General Grant Information

Applicant:	Country Coordinating Mechanism - Romania
Country:	Romania
Round:	2
Component:	HIV/AIDS
Grant Title:	Rising to the Challenges of HIV/AIDS: A Comprehensive, Co-ordinated Multi-Sectored Response in Romania
Grant Number:	ROM-202-G01-H-00
Principal Recipient:	Ministry of Health and Family of the Government of Romania
Other Grants (From the same Proposal)	ROM-202-G02-T-00
Proposal Lifetime: (Years)	5
Lifetime Budget: (USD)	28,192,395
2-Year Budget: (USD)	21,801,000
Disbursed to Date: (USD)	16,493,217
Signature Date:	06-Jun-2003
Program Start Date:	01-Jan-2004

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category: Go

Incremental Phase 2 Amount Recommended for Board Approval (USD): * 5,060,313

Euro Equivalency :

Rationale for Recommendations:

The Secretariat classifies this renewal Request as a "Go".

Program performance:
Available data indicates that performance has progressively improved throughout the Phase 1 period. Despite initial delays, the grant has achieved the majority of targets set for the first five quarters. Targets were exceeded in 25 out of 30 performance indicators. For example:

- 27,678 blood units were donated as a result if information, education and communication (IEC) campaigns and screened for HIV (369% of target);
- 15,394 men who have sex with men (MSM) have been exposed to outreach Programs (307% of target);
- 4,339 injecting drug users (IDUs) are participating in needle exchange Programs (180% of target);
- 20,202 pregnant women have been subject to prevention of mother to child transmission (PMTCT) interventions (202% of target); and
- 5,685 people are currently receiving voluntary counseling and testing (VCT) (568% of target).

The performance of capacity building activities has also been sound, most notably in training activities.

Some minor data issues have been raised regarding rounding of results and some results matching exactly with targets (e.g., target 23%, result 23%). However, the underlying monitoring and evaluation (M&E) system is strong therefore, overall, we are confident in the results.

Program management and governance:
Overall, The Principal Recipient (PR), the Ministry of Health and Family, has performed adequately in its management of the grant during Phase 1. Initially, the Program experienced significant delays in launching full-scale implementation of activities, and, along with problems faced in absorbing financial resources, led to inadequate performance in the first three quarters. Marked acceleration in program implementation occurred in the next two quarters, with a slight decline in Q6. This decline coincided with the transition of management responsibilities in the Project Management Unit (PMU).

The effectiveness of disbursements to sub-recipients has also markedly improved over the past two quarters and the underlying M&E system is currently functioning well.

The CCM has a strong and broad multi-sectoral representation and has been actively engaged in grant oversight since the start of the Program. The CCM has set up an Executive Committee and additional technical committees to ensure efficient monitoring of grant progress and communication with the PR.

Moving into Year 3, the PR needs to demonstrate a more pro-active managerial approach and more effective leadership. In addition, the PR still has to address some outstanding capacity challenges.

The Secretariat classifies this Request as a "Go". In Phase 2, the PR should focus efforts on fulfilling the necessary time bound actions as stated on page 3 of this Grant Score Card.

*** The maximum funding amount available for Phase 2 of each proposal shall be the sum of the incremental amount approved by the Board and the amount of any funds approved for Phase 1 that have not been disbursed by the Global Fund at the end of the Phase 1 period.**

Rationale for Phase 2 Recommended Amount:

To date, the Global Fund has disbursed US$16,493,217 (76% of funds available for Phase 1) to the PR. The PR has directly expended US $623,466 of these funds. The PR has disbursed US$13,456,899 (82% of disbursed funds) to sub-recipients (SRs), of which the SRs have expended US$11,095,156. The combined cash balance of the PR and SRs stood at US$4,774,595 (29% of disbursed funds) on 30 June 2005. These funds are currently being utilized through the procurement of HIV test kits, IT equipment and payment for audit services.

Expected additional disbursements to the end of Phase 1 amount to US$2,787,123. These funds are to cover normal Program activities for Quarters 7 and 8.

It is anticipated that there will be US$2,520,660 (11% of funds available for Phase 1) of undisbursed Phase 1 funds. These funds will be made available for use during Phase 2.

The CCM has identified Phase 2 savings of approximately US$1.2 million. Accordingly, the Secretariat concludes that an amount of US$7,580,973 (85% of maximum Phase 2 amount) is appropriate for additional funding. As there are US$2,520,660 of unutilized Phase 1 funds available to partially fund this amount, the Secretariat recommends to the Board to commit an incremental Phase 2 funding amount of US$5,060,313 for this Program.

Suggested Remedial Actions

Issues	Description of Suggested Remedial Actions
1. Impact indicators need to be measured in Phase 2.	1. Prior to Phase 2 grant signature the PR should revise Attachment 3 to include relevant impact indicators. Impact indicators should be measured by means of a KAP survey to be completed in Q8 as planned, with follow up surveys to be conducted at the end of year 4 or the start of year 5.
2. CCM compliance as per 9th Board decision.	2. Prior to Phase 2 grant signature, the CCM should provide evidence that it has fully adopted all requirements in relation to CCMs as set forth in the Decision taken by the Global Fund Board at the Ninth Board Meeting in November 2004.
3. Financial management systems need strengthening.	3. The PR must document its systems of internal control and financial management & reporting and the human resources needed for this. Such documentation needs to include terms of reference and necessary qualifications for all financial staff involved. Time line: before Phase 2 signature.
4. Understaffing of the Program Management Unit in core management and coordination functions.	4. The PR must, by December 2005, recruit an appropriately qualified M&E HIV/AIDS Coordinator, a Procurement Coordinator and other staff as necessary.
5. Cumbersome procurement practices lead to delays.	5. Prior to Phase 2 signature, the PR must submit a detailed work plan including time-frames for the necessary tender procedures for procurement for Year 3.

B. PHASE 2 BUDGET AND IMPLEMENTATION ARRANGEMENTS

1. Estimated funds available for Phase 2

	Total
Original Phase 2 Adjusted Proposal Amount (*)	**6,391,395**
Expected undisbursed amount at the end of Phase 1	2,520,660
Estimated Maximum Phase 2 Amount	**8,912,055**

Year 3	Year 4	Year 5
3,170,890	1,868,034	1,352,471

(*) Adjustments to the original Board approved proposal amount may be a consequence of TRP review and grant negotiation before Phase 1.

2. Phase 2 Budget and Recommended Amount

	Year 3	Year 4	Year 5	Total Phase 2 Amount	% of maximum Phase 2 Amount	Incremental Phase 2 Amount	% of original Phase 2 Proposal Amount
CCM Request (**)	4,074,352	2,159,941	1,376,561	**7,610,854**	**85%**	**5,090,194**	**80%**
Global Fund Recommendation (**)	4,044,471	2,159,941	1,376,561	**7,580,973**	**85%**	**5,060,313**	**79%**

(**) Including any partial or total roll-over into Phase 2 of undisbursed Phase 1 amounts.

1. Does the Phase 2 budget include a material amount of un-disbursed Phase 1 funds?

☒ Yes ☐ No

If yes, please explain how the CCM anticipates that these extra funds will be absorbed in Phase 2 (e.g. increased scope of activities, increased targets, activities initially planned during Phase 1 to be undertaken in Phase 2, unanticipated increases in program costs, etc).

The CCM anticipates to utilize almost all Phase 1 savings during Phase 2. It has proposed specific amounts and uses for 18 SR projects, together with an increase of $358,000 for PR's human resources and M&E costs. Specifically, the CCM proposes to utilize the Phase 1 savings for expansion of activities started in Phase 1 to reach more people with services and trainings, complete activities initially planned to be concluded within Phase 1, and additional funding for the PR human resources and administrative costs.

2. Is the budget within the permitted maximum?

☒ Yes ☐ No

The total amount requested by the CCM in the Phase 2 application (including the savings identified during Phase 1) is consistent with the overall maximum life-time budget.

3. Is the budget in line with:

Question	Yes	No	Comment
3.1 Usage of funds in Phase 1?	X		Despite some early delays in implementation (described in earlier sections), the PR and the SRs have generally managed the funds successfully towards achieving all, but one of the program targets through the end of the last reporting period (Q5). During implementation, they have also managed to identify some savings amounting to 5% of the total Phase 1 amount. While Phase 1 activities were focused on investing in trainings, health system strengthening, infrastructure enhancements and equipment, there is increase in the Phase 2 budget for human resources aimed at ensuring proper maintenance of the prevention interventions and services already scaled up in Phase 1. The associated costs in the remaining budget categories (originally covered with grant funds in Phase 1) are envisaged to be met by domestic and external sources.
3.2 Anticipated program realities for Phase 2?	X		The funding for Phase 2 included in the original proposal and subsequently requested by the CCM for Years 3-5 is significantly less on an annual basis (~ $2.1m per year) than the originally budgeted Phase 1 funding for Years 1-2 (~ $10.9m.) The original proposal envisaged increased domestic funding to gradually take over activities launched or scaled up in Phase 1 such as VCT and PMTCT interventions and national education activities for instance. While there is political commitment to increased domestic financing for HIV/AIDS activities in Romania, it is important that the financial resources become available in due course. In addition, the CCM and the country stakeholders need to address the issue of sustainability of program funding (especially in the area of prevention activities) beyond the end of the Global Fund grant.
4. Do the budget and workplan show sufficient detail (including key budget assumptions)?	X		The CCM request included a general macro-level program budget by activities and implementing partners, which is generally consistent with the work plan. Additional information was requested from the CCM and the PR in order to get a better understanding of the key budget assumptions. The review of the detailed budgets prepared at the SR level indicated overall reasonable budget assumptions, however, not all SR budgets provided sufficient and consistent level of detail. The Portfolio Cluster considers that this issue could be addressed during grant negotiations and finalization of the detailed Year 3 budget.
5. Are there any other comments on the budget?	X		In response to requests to present and substantiate key budget assumptions used in building up the program macro budget, the PR/CCM submitted multiple detailed budgets at the SR level, some of which did not provide sufficient and consistent level of detail. During grant negotiation, the PR should focus on coordinating the financial consolidation of the various SR budgets to ensure consistent and proper budgeting process to meet the targets for Year 3.

6. Please comment on any changes or proposed changes in implementation arrangements?

No changes are proposed in the current implementation arrangements.

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

The five year Program aims to ensure the implementation of essential prevention interventions to reduce transmission of HIV/AIDS, while strengthening the national systems of healthcare and psycho-social support to reduce the impact of HIV/AIDS on people infected, affected and vulnerable, and increasing the efficiency of resources for treatment and care.

The Program also aims to develop and increase the efficiency of resources for treatment and strengthen the surveillance and monitoring and evaluation systems for HIV/AIDS and associated risk behaviours.

It will promote new partnerships in the responses of six ministries, NGOs and donors to support the initial functioning and efforts of the National Inter-Sectored Commission for HIV/AIDS, (hereinafter referred to as the Country Coordinating Mechanism, or CCM).

Key strategies that seek to achieve the goals focus on:

- Expanding model programs, nationwide information, education and communication campaigns, and targeted interventions for vulnerable populations developed within a supportive environment, with a special focus on STIs and the risk behavior associated with intravenous drug use.
- Establishing and expanding model services and interventions, ensuring human resources and addressing barriers that exist in providing the most cost-efficient and accessible combination of services.
- Building the capacity of the monitoring and surveillance system, initiating second generation surveillance measures and expanding models of data collection, analysis and dissemination.

Program Goals and Impact Indicators

Goal 1	To scale up HIV prevention in priority areas, while strengthening the system of treatment, care, social support and access to services for people living with HIV/AIDS and vulnerable populations.	Baseline		Target				
		Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5
Impact Indicator	HIV rate among general population	0.04%	2001					0.04%
Impact Indicator	Reduced percentage of young people aged 15-24 who are HIV-infected	TBD						TBD
Impact Indicator	Reduced percentage of high-risk groups (CSWs, MSMs, IDUs) who are HIV-infected	TBD						TBD
Impact Indicator	Incidence of syphilis among general population	55/100,000	2001					25/ 100,0000
Impact Indicator	Incidence of Hepatitis C virus (HCV) among injecting drug users (IDUs)	60%	2002					20%
Impact Indicator	Percentage of infants born HIV positive from HIV positive mothers	20%	2001					1-5%
Impact Indicator	AIDS mortality rate/100,000 inhabitants	0.6	2001					0.3
Impact Indicator	Percentage of young people reporting use of condom during sexual intercourse with a non-regular sex partner (*outcome indicator)	27	1999		50	60	65	65
Impact Indicator	Percentage of commercial sex workers (CSWs) reporting use of condom with most recent client (*outcome indicator)	21	1999		35	40	45	50
Impact Indicator	Percentage of men having sex with men (MSMs) reporting use of condom with a non-regular sex partner (*outcome indicator)	30	1999		45	50	55	60
Impact Indicator	Percentage of known IDUs active in the last month reporting sharing injecting equipment last time they injected (*outcome indicator)	52	2002		40	35	30	25
Impact Indicator	Percentage of Roma sexually active in targeted areas that correctly identify means for preventing HIV transmission (*outcome indicator)	28	1999		40	45	50	50
Impact Indicator	Percentage of people living with HIV/AIDS benefiting from the legal forms of applicable social support (*outcome indicator)	40	2001		65	75	80	80

D. SUMMARY OF Y1-2 GRANT PERFORMANCE

1. Overall Grant Rating

B1. Adequate

This section contains the assessment of performance by service delivery area (SDA).

Each grant is structured into goals, objectives, and SDAs.

- Goals are broad and overarching and will typically reflect national disease program goals. The results achieved will usually be the result of collective action undertaken by a range of actors. Examples include "Reduced HIV-related mortality," "Reduced burden of tuberculosis," "Reduced transmission of malaria."
- Objectives describe the intention of the programs for which funding is sought and provide a framework under which services are delivered. Examples linked to the goals listed above include "To improve survival rates in people with advanced HIV infection in four provinces," "To reduce transmission of tuberculosis among prisoners in the ten largest prisons" or "To reduce malaria-related morbidity among pregnant women in seven rural districts."
- SDAs describe the key services to be delivered to achieve objectives. The service delivery area is a defined service that is provided. Examples for the objectives listed above include "Antiretroviral treatment and monitoring for HIV/AIDS", "Timely detection and quality treatment of cases for Tuberculosis," or "Insecticide-treated nets for Malaria". A standard list of service delivery areas agreed and used by international partners is contained in the Monitoring & Evaluation Toolkit.

The table below lists the objectives for this grant (numbered for easy reference and for linking with the SDAs). The "Goal Number" column indicates which goal each objective is linked to (goals are numbered on page 5).

Objective Number	Objective Description	Goal Number
Objective 1	Ensuring sustainable prevention programs to reduce incidence of HIV	1
Objective 2	Strengthening the national system of health care and psycho-social support to reduce the impact of HIV/AIDS on infected, affected and vulnerable people	1
Objective 3	Strengthening the monitoring and surveillance systems for HIV/AIDS and associated risk behaviours	1

2. Service Delivery Area (SDA) Ratings

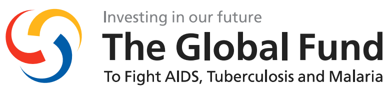
As stated, Service Delivery Areas (SDAs) are linked to an Objective (the 1st column on the left contains the objective number). Some SDAs may appear under different Objectives.

SDAs are typically measured through coverage indicators, categorized into three levels: *Level 3, people reached*; *Level 2, service points supported;* and *Level 1, people trained* (the 3rd, 4th and 5th columns display the number of indicators per level that have been assessed for the SDA indicated).

Based on results achieved against targets for each indicator, SDAs are given a rating: A= *Expected or exceeding expectations; B1= Adequate; B2= Inadequate but potential demonstrated; C=Unacceptable* (the 6th column contains the SDA rating and the 7th contains the rating's justification).

Objective	Service Delivery Area	Level 3	Level 2	Level 1	Rating	Evaluation of Performance (at the SDA Level)
1	Prevention: Behavioral Change Communication - Mass Media	2	0	0	A	Exceeding expectations. Excellent campaign strategy and SR synchronization - creative local IEC campaigns, good coverage of young people, sound message development based on research results.
1	Prevention: Youth Education and Prevention	2	1	2	B1	Target 23% results 23% needs explanation. Absolute numbers reached not great.
1	Prevention: Programmes for specific groups	6	0	3	B1	Increasing numbers of IDUs, MSMs, children in the street, Roma, CSWs, military recruits exposed to outreach programs, more military medical staff trained. However, again target 30%, result 30.4%.
1	Prevention: PMTCT	1	1	0	A	Exceeding targets. Larger number of women receiving pre-and post-test counseling and testing (tests provided under the National Program).
1	Prevention: Counseling and testing	1	1	0	A	Increased number of people receiving VCT due to higher number of VCT centers established (9 in prisons), good promotion and fair quality of services. Tests provided under the National Program.
1	Prevention: Blood safety and universal precautions	0	1	0	B1	Ongoing increased institutionalization of UP and PEP. No level 3 indicator.
1	Prevention: Condom Distribution	1	0	0	A	Increasing coverage in synchronization with other donors.
2	Prevention: STI diagnosis and treatment	0	1	1	B1	Good progress with training staff in STI diagnosis and treatment; delays with lab accreditation experienced.
2	Care and Support: Care and support for orphans and other children	2	0	0	A	2,941 HIV infected children and teens received counseling services related to diagnostic disclosure and special education and social services.

Level 1: No. of people trained indicators.
Level 2: No. of service points supported indicators.
Level 3: No. of people reached indicators.



Objective	Service Delivery Area	Level 3	Level 2	Level 1	Rating	Evaluation of Performance (at the SDA Level)
2	Care and Support: Care and support for the chronically ill and families	1	0	0	A	6,165 HIV infected patients across the country received dental and medical services through the mobile unit.
2	Prevention: Programmes for specific groups	1	0	0	A	2,365 drug-dependent prisoners received psycho-social, medical and testing services.
3	Supportive Environment: Monitoring and evaluation and operations research	1	1	0	B1	Good progress with establishing centers nation-wide using a computerized system for HIV/STI/drug abuse data collection. 7,000 HIV/AIDS patients monitored through an integrated information system. However, Round number results, exactly 7000 reached. Data quality issues.

Level 1: No. of people trained indicators.
Level 2: No. of service points supported indicators.
Level 3: No. of people reached indicators.

3. Indicator level Performance

The numbers to the left of the indicators refer to their coverage level: Level 3, people reached; Level 2, service points supported; and Level 1, people trained.

These early grants typically reported on a quarterly basis, so each period usually represents one quarter. Therefore, results reported in Period 6 are typically from month 18 of the grant term and are the most recent results available.

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results

		Period	Target	Actual	Percent of Target	Percent of Target (0 – 115 – 230 – 345 – 460 – 575)
Objective 1	**Ensuring sustainable prevention programs to reduce incidence of HIV**					
Service Delivery Area 1	**Prevention: Behavioral Change Communication - Mass Media**					
3	Number of people exposed to national mass-media campaign and local IEC campaign messages	Period 5	4100000	5232407	127.62	127.62 %
3	Number of blood units donated as a result of IEC campaigns and screened for HIV	Period 5	7500	27678	369.04	369.04 %
Service Delivery Area 2	**Prevention: Youth Education and Prevention**					
3	Number and percentage of children and teens attending school exposed to HIV/AIDS/drug prevention programs	Period 5	23%	23%	100	100 %
1	Number of teachers trained to deliver health education in schools	Period 5	3600	4700	130.56	130.56 %
3	Number of children and teens in child protection institutions involved in HIV/AIDS education programs	Period 5	3400	3654	107.47	107.47 %
2	Number of child protection institutions having trained staff and HIV/STI/drug abuse programs in place	Period 5	90	132	146.67	146.67 %
1	Number of staff in child protection institutions trained in HIV/AIDS/ education programs	Period 5	218	273	125.23	125.23 %
Service Delivery Area 3	**Prevention: Programmes for specific groups**					
3	Number and percentage of military recruits (Ministry of Defence (MoD)) exposed to IEC sessions	Period 5	30%	30.4%	101.33	101.33 %

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results		Period	Target	Actual	Percent of Target	Percent of Target (chart: 0, 115, 230, 345, 460, 575)
1	Number and percent of Ministry of Administration and Interior (MoIA) medical staff trained to deliver IEC sessions	Period 5	40%	100%	250	250 %
3	Number and percentage of IDUs participating in needle exchange programs	Period 5	2400	4339	180.79	180.79 %
3	Number of MSMs exposed to outreach programmes	Period 5	5000	15394	307.88	307.88 %
3	Number of children and young people living in the street and Roma exposed to outreach programs	Period 5	7200	11788	163.72	163.72 %
3	Number of sex workers and clients exposed to outreach programmes	Period 5	1300	2081	160.08	160.08 %
3	Number and percentage of military recruits, soldiers under contract, military students (MoAI) exposed to IEC sessions	Period 5	90%	99%	110	110 %
1	Number and percentage of Ministry of Justice (MoJ) medical staff - GDP trained to deliver IEC sessions	Period 5	40%	56%	140	140 %
1	Number and percentage of Ministry of Defense (MoD) medical staff trained to deliver IEC sessions	Period 5	40%	44%	110	110 %
Service Delivery Area 4	**Prevention: PMTCT**					
3	Number of pregnant women subject to PMTCT interventions	Period 5	10000	20202	202.02	202.02 %
2	Number of PMTCT centers established (to be located in 16 different districts)	Period 5	10	10	100	100 %
Service Delivery Area 5	**Prevention: Counseling and testing**					

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results		Period	Target	Actual	Percent of Target	Percent of Target (chart)
2	Number of VCT centres established (to be located in 16 different districts)	Period 5	10	19	190	190 %
3	Number of people receiving counseling and testing through the VCT centres	Period 5	1000	5685	568.5	568.5 %
Service Delivery Area 6	**Prevention: Blood safety and universal precautions**					
2	Number and percentage of health units with universal precautions procedures, trained staff and PEP	Period 5	45.02%	54.5%	121.06	121.06 %
Service Delivery Area 7	**Prevention: Condom Distribution**					
3	Number of condoms distributed to target groups	Period 5	700000	971804	138.83	138.83 %
Objective 2	**Strengthening the national system of health care and psycho-social support to reduce the impact of HIV/ AIDS on infected, affected and vulnerable people**					
Service Delivery Area 8	**Prevention: STI diagnosis and treatment**					
1	Number of medical staff trained in STI diagnosis and treatment	Period 5	2914	3255	111.7	111.7 %
2	Number of STI Laboratories accredited	Period 5	4	0	0	0 %
Service Delivery Area 9	**Care and Support: Care and support for orphans and other children**					
3	Number of HIV infected teens receiving counseling services related to diagnostic disclosure	Period 5	1800	2053	114.06	114.06 %
3	Number of children and teens living with HIV/AIDS receiving special education and social services	Period 5	700	888	126.86	126.86 %
Service Delivery Area 10	**Care and Support: Care and support for the chronically ill and families**					

Chart axis: 0, 115, 230, 345, 460, 575

Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results		Period	Target	Actual	Percent of Target	Percent of Target (0 – 115 – 230 – 345 – 460 – 575)
3	Number of HIV infected patients receiving medical care through the mobile unit	Period 5	6021	6165	102.39	102.39 %
Service Delivery Area 11	**Prevention: Programmes for specific groups**					
3	Number and percentage of drug dependent prisoners using psycho-social, medical and testing services	Period 5	35.0% 708 /2022	33.75% 2365 /7007	96.24	96.24 %
Objective 3	**Strengthening the monitoring and surveillance systems for HIV/AIDS and associated risk behaviours**					
Service Delivery Area 12	**Supportive Environment: Monitoring and evaluation and operations research**					
3	Number of HIV/AIDS patients receiving care and treatment services and monitored through an integrated information system nation wide	Period 5	6500	7000	107.69	107.69 %
2	Number of centers using a computerized system for data collection	Period 5	11	11	100	100 %

4. Disbursement History

*Note: In the absence of previous agreements, and noting in the future we will have agreed amounts and dates for disbursement, we have created an expected amount.
The Expected Amount is calculated by subtracting the first disbursement from the 2 year approved budget and spreading the remaining portion evenly over 6 additional disbursement. The Expected Date is calculated by assuming that quarterly updates and disbursement requests are due within 45 days after completion of each quarter.

Expected vs. Actual Disbursements

	Date		Amount		Cumulative	
	Expected	Actual	Expected *	Actual	Expected	Actual
1	15-Jul-2003	15-Jul-2003	3655000	3655000	3655000	3655000
2	16-May-2004	30-Jul-2004	3024333	5722427	6679333	9377427
3	15-Aug-2004	19-Nov-2004	3024333	2078238	9703666	11455665
4	15-Nov-2004	18-Jan-2005	3024333	1341732	12727999	12797397
5	15-Feb-2005	24-Mar-2005	3024333	2134544	15752332	14931941
6	16-May-2005	16-Jun-2005	3024333	1561276	18776665	16493217
7	15-Aug-2005		3024335		21801000	16493217

Expected vs. Actual Disbursements

Millions

$50
$45
$40
$35
$30
$25
$20
$15
$10
$5
$0

Jul 2003 | Oct 2003 | Jan 2004 | Apr 2004 | Jul 2004 | Oct 2004 | Jan 2005 | Apr 2005 | Jul 2005 | Oct 2005 | Jan 2006 | Apr 2006

Actual Cumulative
Expected Cumulative

5. Estimated under-disbursement in Phase 1

Estimated under-disbursement in Phase 1	Amount (in USD)	Amount (in %)
Phase 1 grant agreement amount	21,801,000	100 %
Less: actual disbursed to date	16,493,217	76 %
Less: expected additional disbursement until the end of Phase 1 grant agreement	2,787,123	13 %
Expected undisbursed amount at the end of Phase 1	2,520,660	11 %

1. How many months of the program lifetime are covered by the actual disbursements to date, including buffer period (e.g., 18 months, 21 months, 24 months, etc)?

21 months

2. Are actual disbursements to date significantly behind original disbursement schedules?

If yes, please comment:

☐ Yes ☒ No

Taking into account the expected undisbursed Phase 1 amount identified by the CCM as savings ($1,219,854), and the respective impact on the cumulative budget amount to be spent by the end of Phase 1 ($20,581,146), the PR should have received 92% of the respective cumulative budget (including one quarter buffer), whereas it has received 80% thus far. The PR has been by and large on track with the anticipated schedule, with the last disbursement in Q6 falling slightly behind schedule, which coincided with the transition in management responsibilities in the PMU, coupled with a more rigorous review of the sub-recipients' cash needs for Q6 and Q7.

3. Do the expected additional disbursements until the end of Phase 1 appear to be high compared to amounts previously disbursed?

If yes, please comment:

☒ Yes ☐ No

The average disbursement amount for the grant to date is $2,748,870. The final disbursement of $4.1 million as proposed in the CCM request and adjusted by the LFA represents a significantly sized disbursement and while considerable portion of this funding will be applied towards program activities scheduled for Q7-Q8, it is not likely that the full amount will be spent by the end of Phase 1. Taking into account disbursement and absorption trends under the grant to date and current program realities, the Portfolio Cluster has adjusted down the expected amount to $2,787,123 (following an assessment of Q6 expenditure and rigorous review of SR needs for Q7&8), which is generally in line with the average disbursement trend to date.

4. Is it anticipated that there will be undisbursed funds of a material amount at the end of the Phase 1 period?

If yes, please explain why and provide other relevant comments, inf any:

☒ Yes ☐ No

The CCM request lists an amount of $1,219,854 to remain undisbursed at the end of Phase 1 and the CCM requested its use in Phase 2. The savings amounting to 5% of the Phase 1 amount were identified as resulting from cost-efficiencies realized due to centralized procurements, savings in human resources, administrative and travel costs due to delayed launch of some SR projects, and use of co-funding opportunities at the SR level. Following a review of Q6 expenditure, the Portfolio Cluster has further adjusted down the expected additional disbursement under Phase 1 resulting in expected undisbursed amount of $2,520,660 representing 11% of the Phase 1 amount.

6. Expenditures and Cash Balance

Principal Recipient Cash Balance	Amount (in USD)	Amount (in %)	Date
Actual disbursed to date by the Global Fund (to PR)	16,493,217	100 %	24-Jun-05
Less: Direct payments for PR Expenditures	623,466	4 %	
Less: PR disbursements to sub-recipients	13,456,899	82 %	
PR cash-balance	2,412,852	14 %	30-Jun-05

1. Are there any significant PR commitments to date that will be expended during the current or the next reporting period?

If yes, please give detailed comments:

☒ Yes ☐ No

The LFA has verified that the PR has existing commitments totalling $1,749,813 (73% of cash balance). These consist of centralized procurement of HIV test kits, IT equipment and payment for audit services (PR and sub-recipients). All goods and services are expected to be utilized/covered in Q7 and Q8.

2. Is the PR cash-balance of a material amount (relative to disbursements received from the Global Fund)?

If yes, please explain why and provide other relevant comments, if any: (e.g., if disbursements received from the Global Fund cover a period beyond the expenditure period, unpaid commitments, implementation delays, etc)

☒ Yes ☐ No

It is important to note that the CCM Request was submitted prior to receipt of the last disbursement, hence GF amount disbursed to date in Section G of the CCM Request is listed as USD14,931,941 (differing from the above table). Additionally, the above table does not allow separate line items listing interest received and/or any variations/adjustments. The total PR cash balance incorporating interest earned and a PR 'balancing' amount (considered non-material) is $2,471,762 (15% of total GF disbursements). Taking into account procurement commitments, the actual cash balance can be considered as $721,949 (4.4% of total GF disbursements). Additionally, since the last disbursement ($1,561,276) was received just prior to the time of LFA verification, the PR had limited time to make disbursements to sub-recipients.

E. CONTEXTUAL CONSIDERATIONS

1. Have there been significant adverse external influences (force majeur)?

☐ Yes ☒ No

No comment.

1.1. If yes, have they been (or are they being) alleviated?

☐ Yes ☐ No

Not applicable.

2. Are there any unresolvable internal issues?

☐ Yes ☒ No

A new Government was elected in December 2004, which was followed by a transition period in early 2005 involving changes at the highest level in the MOH and restructuring of the PMU, resulting in the appointment of two new heads and a new financial coordinator. The period of transition of management responsibilities coincided with Q6.
A new CCM Chair was nominated in April 2005 and new members admitted to the CCM. With the exception of faith based organizations (FBOs), CCM membership is representative of all constituencies, and Vice-Chairs represent the academic, HIV/AIDS and TB sectors. Initial discussions with FBOs have commenced.
The CCM Executive Committee has maintained regular interactions with the PR since program commencement. More recently, a reinvigorated Executive Committee has worked to continuously improve systems for coordination and communication between the PR and the CCM.

3. Are there financial and program management issues (e.g., slow or incomplete disbursements to sub-recipients or issues with the PR)?

☒ Yes ☐ No

The PR needs to ensure that the PMU has sufficient human resources capacity, given its current program portfolio. The PMU is responsible for managing also the Global Fund TB grant and the World Bank Health Sector loan. Several key positions for the GF grants (e.g., M&E HIV Coordinator and Procurement Coordinator) have been recently vacated. It will be essential that appropriately qualified persons are appointed as soon as possible to ensure smooth program continuation. The PR has not pro-actively pursued the recruitment of additional staff, even though additional staffing needs were identified during regular grant monitoring and there were sufficient resources to address them.
The program involving a multitude of recipients (currently 29) with nation-wide coverage requires strong oversight and coordination. The Cluster recommends that the PR take immediate steps to improve financial systems and provide key managerial coordination and direction. This includes strengthened mechanisms for budget monitoring and control, appropriate allocation of expenses between the two Global Fund grants and streamlined PMU operations. These actions would also address the current situation when requests for information and clarification take unreasonable time and effort for all parties involved.
As of the date of preparation of this Grant Score Card, the PR has not submitted a finalized audit report pending resolution of an issue related to the Representation Letter between the auditor and the PR. The PR is currently delinquent with meeting the audit reporting requirement under the grant agreement.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation? ☐ Yes ☒ No

Generally, sub-recipient data collection and reporting is systematic. Currently, 11 centers for HIV/STI/drug abuse data collection across the country use a computerized data collection system (the Year 2 target is 73). Going forward, these should be assessed for completeness and reporting effectiveness. While the overall reporting framework is adequate, the PR should strengthen its internal M&E systems to ensure timely coordination across the sub-recipients and adequate verification and reporting on programmatic progress. As a priority the PR also needs to ensure recruitment of qualified M&E personnel, most importantly to fill the recently vacated position of M&E HIV/AIDS coordinator on a priority basis and address any other staff shortages in this area.
A number of studies have been undertaken in Phase 1 with final KAP surveys scheduled for completion in Q8 with the objective to capture how specific interventions have increased the knowledge and changed attitude and behaviors among vulnerable groups such as young people, IDUs, MSMs, inmates, military staff. The results of these surveys could inform possible changes in the indicators for Phase 2.

4.2. Procurement and Supply Chain Management? ☒ Yes ☐ No

The procurement of health products under the program mainly consists of HIV/HBV/HCV tests, HIV rapid tests, syringes, sanitary materials, disinfectants, treatment monitoring tests. ARV drugs are provided under the National Program. While sub-recipients generally undertake procurement, a system of centralized procurement is used for certain IT equipment, software, and some tests. The cumbersome public procurement processes for these items and services, coupled with administrative complications related to ensuring VAT exemptions, led to delays in Phase 1 implementation with signs of overcoming the initial setbacks in Q5.
The position of Procurement Coordinator has been vacant since June 2005. The PR should strengthen its PMS capacity, starting with recruitment of a suitably qualified Procurement Coordinator and adopting a better approach to plan and continuously monitor the procurement process against the program work plan to avoid delays experienced during Phase 1. The PR should ensure compliance with the procurement procedures applied for the program and properly document the tender processes for validation purposes.

4.3. Any other areas? ☐ Yes ☒ No

It is worth noting, however, that a case involving a supplier complaint regarding a tender organized by the PR (not related to the GF Program) has been pursued following proper legal procedures in Romania and the matter is currently before the courts. All stakeholders should continue to be vigilant in program oversight to ensure that any potential issues are identified and appropriately addressed in a timely manner.

5. Are there any material issues concerning quality or validity of data? ☐ Yes ☒ No

Data reported is generally accurate and systems seem to be reliable. For some indicators, actual results as reported significantly exceed targets (e.g., people receiving VCT, PMTCT interventions). Several factors may be operating, including strategic promotion and targeting of interventions, use of co-funding opportunities to increase number of service delivery points, expanding access to target population and successful scale-up of activities. It should be also taken into consideration that some level 3 indicators e.g., 'MSM exposed to outreach services' are also 'proxy' indicators, since confidentiality issues prevent identification of unique individuals reached with services.

6. Are there major changes in the program-supporting environment (e.g., recent initiation of capacity strengthening, support of implementation by technical partners)? ☒ Yes ☐ No

With the adoption of the National HIV/AIDS Strategy 2004-2007, the Government of Romania reaffirmed its commitment to the fight against HIV/AIDS. Other national strategies (Reproductive Health Strategy, STI Strategy, and Anti-Drug Strategy) are harmonized and coordinated with this strategy.
National domestic funding for HIV/AIDS has increased year on year from 2003 (USD29.9 million) and is anticipated to do so until 2007 (when it will reach USD43.9 million). External funding sources reached a maximum of USD17.9 million in 2004 and have been slowly declining (forecast to be USD15 million in 2007).
Since the National Strategy only extends to 2007, it will be important to ensure funding for treatment, care and support services, as well as for prevention activities to address sustainability of interventions beyond the end of the GF grant. Technical partnerships have expanded during implementation, with international donors providing technical assistance, financial and logistical support to the PR and sub-recipients and active involvement in the CCM work.

7. Has the program demonstrated significant improvements in implementation over the last 6 months?

☒ Yes ☐ No

Program implementation has accelerated over the past 6 months resulting in reaching and exceeding program targets in Q5. The PR has overcome the slow start experienced at program launch due to lengthy administrative procedures, extended processes for completing SR agreements, and procurement delays. Movement to the revised Attachment 2 (in line with the M&E Toolkit) has enabled progress to be more effectively monitored and verified.

8. Have there been any changes in disease trends?

☐ Yes ☒ No

Official data indicates that over the past 2 years there has been an increase of over 1,000 people living with HIV/AIDS (9,704 people in 2003 to 10,735 in 2004). The main mode of transmission remains through sexual transmission, especially affecting young people between 15-29 years. There has been a significant increase in the number of people in need of treatment, as the mortality rate has decreased and there is expanded access to treatment and care.

9. Is there information that would indicate that the program was not advancing the Global Fund's operating principles to:

9.1. Promote broad and inclusive partnerships?

☐ Yes ☒ No

There are 29 sub-recipients now actively involved in the program implementation with robust NGO engagement. Active involvement of NGOs in program implementation is envisaged to be sustained in Phase 2.

The UN agencies and other international donors are actively engaged in providing technical assistance and overall support through CCM participation.

GF funding and program implementation mechanisms have led to strengthening the capacities of the PR and Sub-recipients alike. The process has significantly expanded HIV/AIDS partnerships and encouraged better communication and coordination among organizations involved in the fight against HIV/AIDS.

9.2. Promote sustainability and national ownership through use of existing systems and linkages with related strategies and programs?

☐ Yes ☒ No

The GF funding support is used for expanding model prevention programs, services and interventions, while effectively building upon existing structures, services and capacities in the country. GF supported activities are effectively integrated into the multi-sectoral HIV/AIDS response within Romania.

It will be important that the CCM and PR ensure sustainability of program activities by pursuing continued domestic funding and integration into the National Strategy beyond 2007.

9.3. Provide additional resources?

☐ Yes ☒ No

See previous comments under Item E.6.

Over the period 2004-2007, Global Fund financing represents approximately 10.2% of total financial contributions to HIV/AIDS activities in Romania, with national funding increasing year on year to 2007.

No data is available for 2008 and beyond given that the current National HIV/AIDS Strategy runs through to 2007. Sustainability of program activities beyond the GF grant needs to be addressed.

10. Are there any synergies between this grant and other Global Fund financed programs (e.g., grants to be signed, other on-going grants, etc)?

☒ Yes ☐ No

The Romania CCM TB proposal was also approved in 2002. The PR's PMU also manages the Global Fund TB grant. Both grants are primarily implemented by Sub-recipients (both government and non-government).

A key role for the PR is to effectively manage and coordinate financial and programmatic implementation and accountability under both grants.

The synergies between the GF HIV/AIDS program and the national program enable effective expansion of prevention, treatment, care and support activities undertaken across Romania.