Chair: Currently the elected Vice Chair would serve a minimum of one round with the Chair, and then replace the Chair in the subsequent round. On the reasonable assumption that the Vice Chair would only be appointed as Chair in his/her second TRP round, the current practice of a maximum 3-round term will allow the Chair only to serve for a single round before being rotated off.

   Thus, in the present situation, Jonathan Bloomberg (South Africa) has been elected by the members of TRP 3 to serve as Vice Chair for Round 4 with the current Chair. He would then take over the Chair for Round 5. The TRP believes that having the TRP Chair serve for only one round will undermine the stability and productivity of the TRP, as well as mitigate against an effective relationship between the TRP, the Secretariat and the Board. Conversely, the use of a 4-round-term would allow the Chair to serve for two rounds before being rotated off.

3. The proposed 4-round term rotation will allow a smooth handing over of leadership in the TRP. Since the TRP has decided that Chair and Vice Chair will have a North and South representation, the process will further ensure that North and South alternate in the leadership of the TRP.

**5.4.2. Renewal of TRP**

1. The largely renewed TRP 3 (i.e. over 50 % of the members serving for the first time) appeared more homogeneous in quality than in previous rounds, which was probably due to a sub-optimal renewal process.

   - Cross-cutting experts who represent 11/26 members feel they have sufficient numbers in the “new” TRP to face the amount of work and allow for two of them to examine each application. At the same time, it is crucial that the TRP maintains the needed numbers of disease experts to allow for an appropriate review of the pertinence of the submitted proposals.

2. **In order to improve the renewal process of the TRP, the TRP suggests that, in addition to the decisions made by the PMPC and the Board in June 2003, a nomination process is set up whereby multilateral organizations and TRP members would contribute to build the database for future TRP member renewals.**

### 5.4.3. TRP reporting form

1. The TRP considered, as it had done in Round 2, that it could not provide a quantitative score on items such as "feasibility of implementation" or "potential for sustainability". It was thought that these items would best be presented to the Board as text under the section on "strengths and weaknesses" on page 1 of the TRP report.
2. In addition, page 2 of the review form has been a source of misunderstanding, as some countries have pointed out that they were classified as category 3 despite "good" scores on page 2 of the reporting form. The TRP may judge an application as having a sound approach and a reasonable M&E plan and yet exhibit a number of weaknesses in the work plan that would not allow us to grade it among the high priorities to be presented to the Board.
3. To resolve this, the TRP decided not to use page 2 of the reporting form in Round 3, but rather developed a list of items that the cross-cutting reviewers would systematically consider in all applications and discuss under "strengths" and "weaknesses" on page 1. The elements are the following:
   - Appropriateness of work plan: Are the activities and responsibilities appropriate to the stated goals and objectives of the proposal?
   - Appropriateness of budget: Does the budget link to activities? Are unit costs appropriate? Are the relative expenditures on different budget categories appropriate? Is the budget internally consistent? Does the budget appear consistent with evidence on current expenditures on these and related activities?
   - Implementation and absorptive capacity: To what extent is the proposal developed that it is ready to be implemented? To what extent are the country and its institutions capable of implementing the proposal within the proposed time frames, considering other ongoing commitments and activities? To what extent are the following requirements in place for effective implementation of the proposals: appropriate institutions, including financial and management resources; appropriate human resources; appropriate policies; appropriate procurement, supply and logistics systems?

### 5.4.4. Application Clarification process

1. **The TRP recommends to the Board that it limit in time the clarification process for applications that are recommended for funding in categories 1 and 2. A clarification response period of 4 weeks is proposed for applicants in categories 1 and 6 weeks for applicants in category 2.**
2. **In case the reviewers and TRP Chairs consider the answer of the applicant in category 2 to be insufficient in addressing the issues raised by the TRP, it is proposed that the revisions and sub-sequent re-review process should take place in 3 months and not to exceed 4 months.**

3. **The TRP suggests that the Board considers approving proposals for funding after the clarification process is over, which should be possible if the time frame suggested is fully respected.**
4. Additional suggestions from the TRP for improvement of the clarifications process include:
    a. Providing TRP members with an updated organigram indicating the portfolio manager responsible for the management of each component under clarification;
    b. Improving communication between the Fund, TRP reviewers and applicants to ensure timely action by all parties involved;
    c. The primary reviewer being responsible for coordinating the TRP comments and preparing the comments for the Secretariat on behalf of the review team for that specific component.
    d. Assuring that TRP members make themselves available during the clarification process;
    e. Recommending that all parties adhere to the time line suggested for the settlement of clarifications;
    f. Requesting that the Secretariat adopt the necessary measures to ensure that confidentiality is fully respected;
    g. Requesting that the Secretariat develop a standardized applicant response format. This will allow the Secretariat to ensure that all issues raised by the TRP are answered prior to forwarding them to the primary reviewer;
    h. Further clarifying the steps and accountabilities in grant negotiations and agreements to help the TRP members with their reviews.

#### 5.4.5. Confidentiality and Conflicts of Interest

1. Confidentiality: The TRP wants to assure that strict confidentiality be maintained over its deliberations. The TRP requests the Secretariat to reinforce a "confidentiality policy" at all steps of the review process, including:
    - In no case, providing the name of a reviewer on a document sent to an applicant country;
    - Limiting participation in plenary sessions to WHO, UNAIDS and Secretariat senior staff delegated by their respective organisations and requiring that all attendees sign a confidentiality agreement.
2. Conflicts of interest: The TRP members are required to self-declare a conflict of interest. The TRP wishes to emphasize that being a TRP member is incompatible with also being member of a CCM or work group providing technical assistance to countries for drafting proposals or working with an LFA.

## *Annex II : List of components reviewed, classified by category*

| No. | PTS | GFProjNum | Sourc | Country | WHO Region | Component | BUDGET Requested | Total 2 Years | Total 5 Years |
|---|---|---|---|---|---|---|---|---|---|
| **Category 1** | | | | | | | **$16,296,715** | **$29,326,492** | **$45,742,955** |
| | | | | | | | | | |
| 1 | 3951 | CIV-303-003 | NGO | Cote D'Ivoire | Africa | HIV/AIDS | $536,567 | $1,023,534 | $1,023,534 |
| 2 | 4581 | HTI-303-003 | CCM | Haiti | America | Tuberculosis | $4,997,889 | $8,131,836 | $14,665,170 |
| 3 | 4561 | LBR-303-002 | CCM | Liberia | Africa | Malaria | $6,282,353 | $12,140,921 | $12,140,921 |
| 4 | 7241 | Ser-303-004 | CCM | Serbia | Europe | Tuberculosis | $1,337,023 | $2,428,986 | $4,087,979 |
| 5 | 7441 | SOM-303-005 | CCM | Somalia | Africa | Tuberculosis | $3,142,883 | $5,601,215 | $13,825,351 |
| **Category 2A** | | | | | | | **$216,488,189** | **$452,485,907** | **$1,175,449,096** |
| | | | | | | | | | |
| 1 | 5721 | BLR-303-003 | CCM | Belarus | Europe | HIV/AIDS | $3,180,492 | $6,818,796 | $17,369,100 |
| 2 | 6061 | Bel-303-005 | CCM | Belize | America | HIV/AIDS | $589,907 | $1,298,884 | $2,403,678 |
| 3 | 4931 | Bol-303-002 | CCM | Bolivia | America | HIV/AIDS | $2,837,863 | $6,019,023 | $16,071,831 |
| 4 | 4931 | Bol-303-002 | CCM | Bolivia | America | Tuberculosis | $1,022,964 | $2,381,646 | $5,688,896 |
| 5 | 3471 | CMR-303-004 | CCM | Cameroon | Africa | HIV/AIDS | $7,442,215 | $14,641,407 | $55,735,254 |
| 6 | 3471 | CMR-303-004 | CCM | Cameroon | Africa | Malaria | $12,416,102 | $16,938,794 | $32,770,143 |
| 7 | 3471 | CMR-303-004 | CCM | Cameroon | Africa | Tuberculosis | $1,932,086 | $2,986,220 | $6,218,220 |
| 8 | 7411 | Chn-303-002 | CCM | China | Western Pacific R | HIV/AIDS | $11,426,650 | $32,122,550 | $97,888,170 |
| 9 | 6311 | Com-303-003 | CCM | Comores | Africa | HIV/AIDS | $596,700 | $751,700 | $1,360,900 |
| 10 | 6981 | ZAR-303-007 | CCM | Congo (Kinshasa) | Africa | Malaria | $8,827,125 | $24,966,676 | $53,936,609 |
| 11 | 6981 | ZAR-303-007 | CCM | Congo (Kinshasa) | Africa | HIV/AIDS | $16,565,589 | $34,799,786 | $113,646,453 |
| 12 | 5041 | DMR-303-002 | CCM | Dominican Republic | America | Tuberculosis | $1,578,721 | $2,636,816 | $4,611,860 |
| 13 | 3791 | TMP-303-002 | CCM | East Timor | South East Asia | Tuberculosis | $457,575 | $967,650 | $2,299,659 |
| 14 | 3281 | GAB-303-002 | CCM | Gabon | Africa | HIV/AIDS | $1,157,000 | $3,154,500 | $5,405,000 |
| 15 | 3501 | GMB-303-001 | CCM | Gambia | Africa | HIV/AIDS | $3,726,148 | $6,241,743 | $14,568,679 |
| 16 | 3501 | GMB-303-001 | CCM | Gambia | Africa | Malaria | $3,524,937 | $5,665,500 | $13,861,866 |
| 17 | 4791 | GEO-303-002 | CCM | Georgia | Europe | Malaria | $438,900 | $645,700 | $806,300 |
| 18 | 5511 | GUA-303-003 | CCM | Guatemala | America | HIV/AIDS | $3,456,146 | $8,423,807 | $40,921,918 |
| 19 | 3441 | GNB-303-001 | CCM | Guinea-Bissau | Africa | Tuberculosis | $889,540 | $1,503,587 | $2,646,004 |
| 20 | 4441 | GYA-303-002 | CCM | Guyana | America | HIV/AIDS | $4,812,125 | $9,486,122 | $27,163,231 |
| 21 | 4441 | GYA-303-002 | CCM | Guyana | America | Malaria | $1,405,675 | $2,055,675 | $2,924,675 |
| 22 | 5331 | IDA-303-023 | CCM | India | South East Asia | HIV/TB | $661,714 | $2,667,346 | $14,819,773 |
| 23 | 7541 | IRN-303-003 | CCM | Iran (Islamic Republic of) | Eastern Mediterra | HIV/AIDS | $2,000,000 | $4,000,000 | $9,658,868 |
| 24 | 3981 | JAM-303-002 | CCM | Jamaica | America | HIV/AIDS | $4,045,334 | $7,560,365 | $23,318,821 |
| 25 | 4351 | KEN-303-009 | CCM | Kenya | Africa | Tuberculosis | $1,194,575 | $1,812,250 | $3,790,249 |
| 26 | 6681 | PRK-303-002 | CCM | DPR Korea | South East Asia | Malaria | $1,443,600 | $3,227,300 | $8,548,200 |
| 27 | 4431 | MDG-303-005 | CCM | Madagascar | Africa | Malaria | $3,084,334 | $5,232,448 | $10,400,722 |
| 28 | 3331 | MYN-303-002 | CCM | Myanmar | South East Asia | Malaria | $3,531,322 | $9,462,062 | $27,050,046 |
| 29 | 3291 | NGR-303-001 | CCM | Niger | Africa | HIV/AIDS | $5,533,892 | $8,475,297 | $11,968,331 |
| 30 | 3291 | NGR-303-001 | CCM | Niger | Africa | Malaria | $2,908,031 | $4,815,109 | $5,886,835 |
| 31 | 4271 | PKS-303-006 | CCM | Pakistan | Eastern Mediterra | Malaria | $934,068 | $1,548,636 | $1,548,636 |
| 32 | 4271 | PKS-303-006 | CCM | Pakistan | Eastern Mediterra | Tuberculosis | $3,171,469 | $6,768,734 | $13,085,948 |
| 33 | 3351 | PNG-303-002 | CCM | Papua New Guinea | Western Pacific R | Malaria | $2,499,064 | $6,106,556 | $20,105,689 |
| 34 | 3921 | PRY-303-003 | CCM | Paraguay | America | Tuberculosis | $603,351 | $1,194,902 | $2,799,545 |
| 35 | 4951 | PHL-303-002 | CCM | Philippines | Western Pacific R | HIV/AIDS | $1,818,456 | $3,496,865 | $5,528,825 |
| 36 | 3421 | RUS-303-002 | NGO | Russian Federation | Europe | HIV/AIDS | $14,770,220 | $31,596,308 | $88,742,355 |
| 37 | 3371 | RWN-303-003 | CCM | Rwanda | Africa | HIV/AIDS | $5,790,465 | $14,890,735 | $56,676,465 |
| 38 | 3371 | RWN-303-003 | CCM | Rwanda | Africa | Malaria | $7,802,272 | $13,045,301 | $17,676,240 |
| 39 | 7261 | SAF-303-019 | CCM | South Africa | Africa | HIV/AIDS | $6,166,120 | $15,521,456 | $66,509,557 |
| 40 | 4121 | SWZ-303-003 | CCM | Swaziland | Africa | Tuberculosis | $813,200 | $1,348,400 | $2,507,000 |
| 41 | 4401 | TNZ-303-005 | CCM | Tanzania | Africa | HIV/TB | $10,932,632 | $23,951,034 | $86,987,868 |
| 42 | 5391 | TNZ-303-012 | CCM | Tanzania-Zanzibar | Africa | Tuberculosis | $809,993 | $959,482 | $1,699,867 |
| 43 | 3431 | TCD-303-002 | CCM | Tchad | Africa | HIV/AIDS | $3,681,556 | $7,380,156 | $18,581,945 |
| 44 | 3431 | TCD-303-002 | CCM | Tchad | Africa | Malaria | $1,522,120 | $3,028,688 | $8,030,340 |
| 45 | 5061 | Tha-303-005 | NGO | Thailand | South East Asia | HIV/AIDS | $502,525 | $911,542 | $1,371,348 |
| 46 | 6091 | TGO-303-002 | CCM | Togo | Africa | Malaria | $2,424,045 | $3,479,337 | $5,885,906 |
| 47 | 6091 | TGO-303-002 | CCM | Togo | Africa | Tuberculosis | $888,309 | $1,752,982 | $2,617,655 |
| 48 | 6561 | UGD-303-007 | CCM | Uganda | Africa | HIV/AIDS | $31,078,450 | $70,357,632 | $118,565,707 |
| 49 | 4891 | VTN-303-003 | CCM | Vietnam | Western Pacific R | Malaria | $7,592,612 | $13,388,402 | $22,787,909 |

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| Category 2B | | | | | | | $68,952,521 | $138,463,324 | $291,825,058 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 1 | 3881 | DZA-303-002 | CCM | Algeria | Eastern Mediterra | HIV/AIDS | $3,130,000 | $6,185,000 | $8,869,360 |
| 2 | 4011 | AGO-303-002 | CCM | Angola | Africa | Malaria | $11,779,000 | $25,259,000 | $38,383,000 |
| 3 | 5071 | Ban-303-004 | CCM | Bangladesh | South East Asia | Tuberculosis | $8,782,804 | $17,169,684 | $43,768,069 |
| 4 | 6201 | Ben-303-028 | CCM | Benin | Africa | Malaria | $1,028,941 | $1,383,931 | $2,145,813 |
| 5 | 4931 | Bol-303-002 | CCM | Bolivia | America | Malaria | $4,020,447 | $6,099,563 | $10,176,979 |
| 6 | 7511 | CIV-303-010 | CCM | Cote D Ivoire | Africa | Tuberculosis | $950,374 | $2,877,316 | $3,837,301 |
| 7 | 4141 | ERT-303-003 | CCM | Eritrea | Africa | HIV/AIDS | $4,139,280 | $8,124,910 | $17,354,035 |
| 8 | 4581 | HTI-303-003 | CCM | Haiti | America | Malaria | $4,093,968 | $7,390,556 | $14,856,557 |
| 9 | 4771 | MKD-303-001 | CCM | Macedonia, The Former Yugoslav Republic of | Europe | HIV/AIDS | $2,441,871 | $4,348,599 | $6,309,972 |
| 10 | 4431 | MDG-303-005 | CCM | Madagascar | Africa | HIV/AIDS | $6,663,438 | $13,415,118 | $20,009,441 |
| 11 | 6021 | MAM-303-009 | Reg.Org | Multi-country Americas | America | HIV/AIDS | $3,294,900 | $6,100,900 | $12,663,600 |
| 12 | 3331 | MYN-303-002 | CCM | Myanmar | South East Asia | HIV/AIDS | $9,246,156 | $19,221,525 | $54,300,034 |
| 13 | 4681 | RUS-303-004 | Sub-CC | Russian Federation | Europe | Tuberculosis | $3,222,312 | $6,341,210 | $10,800,827 |
| 14 | 5981 | SUD-303-016 | CCM | Sudan | Africa | HIV/AIDS | $3,500,520 | $7,842,140 | $20,781,000 |
| 15 | 5881 | Taj-303-003 | CCM | Tajikistan | Europe | Tuberculosis | $660,800 | $1,521,040 | $3,071,150 |
| 16 | 4151 | UZB-303-001 | CCM | Uzbekistan | Europe | HIV/AIDS | $1,997,710 | $5,182,832 | $24,497,920 |
| Recommended Proposals | | | | | | TOTALS | **$301,737,425** | **$620,275,723** | **$1,513,017,109** |
| | | | | | | | | | |
| **Category 3** | | | | | | | **$486,071,106** | **$976,534,490** | **$2,684,984,461** |
| | | | | | | | | | |
| 1 | 5451 | AFG-303-004 | CCM | Afghanistan | Eastern Mediterra | HIV/AIDS | $1,187,713 | $2,439,177 | $3,732,386 |
| 2 | 5451 | AFG-303-004 | CCM | Afghanistan | Eastern Mediterra | Malaria | $2,011,658 | $4,150,960 | $6,566,069 |
| 3 | 5451 | AFG-303-004 | CCM | Afghanistan | Eastern Mediterra | Tuberculosis | $2,658,383 | $5,941,748 | $9,195,317 |
| 4 | 4011 | AGO-303-002 | CCM | Angola | Africa | HIV/AIDS | $10,863,922 | $19,067,584 | $53,672,293 |
| 5 | 4011 | AGO-303-002 | CCM | Angola | Africa | Tuberculosis | $1,995,962 | $4,184,487 | $6,304,495 |
| 6 | 5071 | Ban-303-004 | CCM | Bangladesh | South East Asia | Malaria | $6,718,176 | $13,532,089 | $24,159,529 |
| 7 | 5121 | BTN-303-002 | CCM | Bhutan | South East Asia | HIV/AIDS | $201,700 | $412,700 | $1,013,700 |
| 8 | 5121 | BTN-303-002 | CCM | Bhutan | South East Asia | Malaria | $200,000 | $395,000 | $1,000,000 |
| 9 | 4111 | Bot-303-003 | CCM | Botswana | Africa | Tuberculosis | $1,183,500 | $2,243,500 | $2,243,500 |
| 10 | 4831 | Bul-303-002 | CCM | Bulgaria | Europe | Tuberculosis | $745,950 | $1,013,280 | $1,873,180 |
| 11 | 5481 | Bur-303-004 | CCM | Burkina Faso | Africa | Tuberculosis | $389,411 | $827,120 | $2,375,501 |
| 12 | 6511 | Cam-303-003 | CCM | Cambodia | Western Pacific R | HIV/AIDS | $6,893,832 | $14,731,002 | $42,910,545 |
| 13 | 6511 | Cam-303-003 | CCM | Cambodia | Western Pacific R | Malaria | $2,083,958 | $3,865,042 | $8,646,085 |
| 14 | 5111 | CAF-303-004 | CCM | Central African Republic | Africa | Malaria | $3,980,065 | $7,741,975 | $13,438,661 |
| 15 | 5111 | CAF-303-004 | CCM | Central African Republic | Africa | Tuberculosis | $1,019,885 | $1,687,749 | $4,703,130 |
| 16 | 6591 | COG-303-002 | CCM | Congo (Brazzaville) | Africa | HIV/AIDS | $4,052,838 | $8,242,988 | $13,626,984 |
| 17 | 7531 | COG-303-004 | NGO | Congo (Brazzaville) | Africa | HIV/AIDS | $1,700,000 | $3,325,000 | $7,600,000 |
| 18 | 7511 | CIV-303-010 | CCM | Cote D Ivoire | Africa | Malaria | $5,284,611 | $9,855,759 | $23,591,348 |
| 19 | 3511 | DJB-303-001 | CCM | Djibouti | Africa | HIV/AIDS | $2,507,500 | $5,807,900 | $17,143,900 |
| 20 | 3511 | DJB-303-001 | CCM | Djibouti | Africa | Malaria | $1,345,995 | $2,274,390 | $4,969,025 |
| 21 | 3511 | DJB-303-001 | CCM | Djibouti | Africa | Tuberculosis | $665,000 | $1,291,000 | $2,819,000 |
| 22 | 5741 | ECU-303-003 | CCM | Ecuador | America | Malaria | $3,385,448 | $4,565,029 | $8,035,672 |
| 23 | 5741 | ECU-303-003 | CCM | Ecuador | America | Tuberculosis | $3,039,007 | $5,977,416 | $17,065,873 |
| 24 | 4141 | ERT-303-003 | CCM | Eritrea | Africa | Tuberculosis | $1,153,878 | $1,486,180 | $2,578,673 |
| 25 | 3281 | GAB-303-002 | CCM | Gabon | Africa | Malaria | $552,640 | $1,004,778 | $1,438,264 |
| 26 | 3281 | GAB-303-002 | CCM | Gabon | Africa | Tuberculosis | $274,300 | $604,000 | $683,300 |
| 27 | 3501 | GMB-303-001 | CCM | Gambia | Africa | Tuberculosis | $5,697,846 | $6,220,664 | $7,951,258 |
| 28 | 5261 | GHN-303-004 | CCM | Ghana | Africa | HIV/AIDS | $7,612,516 | $16,707,652 | $45,146,527 |
| 29 | 5261 | GHN-303-004 | CCM | Ghana | Africa | Malaria | $12,573,248 | $21,921,387 | $44,813,933 |
| 30 | 5261 | GHN-303-004 | CCM | Ghana | Africa | Tuberculosis | $7,879,970 | $13,071,408 | $28,439,720 |
| 31 | 7361 | GIN-303-003 | CCM | Guinea | Africa | Tuberculosis | $2,002,595 | $3,488,280 | $5,284,633 |
| 32 | 3441 | GNB-303-001 | CCM | Guinea-Bissau | Africa | HIV/AIDS | $2,355,133 | $4,129,958 | $10,394,878 |
| 33 | 3441 | GNB-303-001 | CCM | Guinea-Bissau | Africa | Malaria | $1,644,646 | $2,755,057 | $5,063,441 |
| 34 | 5331 | IDA-303-023 | CCM | India | South East Asia | HIV/AIDS | $16,630,000 | $38,390,000 | $109,970,000 |
| 35 | 5331 | IDA-303-023 | CCM | India | South East Asia | Malaria | $20,477,625 | $42,883,376 | $89,021,562 |
| 36 | 5101 | Ind-303-002 | CCM | Indonesia | South East Asia | HIV/AIDS | $7,263,000 | $23,101,000 | $101,099,000 |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 37 | 7541 | IRN-303-003 | CCM | Iran (Islamic Republic of) | Eastern Mediterra | Malaria | $2,297,822 | $3,299,697 | $5,777,139 |
| 38 | 3301 | KAZ-303-002 | CCM | Kazakhstan | Europe | Tuberculosis | $2,684,158 | $5,393,118 | $11,405,345 |
| 39 | 4351 | KEN-303-009 | CCM | Kenya | Africa | HIV/AIDS | $19,761,142 | $58,004,104 | $392,706,750 |
| 40 | 7111 | KGZ-303-002 | CCM | Kyrgyzstan | Europe | Malaria | $440,000 | $785,000 | $1,490,000 |
| 41 | 4771 | MKD-303-001 | CCM | Macedonia, The Former Yugoslav Republic of | Europe | Tuberculosis | $723,300 | $1,142,500 | $2,132,400 |
| 42 | 4431 | MDG-303-005 | CCM | Madagascar | Africa | Tuberculosis | $920,739 | $1,681,016 | $3,458,007 |
| 43 | 3411 | MDV-303-002 | CCM | Maldives | South East Asia | HIV/AIDS | $567,300 | $1,005,100 | $1,875,100 |
| 44 | 3901 | Mal-303-002 | CCM | Mali | Africa | HIV/AIDS | $6,306,712 | $17,492,950 | $33,807,445 |
| 45 | 5811 | MRT-303-003 | CCM | Mauritania | Africa | HIV/AIDS | $1,510,147 | $2,445,256 | $5,238,664 |
| 46 | 6121 | MAF-303-044 | Reg.Org | Multi-country Africa | Africa | Malaria | $1,484,559 | $3,033,458 | $8,757,113 |
| 47 | 6701 | MAF-303-050 | Reg.Org | Multi-country Africa | Africa | HIV/AIDS | $1,557,000 | $3,077,000 | $7,872,000 |
| 48 | 6811 | MAM-303-012 | Reg.Org | Multi-country Americas | America | Malaria | $7,378,000 | $15,909,000 | $26,483,000 |
| 49 | 6381 | MSE-303-002 | Reg.Org | Multi-country South East Asia | South East Asia | HIV/AIDS | $2,181,002 | $4,125,894 | $6,229,688 |
| 50 | 3291 | NGR-303-001 | CCM | Niger | Africa | Tuberculosis | $866,001 | $1,867,084 | $3,522,585 |
| 51 | 6651 | NGA-303-004 | CCM | Nigeria | Africa | HIV/AIDS | $40,829,620 | $87,783,683 | $157,186,538 |
| 52 | 4271 | PKS-303-006 | CCM | Pakistan | Eastern Mediterra | HIV/AIDS | $2,439,151 | $6,138,487 | $13,241,330 |
| 53 | 5621 | Pan-303-004 | CCM | Panama | America | HIV/AIDS | $3,901,648 | $8,075,594 | $18,475,669 |
| 54 | 3351 | PNG-303-002 | CCM | Papua New Guinea | Western Pacific R | HIV/AIDS | $1,086,000 | $2,290,000 | $6,172,000 |
| 55 | 3921 | PRY-303-003 | CCM | Paraguay | America | HIV/AIDS | $4,920,306 | $9,811,763 | $24,857,053 |
| 56 | 4681 | RUS-303-004 | Sub-CC | Russian Federation | Europe | HIV/AIDS | $2,270,445 | $3,492,841 | $6,768,425 |
| 57 | 6861 | RUS-303-006 | CCM | Russian Federation | Europe | HIV/AIDS | $10,531,594 | $24,076,047 | $89,402,330 |
| 58 | 6861 | RUS-303-006 | CCM | Russian Federation | Europe | Tuberculosis | $17,570,152 | $24,298,048 | $44,261,635 |
| 59 | 3261 | STP-303-002 | CCM | Sao Tome and Principe | Africa | HIV/TB | $1,321,949 | $2,139,658 | $2,139,658 |
| 60 | 3261 | STP-303-002 | CCM | Sao Tome and Principe | Africa | Malaria | $975,382 | $1,975,026 | $1,975,026 |
| 61 | 7091 | Ser-303-003 | Sub-CC | Serbia | Europe | HIV/AIDS | $879,983 | $1,909,799 | $2,537,999 |
| 62 | 5301 | SLE-303-003 | CCM | Sierra Leone | Africa | HIV/AIDS | $5,153,197 | $10,855,343 | $22,249,086 |
| 63 | 5301 | SLE-303-003 | CCM | Sierra Leone | Africa | Malaria | $2,373,006 | $4,154,607 | $10,239,802 |
| 64 | 4531 | SOM-303-003 | NGO | Somalia | Africa | HIV/AIDS | $1,550,000 | $2,950,000 | $4,420,000 |
| 65 | 4531 | SOM-303-003 | NGO | Somalia | Africa | Malaria | $338,000 | $588,000 | $953,000 |
| 66 | 4531 | SOM-303-003 | NGO | Somalia | Africa | Tuberculosis | $1,555,000 | $2,955,000 | $4,155,000 |
| 67 | 7261 | SAF-303-019 | CCM | South Africa | Africa | Tuberculosis | $7,307,353 | $14,996,075 | $40,385,688 |
| 68 | 7301 | SAF-303-023 | CCM | South Africa | Africa | HIV/AIDS | $4,150,823 | $8,553,624 | $25,011,428 |
| 69 | 7351 | SAF-303-025 | CCM | South Africa | Africa | HIV/AIDS | $4,518,100 | $23,136,451 | $89,805,132 |
| 70 | 7381 | SAF-303-027 | CCM | South Africa | Africa | HIV/AIDS | $2,302,000 | $2,668,769 | $2,700,677 |
| 71 | 7931 | SAF-303-301 | CCM | South Africa | Africa | HIV/AIDS | $43,141,862 | $69,898,308 | $292,922,500 |
| 72 | 7931 | SAF-303-301 | CCM | South Africa | Africa | Malaria | $8,027,353 | $7,688,722 | $41,105,688 |
| 73 | 8051 | SAF-303-038 | CCM | South Africa | Africa | Integrated | $28,534,927 | $57,069,854 | $81,088,928 |
| 74 | 8131 | SAF-303-043 | CCM | South Africa | Africa | HIV/TB | $4,293,500 | $9,062,250 | $29,986,888 |
| 75 | 5981 | SUD-303-016 | CCM | Sudan | Africa | Tuberculosis | $1,504,700 | $2,993,000 | $6,066,100 |
| 76 | 7181 | SUD-303-018 | Sub-CC | Sudan | Africa | HIV/AIDS | $13,922,820 | $25,585,580 | $66,394,187 |
| 77 | 7181 | SUD-303-018 | Sub-CC | Sudan | Africa | Malaria | $10,019,872 | $18,810,078 | $40,557,540 |
| 78 | 7181 | SUD-303-018 | Sub-CC | Sudan | Africa | Tuberculosis | $2,717,359 | $4,809,284 | $11,455,992 |
| 79 | 3391 | SUR-303-002 | CCM | Suriname | America | HIV/AIDS | $1,462,129 | $2,188,432 | $4,676,831 |
| 80 | 3391 | SUR-303-002 | CCM | Suriname | America | Malaria | $1,581,015 | $2,775,330 | $4,724,035 |
| 81 | 5881 | Taj-303-003 | CCM | Tajikistan | Europe | HIV/AIDS | $635,137 | $913,418 | $8,752,490 |
| 82 | 5881 | Taj-303-003 | CCM | Tajikistan | Europe | Malaria | $860,036 | $1,835,399 | $4,203,998 |
| 83 | 7331 | Ukr-303-005 | CCM | Ukraine | Europe | Tuberculosis | $11,401,070 | $27,804,760 | $74,719,030 |
| 84 | 4151 | UZB-303-001 | CCM | Uzbekistan | Europe | Tuberculosis | $5,265,777 | $14,639,371 | $41,844,049 |
| 85 | 4091 | YEM-303-003 | CCM | Yemen | Eastern Mediterra | HIV/AIDS | $3,134,828 | $5,500,405 | $14,764,062 |
| 86 | 4091 | YEM-303-003 | CCM | Yemen | Eastern Mediterra | Tuberculosis | $461,278 | $1,073,925 | $3,808,052 |
| 87 | 8001 | ZIM-303-005 | CCM | Zimbabwe | Africa | HIV/AIDS | $31,394,600 | $56,057,370 | $141,764,620 |
| 88 | 8001 | ZIM-303-005 | CCM | Zimbabwe | Africa | Tuberculosis | $2,829,342 | $6,382,377 | $9,885,377 |

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| Category 4 | | | | | | | $147,640,383 | $253,504,559 | $557,841,110 |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| 1 | 8181 | ACR-303-006 | Reg.Org | Africa Caribbean | Inter regional | HIV/AIDS | $7,940,864 | $12,773,451 | $40,436,931 |
| 2 | 5071 | Ban-303-004 | CCM | Bangladesh | South East Asia | HIV/AIDS | $4,922,225 | $11,456,195 | $29,596,475 |
| 3 | 5271 | BRB-303-001 | CCM | Barbados | America | HIV/AIDS | $5,637,741 | $9,208,353 | $10,157,002 |
| 4 | 5041 | DMR-303-002 | CCM | Dominican Republic | America | Malaria | $1,052,057 | $2,034,530 | $4,942,432 |
| 5 | 6871 | IRQ-303-002 | Reg.Org | Iraq | Eastern Mediterra | Integrated | $4,582,481 | $9,463,037 | $16,586,640 |
| 6 | 4351 | KEN-303-009 | CCM | Kenya | Africa | Integrated | $7,552,072 | $25,092,923 | $44,753,257 |
| 7 | 4661 | MAF-303-024 | Reg.Org | Multi-country Africa | Africa | HIV/AIDS | $8,203,000 | $15,477,500 | $21,517,000 |
| 8 | 5421 | MAF-303-033 | Reg.Org | Multi-country Africa | Africa | Malaria | $16,171,000 | $21,747,000 | $59,909,000 |
| 9 | 5861 | MAF-303-041 | Reg.Org | Multi-country Africa | Africa | Malaria | $51,179,486 | $51,179,486 | $51,179,486 |
| 10 | 7432 | MAF-303-053 | Reg.Org | Multi-country Africa | Africa | Malaria | $553,656 | $1,123,580 | $1,586,854 |
| 11 | 7821 | MAF-303-054 | Reg.Org | Multi-country Africa | Africa | HIV/TB | $1,303,824 | $2,566,176 | $6,069,417 |
| 12 | 8111 | MAF-303-058 | Reg.Org | Multi-country Africa | Africa | HIV/AIDS | $10,870,310 | $34,170,415 | $177,947,238 |
| 13 | 8201 | MAF-303-059 | Reg.Org | Multi-country Africa | Africa | Malaria | $7,980,458 | $7,980,458 | $7,980,458 |
| 14 | 4271 | PKS-303-006 | CCM | Pakistan | Eastern Mediterra | HIV/TB | $157,000 | $314,000 | $314,000 |
| 15 | 7951 | SAF-303-033 | CCM | South Africa | Africa | HIV/TB | $8,920,497 | $30,443,293 | $40,401,047 |
| 16 | 8071 | SAF-303-040 | CCM | South Africa | Africa | HIV/TB | $300,000 | $776,000 | $5,031,000 |
| 17 | 8151 | SAF-303-045 | CCM | South Africa | Africa | HIV/TB | $2,853,703 | $5,698,953 | $8,683,346 |
| 18 | 6741 | TNZ-303-014 | CCM | Tanzania | Africa | HIV/AIDS | $1,603,969 | $3,495,249 | $20,217,262 |
| 19 | 4811 | TUR-303-003 | CCM | Turkey | Europe | HIV/AIDS | $5,160,170 | $6,975,950 | $8,447,705 |
| 20 | 4811 | TUR-303-003 | CCM | Turkey | Europe | Malaria | $20,200 | $235,150 | $309,900 |
| 21 | 4811 | TUR-303-003 | CCM | Turkey | Europe | Tuberculosis | $675,670 | $1,292,860 | $1,774,660 |
| **Technically Sound** | | | | | | | | | |
| | | | | | | | | | |
| 1 | 5701 | MAM-303-005 | Reg.Org | Multi-country Americas | America | HIV/AIDS | **$793,629** | $2,553,861 | $10,172,497 |
| | | | | | | | **TOTALS** | **$1,852,868,633** | **$4,766,015,177** |

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