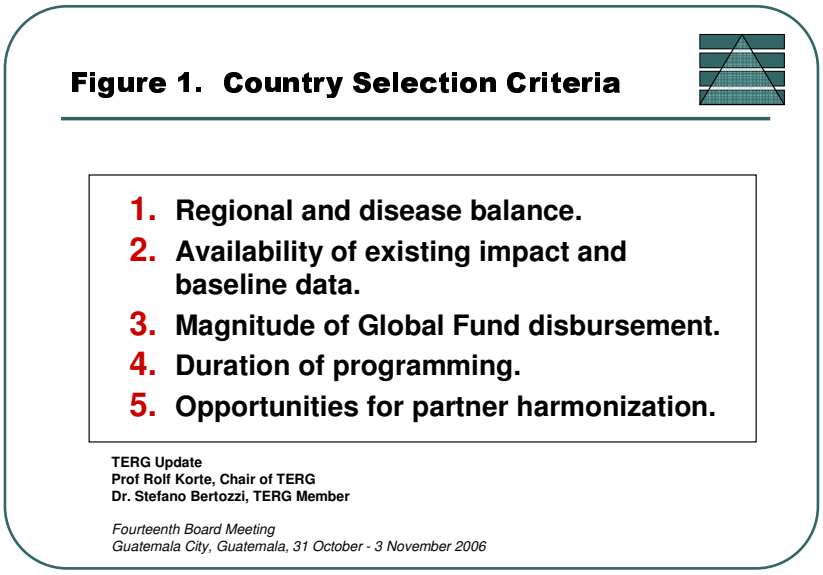
Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

THE GLOBAL FUND FIVE-YEAR EVALUATION COUNTRY SELECTION PROCESS

I. PURPOSE

The Global Fund Five-Year Evaluation (5YE) was designed to include an evaluation of disease impact (Study Area 3) in a total of 20 countries, including 8 'Comprehensive Evaluation Countries' (CECs) and 12 'Secondary Evaluation Countries' (SACs). At the Fourteenth Board Meeting of the Global Fund, the Technical Evaluation Reference Group of the Global Fund (TERG) set forth 5 criteria to drive the process of selecting countries for impact evaluation (Figure 1).

This paper describes the operationalization and application of these criteria and the resulting selection by TERG of 12 CECs, and a proposed selection of 8 SACs to participate in the Global Fund Five-Year Impact Evaluation. In addition, a provisional selection is proposed of 16 countries for Study Area 2 (Global Fund partner environment and grant performance), which was in part based on the same selection process and criteria.



II. DESIRED REGIONAL DISTRIBUTION OF COUNTRIES

The desired regional distribution of impact evaluation countries was decided prior to applying the country selection criteria, with the aim to mirror the regional distribution in Global Fund grant commitments, and to ensure that the impact evaluation takes place in a wide variety of contexts.

The 20 countries will be distributed proportional to grant disbursements to regions. Figure 2 shows the distribution of Global Fund grant disbursements over the 8 global Fund regions, as of December 2006. It is of note that grant *commitments*, over the full 3-5 year lifecycle of approved grants, for grants from rounds 1-5 show an almost identical regional distribution (not shown). Figure 3 shows the corresponding distribution of 20 target countries over the 8 Global Fund regions.

Just over half of all grant disbursements (55%) have been to sub-Saharan Africa, and therefore just over half of the 20 countries (11 of 20 countries) will also be selected from

these regions: 5 from East Africa, 3 from Southern Africa and 3 from West and Central Africa (Figure 3). For the remaining regions, the distribution of disbursements suggest 3 countries in East Asia and the Pacific (15% of total disbursements); 2 countries each from Eastern Europe & Central Asia and from Latin American & the Caribbean (which each account for 10% of total disbursements); and 1 country each from North Africa & the Middle East and from South Asia (which each have received about 5% of cumulative disbursements).

Figure 2. Dispersion of GF disbursements (mln US$), by region (Dec. 2006)

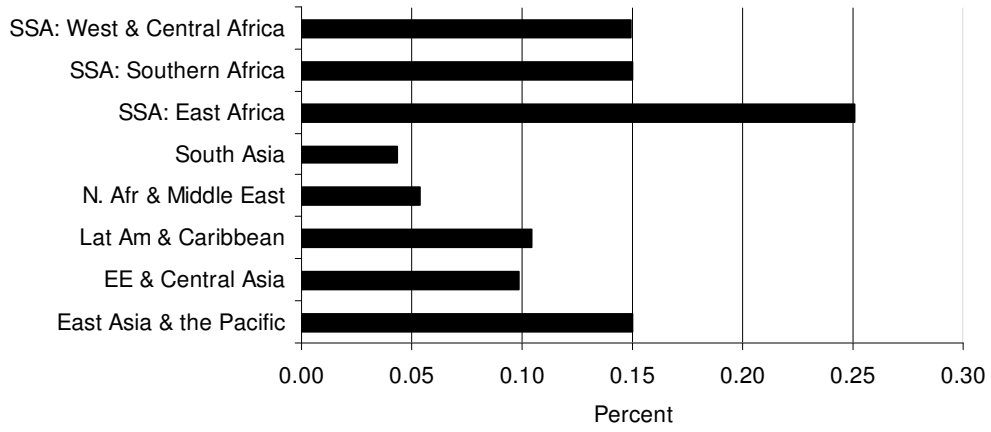


Figure 3. Desired distribution of 20 impact evaluation countries according to distribution of grant disbursements

Region	*Cumulative grant disbursements (December 2006)*	*Corresponding distribution of 20 countries for impact evaluation*
East Asia & the Pacific	15%	3
Eastern Europe & Central Asia	10%	2
Latin America & Caribbean	10%	2
North Africa & Middle-East	5 %	1
South Asia	4 %	1
Sub-Saharan Africa: East Africa	25 %	5
Sub-Saharan Africa: Southern Africa	15 %	3
Sub-Saharan Africa: West & Central Africa	15 %	3
TOTAL	**100%**	**20**

III. COUNTRY SELECTION PROCESS

A total of 113 countries which have at least one active Global Fund grant from rounds 1 to 5, as of December 2006, were eligible for selection.

In summary, the selection process entailed, first, the screening of the 113 countries based on 4 initial selection criteria (minimum country size, minimum 2 diseases with grants, minimum grant duration, minimum total disbursements). Secondly, countries that 'qualified' according to these four screens were ranked, within geographical region, by level of disease burden and grant cumulative disbursements – where the countries ranking highest in terms of disease burden, and as secondary criterion grant magnitude, were considered to be the most logical candidates.

The third step consisted of proposing this ranked list to country and regional experts within and outside the Global Fund, to take into account their estimation of the partner environment and preparedness and capacity for impact evaluation for the countries within each region. This expert input resulted in selecting-out, from the top-listed number of countries within each regional quotum, certain countries ranking high in disease burden and, as secondary criterion, grant amount, and selecting-in several lower-burden / lower grant amount countries that were judged particularly suitable in view of an advanced state of preparedness and capacity for impact evaluation.

Fourth, from the thus obtained shortlist of (32) countries, TERG pre-selected CECs and is in the process of selecting SACs, with further input from country experts in partner organizations. For CECs, countries with highest burden and highest-grant amounts were prioritized, provided they were judged acceptable in terms of quality of routine data collection and M&E, and again country capacity and readiness for impact evaluation, taking account also of the strength of the national partnership system. For SACs, countries with relatively good baseline (survey and financial) data were prioritized. Also priority was given to countries able to participate to both Study area 3 and Study area 2, as complete case studies will be valuable to learn lessons from such comprehensive evaluations.
The same 32 countries were finally reviewed to select 16 candidates for Study Area 2, seeking a balance between well-performing and less well performing recipients, according to average grant Phase 2 ratings.

These steps are described in detail below.

Step 1. Initial screening (result: 56 QUALIFYING countries)
Four initial screens were applied to the pool of 113 recipient countries from Global Fund Rounds 1-5, to immediately exclude countries which would be of lesser interest:

1. "Minimum population size" excluding countries with population size, as of 2006, in the lowest decile (<1.42 million).
2. "Minimum 2 diseases with grants" excluding countries receiving GF grant/s for only one disease.
3. "Minimum grant duration" excluding countries that received their first grant disbursement later than July 2004.
4. "Minimum grant amount" excluding countries with cumulative grant disbursement amounts in the lowest two deciles (<US$ 5.0 million), as of December 2006.

This screening resulted in the exclusion of 57 countries (Figure 4), leaving a total of 56 'qualifying' countries with relatively more significant population size, mix of diseases with Global Fund grants in terms of diseases, duration of funding and disbursement amount.

Figure 4. Initial country screening and number of excluded countries

Criterion	Countries excluded, out of 113 recipients*
"Minimum population size"	14
"Minimum 2 diseases with grants"	29
"Minimum grant duration"	35
"Minimum grant amount"	23
Total excluded	57
Total qualifying	56

Note: screening criteria are not mutually exclusive. A country may be excluded for not meeting any one or more of the criteria.

Step 2. Ranking by disease burden and grant magnitude
(result: WITHIN-REGION RANKS among qualifying countries)

Within each region, the qualifying countries were ranked by level of disease burden and grant financial amount.

A. Disease burden. Disease burden was operationalized by using one key indicator for each disease: adult HIV prevalence rate (2005 estimates), tuberculosis disease incidence rate (2004 estimates) and malaria mortality rate (2005 estimates). For the purpose of obtaining one overall, cross-disease score for each country, country scores for each disease indicator were categorized into quartiles. For each country, quartile scores for the diseases for which it has/had Global Fund grants, were averaged (so that, for example, the level of malaria burden would not factor in for countries with no malaria grant).

B. Grant amount. Two indicators of Global Fund grant amount were considered: 1) total disbursements from all grants in a country, up to December 2006, *per capita*; and 2) total disbursements as proportion of the total national health expenditure in 2003 (the most recent expenditure data available). Country values for both indicators were grouped into terciles, and, for each country, summed.

The disease burden score (range 1-4) and grant amount score (range 2-6) were then each standardized on a scale of 1-10. Within each region, the countries ranking highest in terms of disease burden, and, among countries with the same disease burden rank, as secondary criterion grant amount, were considered to be the most logical candidates.

Step 3. Appraisal of country capacity and partnerships
(result: 32 SHORTLISTED countries)

The third step consisted of proposing the ranked lists of countries within each region, to country and regional experts within and outside the Global Fund. Outside to the Global Fund, comments were seek from WHO, Office of the Global AIDS Coordinator (OGAC), Worldbank, UNAIDS and other stakeholders (bilateral donors) to take into account their estimation of the:

1) preparedness of national partners (including Government and CCM/PR) and capacity of the country to implement, in collaboration with the cross-country coordinating body contracted by the TERG/Secretariat, the impact evaluation activities and to achieve the objectives of the impact evaluation; and
2) strength and support of the network of partners in each country (e.g., international programmes of HIV/AIDS, tuberculosis and malaria control and/or financial support).

The strength of the partnership network was furthermore assessed by scoring the presence of PEPFAR, World Bank Malaria booster programme, World Bank Multi-country programme on AIDS (MAP) USA President's Malaria Initiative and WHO/Stop TB in each country. As of December 2006, 15 countries were supported by PEPFAR, 9 by the World Bank Malaria booster programme, 30 by MAP, 16 by PMI and 22 (high-burden countries) by WHO/Stop TB.

This expert input resulted in selecting-out, from the top-listed countries within each regional quotum (Figure 3), certain countries ranking high in disease burden and, secondarily, grant amount, while selecting-in several lower-ranking countries that were judged particularly suitable in view of an advanced state of preparedness and capacity for impact evaluation. The

result was a shortlist of 32 countries, most of which were still among the highest ranked within their region in terms disease of burden and, secondarily, grant amount.

Step 4. Further country-expert input and appraisal of data availability
(result: 12 candidate-CECs & 8 additional SACs)

From countries on this shortlist, the TERG provisionally selected 12 of them to be invited to be candidate CECs: countries with highest burden and highest grant amounts were prioritized, provided they were judged acceptable in terms of quality of routine data collection and country capacity and readiness for impact evaluation, considering also the national partnership system.

For SACs, for which the impact evaluation would involve no or only limited primary data collection, countries were sought with relatively good baseline data. To judge this, a data availability score was constructed for each country, comprising of:

- The number of population-based (household or target-population) surveys, conducted between 2000 and 2007 (according to plannings of summer 2006), which measured indicators of the three diseases and/or the coverage of relevant interventions:
    - for HIV/AIDS: Demographic and Health Surveys (DHS)[1], Multiple Indicator Cluster Surveys (MICS)[2], AIDS Indicator Surveys (AIS), Behavioral Surveillance Survey (BSS) and Sexual Behavior Surveys (SBS);
    - for TB: Prevalence surveys and tuberculin surveys recorded in the WHO/STB database;
    - for Malaria: DHS, MICS, Netmark survey, Malaria Indicator survey, WHO/Headquarters' World Health Surveys, AIDS indicator survey and surveys conducted in conjunction with Expanded Programme of Immunization (EPI) campaigns or surveillance[3].
- Existence of national health accounts (NHA) with sub-account components for the three diseases[4].
- Existence of relevant health facility surveys (Service availability and provision assessments, Service Availability Mapping, facility censuses, etc.).

A country's overall household survey score was constructed as the average number of population-based surveys for the diseases with grants (e.g., not counting number of TB surveys for countries with no TB grants). The overall data availability score weighted the existence of NHAs twice compared to the other two data types, to appraise the importance of NHAs as the only means to identify the financial share of Global Fund (and other partners' and programmes') in total national health expenditures.

Step 5. Appraisal of grant performance (result: provisional proposal 16 countries for SA-2)

TERG then reviewed the same shortlist of 32 countries to select 16 candidates for Study Area 2, seeking a balance between well-performing and less well performing recipients. Grant performance was based on the average of all grant Phase 2 ratings within each country; as all countries on the shortlist had, as of December 2006, completed at least 1 Phase 2 review (range 1-7). To this end, Phase 2 ratings of A, B1, B2 and C were quantified as scores 1,2,3, and 4; countries with an average Phase 2 score of less than 1.8 were categorized as well-performing, countries with an average score of 1.8-2.5 as medium-performing and countries

[1] ORC Macro - MEASURE *DHS+*. Demographic and Health Surveys (DHS): ORC Macro, Calverton, MD, USA http://www.measuredhs.com/

[2] UNICEF, http://www.childinfo.org/MICS2/MICSCTY/MICScntry2.htm

[3] Source: Household Survey Status in Africa south of the Sahara; as of May 4 2005 http://www.rollbackmalaria.org/partnership/wg/wg_monitoring/docs/HHsurvey_schedule.xls

[4] http://www.who.int/nha/en/

with an average score of above 2.5 as poor performing. In this way, 6 well-performing, 6 medium-performing and 4 poor-performing countries were selected for Study Area 2.

Step 6 / Next steps

Under a recently signed Memorandum of Understanding (MOU) with the GF**,** UNAIDS has agreed to facilitate, the fast-tracking of impact evaluation activities by bringing together all relevant country-level partners involved in HIV, TB and malaria in the 12 CEC candidate countries. In particular, UNAIDS will support the establishment of country level Impact Evaluation Task Forces, and will facilitate the development of country impact evaluation implementation plans with gap analyses. It is expected that bilateral and multilateral partners, in addition to local stakeholders including governments, CCM/PR, civil society representatives, local universities and more will be involved in these intensive in-country efforts.

Representatives of the 12 CEC candidates will be invited to a '*Partners in Impact' Forum* in Geneva, 26-28 February 2007, to strengthen country impact evaluation plans and activities based on sharing of experiences between countries and on partners' technical expertise.
Immediately following the Forum, TERG will select the final list of 8 CECs, based on the quality of presented country impact evaluation plans, and reviewing existing criteria such as geographical distribution and grant performance. The 4 remaining CECs candidates will be invited to participate in the impact evaluation as SACs.

IV. RESULTING SELECTION OF CECS CANDIDATES AND PROPOSAL FOR SECS

This section describes and explains TERG's selection of 12 CEC candidates – of which 8 will ultimately become CECs and 4 SACs – and a proposal for 8 additional SACs. The selections are compared with the burden & grant amount ranks of these countries among all qualifying countries within their region.

In the East Asia and Pacific region, China was selected as CEC candidate despite its low ranking on disease burden and grant amount. This is because China's large national population, the denominator for both disease burden indicators and for disbursements *per capita*, masks the significant absolute disease burden and grant amount in the country (for example, 15% of worldwide incident TB cases are in China according to 2004 estimates). Regions of China with relatively higher disease burden and investments will be selected to evaluate impact. Furthermore, China has shown a high level of preparedness and capacity to partake in the evaluation. Highest-burden high-grant Papua New Guinea was judged poorly in terms of preparedness, capacity and a supportive environment, and so was not selected.
As a SAC, Viet Nam could be selected over Thailand, in view of high burden, good data availability and positive opinion among regional experts, compared to (second choice) Thailand.

In Eastern Europe and Central Asia, Moldova was selected as CEC candidate as it ranked highest in disease burden and secondarily grant amount. Russia, ranking equally high in terms of disease burden, was not selected, because of low grant amount criteria and data availability. Furthermore, experience in country indicates that it would not be an efficient or even welcoming place to conduct an evaluation. Kyrgyzstan would be a logical SAC candidate, more so than slightly higher-burden Georgia and Romania because of better data availability.
In the Latin America and Caribbean region, Haiti and Peru, the two qualifying highest-burden countries, were selected as CEC candidate. It is proposed to not select any SACs in this region, so as not to over-represent the region compared to its share in total disbursements (Figure 3).

In South Asia, India was selected as CEC candidate, over Nepal which had similar disease burden, but less data available and less support from stakeholders within and outside the Global Fund. In addition, although the standardized grant amount score was higher for Nepal, India would score higher in terms of grant amount if this were calculated against populations of certain high-burden, programme-targeted states – which are the unique focus of the Global Fund supported control programmes and which will also be the focus of the 5YE – instead of the national population. Bangladesh, with similarly high burden, could be selected as SAC.
From the Global Fund region North Africa and the Middle East, none of the four qualifying countries were selected as CEC candidate, or are proposed as SAC. This is because the two highest ranking countries, Mali and Chad, are (per UN-designation) located in West Africa, where Burkina and Ghana were already appointed CAC candidate and Senegal is proposed as SAC. The two remaining countries, Somalia and Yemen, were not selected because Somalia lacks published data on total health expenditures and Yemen suffers from a lack of baseline data for the 3 diseases.

In sub-Saharan Africa almost all countries rank very high in terms of disease burden, grant amount and data availability. In these regions, constituting 11 or 12 of the total 20 countries to participate in the evaluation, there are still several countries to be selected. In these regions, expert judgement on country preparedness, capacity played a comparatively large role in the selection. A balance was furthermore sought between countries with strong presence of international financing and technical partners, and countries with a weaker partnership network. In East Africa, highest-burden Tanzania became CEC candidate, instead of Uganda which met less support from country experts. Ethiopia was selected as a second CECs, over higher-burden Burundi and Kenya, because of comparably favorable expert opinions on country readiness, capacity and availability of baseline data. Kenya and Rwanda, with comparatively good data availability, are proposed as SACs.
From Southern Africa, Zambia and Malawi were selected as CEC candidate. South Africa and Lesotho, with equally high burden, were not, due to less favorable judgment on country readiness and capacity for impact evaluation. Mozambique (if not Benin) might be selected as SAC.

From Western & Central Africa, Burkina Faso and Ghana were selected as CEC candidate, mainly because of favorable judgement on country readiness and capacity compared to some higher-burden countries. Highest-burden Nigeria, and Senegal, and perhaps Benin (if not Mozambique), are potential SACs.

V. LIMITATIONS IN THE SELECTION PROCESS

Several limitations are acknowledged in the selection process. Most important, the selection of countries is a purposeful (i.e. convenience) sample rather than a probabilistic sample, and therefore the sample cannot be assumed to be representative of the total of countries with active Global Fund grants. While regional balance was ensured by selecting the number of countries for each region in proportion to the regions' shares in disbursement, TERG purposefully selected as CECs countries where expected total health impact would be relatively important and likely to be measurable, by excluding countries with short grant duration, relatively low Global Fund disbursements and/or only one type of disease grant. This choice also reflects the aim to learn 'best evaluation practices' from successful case studies within CECs, and to build the desired 'model platform' for impact evaluation that can subsequently be applied in other countries.

The definitions of disease burden, grant amount and data availability scores were kept simplistic, and may in some cases have led to unintended, arbitrary rank orders. Notably, grant amount was scored on a *per capita* basis compared to national population sizes (and national health expenditures), whereas in certain countries, notably some very large ones where disease burden and Global Fund-supported programmes are largely limited to sub-areas of the country. When instead expressing grant disbursements per person with HIV or tuberculosis and per person living in a malaria transmission risk area, the larger countries China, Indonesia and Russia get higher grant amount scores, although the scores for India, Ethiopia and Nigeria would decrease.

Second, the data availability score did not take into account the (varying) quality, coverage and completeness of vital registration in qualifying countries, a potentially important data source for mortality impact, for lack of complete, standardized statistics about vital registration systems for the total set of qualifying countries.
As a third example, the scoring of disease burden and grant amount into quartiles and tertiles, respectively, ignored variation and precision in available data and estimates. This may have biased the ranking between countries in the same quartile for burden but differing tertiles of grant amounts.

A final limitation is that the important judgments and knowledge on country preparedness and capacity to undertake impact evaluation from country-experts within the Global Fund and among external Stakeholders on Impact, were seriously taken into account at several stages of the selection process, but not documented in detail.

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Candidate Countries for Study Areas 3 (CECs & SACs) and 2

For calculations & complete background data see worksheet 'All 113 c'ies, subselect 56 & 32'

Data reflect situation of December 2006

GF Region (& desired no. of c'ies for SA3, to achieve regional distribution proportional to disbursements)	**Country**	**GF cumulative disbursements (US $)** HIV/AIDS	TB	Malaria	**QUALIFY** (pre-screen, from 113 to 56 countries)	**Standardized scorings** **Disease burden quartiles (Range 1-10)**	Grant finance amount (Range 1-10)	Data availability (Range 1-6)	Secretariat Judgements of suitability for 5YE - among 56 qualifying c'ies Operations	Perfo. Evaluation & Policy	Grant Performance (av. Phase 2 rating)	International partners	**Study Area 3** **12 candidate Comprehensive Evaluation countries (CECs)**	**Proposed 8 (additional) Secondary Analysis countries (SACs)**	**Study Area 2** **Proposed 16 countries, by level of grant performance** Good perf.	Medium perf.	Poor perf.
E. Asia & Pacific (3)	Cambodia	35,821,348	5,139,871	11,191,835	YES	**8**	10	2.7	Good	Good	Medium	5	x			x	
E. Asia & Pacific (3)	Vietnam	8,694,722	2,500,000	12,355,174	YES	**5**	1	5.0	Good	Neutral	Medium	1,5		x			
E. Asia & Pacific (3)	Indonesia	20,874,406	38,429,197	15,410,639	YES	**4**	1	2.0	Good	Neutral	Medium	5					
E. Asia & Pacific (3)	China	56,008,431	58,114,728	13,295,197	YES	**2**	1	2.3	Good	Good	Good	5	x		x		
EE & Central Asia (2)	Ukraine	51,834,560	-	-	NO: HIV grant	**7**	6	4.0	Poor		Medium	-					
EE & Central Asia (2)	Moldova	4,553,971	4,553,971	-	YES	**6**	6	0.5	Good	Neutral	Good	-	x		x		
EE & Central Asia (2)	Georgia	5,270,905	1,339,913	806,300	YES	**3**	6	0.7	Good	Neutral	Medium	-					
EE & Central Asia (2)	Kyrgyzstan	7,454,538	1,466,311	933,345	YES	**2**	6	2.0	Good	Neutral	Medium	-		x		x	
L A & Carib (2)	Haiti	52,170,677	6,871,331	6,544,146	YES	**7**	10	1.3	Good	Neutral	Good	1	x		x		
L A & Carib (2)	Peru	19,333,815	24,626,409	-	YES	**6**	6	3.0	Good	Good	Medium	-	x			x	
L A & Carib (2)	Dominican Republic	13,853,287	1,683,124	-	YES	**6**	3	3.0	Good	Neutral	Good	-					
L A & Carib (2)	Honduras	20,934,987	5,070,310	5,542,598	YES	**5**	8	1.0	Neutral	Neutral	Poor	-					
N. Afr & Mid-East (1)	Yemen	3,378,501	2,309,685	5,278,128	YES	**5**	3	0.0	Good	Neutral	Poor	-					x
South Asia (1)	Nepal	3,194,329	1,442,630	1,673,683	YES	**4**	3	1.3	Good	Neutral	Medium	-					
South Asia (1)	India (one state)	22,327,050	17,977,450	13,419,026	YES	**4**	1	4.7	Good	Good	Medium	5	x				
South Asia (1)	Bangladesh	8,287,114	22,767,367	-	YES	**4**	1	4.0	Good	Neutral	Good	5		x	x		
SSA: East (5)	Tanzania (& Zanzib	59,675,677	1	49,527,765	YES	**10**	10	5.3	Good	Good	Medium	1,2,3,5	x			x	
SSA: East (5)	Uganda	33,657,270	4,599,506	52,204,485	YES	**10**	10	3.3	Neutral	Neutral	Poor	1,2,3,5					
SSA: East (5)	Burundi	13,516,474	1,368,790	16,568,331	YES	**9**	10	1.0	Good	Neutral	Medium	3					
SSA: East (5)	Kenya	29,326,570	5,968,645	56,829,416	YES	**9**	10	3.0	Neutral	Neutral	Poor	1,2,3,5		x			x
SSA: East (5)	Ethiopia	95,415,280	15,327,331	107,989,811	YES	**8**	10	5.7	Neutral	Good	Medium	1,2,3,4,5	x				
SSA: East (5)	Rwanda	40,737,695	20,202,699	49,049,296	YES	**8**	10	4.7	Good	Neutral	Good	1,2,3		x			
SSA: Southern (3)	Malawi	64,297,184	-	6,363,507	YES	**10**	10	4.0	Good	Good	Medium	2,3,4	x			x	
SSA: Southern (3)	Zambia	68,954,692	19,479,427	31,358,089	YES	**10**	10	6.0	Good	Good	Good	1,2,3,4	x		x		
SSA: Southern (3)	Lesotho	12,542,234	1,654,010	-	YES	**10**	10	1.0	Neutral	Neutral	Poor	-					
SSA: Southern (3)	Mozambique	20,522,476	7,215,542	6,653,718	YES	**9**	8	2.0	Neutral	Neutral	Medium	1,2,3,5		*x?*			*x?*
SSA: West & Central (3)	DR Congo	30,142,942	12,327,396	22,748,859	YES	**10**	10	2.3	Poor	Neutral	Medium	3,4,5					
SSA: West & Central (3)	Nigeria	20,534,904	-	27,743,554	YES	**10**	3	5.5	Good	Neutral	Poor	1,3,4,5		x		x	
SSA: West & Central (3)	Burkina Faso	9,611,923	5,599,615	7,119,071	YES	**8**	6	3.7	Neutral	Neutral	Good	3,4	x				
SSA: West & Central (3)	Benin	16,729,577	3,095,159	4,338,728	YES	**7**	10	3.3	Neutral	Neutral	Medium	2,3,4		*x?*			*x?*
SSA: West & Central (3)	Ghana	20,066,182	11,318,383	23,469,067	YES	**7**	8	2.7	Good	Good	Good	2,3	x		x		
SSA: West & Central (3)	Senegal	8,987,935	-	16,143,961	YES	**6**	6	2.5	Good	Neutral	Poor	2,3,4		x			x
TOTAL	**32**												**12**	**8**	**6**	**6**	**4**

Legend

10 = highest b 10 = highest (6 = best data availability
1 = lowest bu 1 = lowest (rel 1 = least data availability

Good = averag 1=PEPFAR
Medium = aver 2=President's Malaria Initiative
Poor = averag 3=Worldbank Multicountry AIDS Programme
4=Worldbankk Malaria Booster Programme
5=StopTB 'high-burden' country

To complement 4 SACs from the 12 candidate CECs which will not become CECs.