General Grant Information

Applicant:	The Country Coordinating Mechanism of Romania
Country:	Romania
Round:	2
Component:	Tuberculosis
Grant Title:	Rising to the Challenges of Tuberculosis: A Comprehensive, Coordinated Multi-Sectored Response in Romania
Grant Number:	ROM-202-G02-T-00
Principal Recipient:	The Ministry of Health and Family of the Government of Romania
Other Grants (From the same Proposal)	ROM-202-G01-H-00
Proposal Lifetime: (Years)	5
Lifetime Budget: (USD)	18,283,000
2-Year Budget: (USD)	16,870,000
Disbursed to Date: (USD)	12,504,600
Signature Date:	06-Jun-2003
Program Start Date:	01-Feb-2004

A. SECRETARIAT PHASE 2 RECOMMENDATION

Phase 2 Recommendation Category: Conditional Go

Incremental Phase 2 Amount Recommended for Board Approval (USD): * -126,359

Euro Equivalency :

Rationale for Recommendations:

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

Program performance:
Despite initial delays, programmatic performance has progressively improved and Quarter 6 results were strong. The Program is well advanced into achieving the key Program goal of reaching WHO Recommended TB Control Targets (as verified by the April WHO Review of the National TB Program). The Program is contributing to the National Tuberculosis Program (NTP) by improving the bacteriological laboratory network and continuing to upgrade the national disease surveillance network. Additionally, the Program is well on target to training 10,000 professionals in DOTS; MDR protocols have been developed and 90 MDR-TB patients have been placed on therapy, with the expectation this would increase to 200 by end of Phase 1.

In summary, targets were achieved or exceeded in 12 of the Program's 16 key indicators; 2 are partially achieved (one at 95%) and 2 have not been achieved (number of pharmacists trained and number of TB dispensaries using centralized systems for data collection). Sub-recipients (SRs) have accelerated implementation over the past 3 quarters and greater numbers of vulnerable populations have been reached with services.

The Program has achieved these results with considerable savings, primarily due to a significant over estimation of initial costs (notably of drugs for treatment of MDR-TB), together with savings resulting from initial delays.

Program management and governance:
The management of the grant to date by the Principal Recipient (PR), the Ministry of Health and Family, has not been wholly satisfactory. The Program experienced significant delays in launching full scale implementation of activities in the first three quarters. This was primarily due to lengthy procedures associated with selection and contracting of sub-recipients, procurement processes for capital works and equipment and the process for achieving approval of the Green Light Committee of the Stop TB Partnership and procuring MDR-TB drugs with the International Dispensary Association. Implementation was also slow at the sub-recipient level and in securing VAT exemption. Ministerial changes and personnel changes within the Project Management Unit also had an impact on PR management of implementation. However, the PR has been able to accelerate implementation over the past six months and achieve results. Nonetheless, the PR has been challenged in coordinating and effectively leading Sub- recipient implementation. The PR's capacity to provide strategic leadership and coordinate, in a timely way, options for utilizing unallocated budgets (derived from savings) for CCM and Global Fund consideration has been lacking.

Going forward into Phase 2 of the grant the PR needs to improve its strategic management and demonstrate effective leadership from the outset. The PR should also undertake measures to ensure improved capacities in a number of areas, in proportion to the activities to be undertaken. Notably, this should include improvements to financial management systems and may involve strengthening the monitoring and evaluation (M&E) capacity of the key sub-recipient in order to promote sustainability within the NTP over the longer term.

While the CCM is engaged in broad oversight, consideration should be given to establishing a TB Working Group within the CCM comprised of the TB representatives (namely people with the disease, public health, clinical, academic, policy, and planning representatives). This would facilitate more regular meetings with appropriate representation while enabling greater Program oversight, closer national TB coordination and promoting sustainability.

The Secretariat classifies this Request as a "Conditional Go". In Phase 2 the PR should prioritize efforts on fulfilling the suggested remedial actions as stated on page 3 of this Grant Score Card.

Significantly, since the Romanian domestic financial contributions against TB were not available beyond 2005, the Secretariat noted that 'Additionality' had not been demonstrated for the Phase 2 period. However, it noted that the Health Sector Reform initiative announced by the Romanian Minister of Health in September 2005, pledged 5% of GDP for the health sector budget, and the intention to move to multi-year budgeting for all public health programs including TB. Additionally, assurances were given that, at a minimum, current funding levels would be maintained for 2006 and 2007. The Secretariat notes that the budget for the National TB Strategy for 2006-2010 will not be finalized until end November 2005. The Phase 2 recommended amount is therefore based on the assumption that, at a minimum, the current national funding levels are maintained.

*** 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:
At 6 October 2005, the Global Fund had disbursed US$12,504,600 (74% of funds available for Phase 1) to the PR. At 30 June 2005, the PR had spent US$392,436 and disbursed US$8,424,536 (67%) to sub-recipients. Sub-recipient expenditures amounted to US$6,723,826 (80% of funds disbursed by the PR). The combined cash balance of the PR and SRs stood at US$5,388,338 (43% of disbursed funds to date). However, more recently verified information (30 September 2005) indicates that much of these funds have since been utilized and the remaining unspent funds are committed largely for the procurement of TB drugs and laboratory equipment, multifunction vehicles, sub-recipient audits and the procurement of PCs for dispensaries. There are no more expected disbursements for Phase 1. Therefore an amount of US$4,365,400 (26% of funds available for Phase 1) will remain undisbursed at the end of Phase 1. This amount was identified as savings, largely due to the over-estimation of anti-TB drug costs and savings acquired due to initial program delays. These funds are available for Phase 2 activities. The Secretariat concludes that a total amount of US$4,239,041 is appropriate for additional funding for Phase 2 of the proposal agreed by the Board in 2002. This amount is US$126,359 less than the funds already committed to the grant for the Phase 1 period. Accordingly, the Secretariat finds that it will not be necessary to approve additional funding for this grant, but rather recommends that the use of the undisbursed Phase 1 amount minus US$126,359 be approved for disbursement during Phase 2. Additionally, the Secretariat recommends that the Board endorse the CCM request to reduce the term of the grant proposal from 5 to 4 years given that Phase 2 activities can be performed in two years.

Suggested Remedial Actions	
Issues	**Description of Suggested Remedial Actions**
1. The need to strengthen PR systems and capacity in a number of areas.	1. Prior to Phase 2 signature, the PR must: (i) clearly define PMU and SR functions and accountabilities, ensuring that all necessary functions are filled by appropriately qualified personnel; (ii) prepare a detailed M&E plan including giving consideration to strengthening the M&E function of the key SR; (iii) undertake additional improvements to the financial management systems as identified within this review and by the audit process; and (iv) prepare a workplan detailing procurement activities for Year 3.
2. The need to provide greater budget clarity on (i) Program Management Unit; (ii) human resources; and (iii) M&E (the three items comprising a total of 35% of the budget).	2. Prior to Phase 2 signature the PR must provide further detail on costs listed under budget lines (i) PMU ; (ii) human resource; and (iii) M&E.
3. The need to address inconsistencies between Attachment 3, budget and workplan.	3. Prior to Phase 2 signature, the PR should further refine Attachment 3 to ensure consistency between budget and workplan and to give effect to the Phase 2 decision taken by the Board.
4. CCM compliance as per 9th Board decision.	4 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.

B. PHASE 2 BUDGET AND IMPLEMENTATION ARRANGEMENTS

1. Estimated funds available for Phase 2

	Total
Original Phase 2 Adjusted Proposal Amount (*)	1,413,000
Expected undisbursed amount at the end of Phase 1	4,365,400
Estimated Maximum Phase 2 Amount	5,778,400

Year 3	Year 4	Year 5
869,500	317,500	226,000

(*) 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 (**)	3,958,492	1,389,086	0	5,347,578	93%	982,178	70%
Global Fund Recommendation (**)	2,474,955	1,764,086	0	4,239,041	73%	-126,359	-9%

(**) 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 requested to reintegrate $3.9m of the Phase 1 underspend. The Secretariat recommends reducing the proposed reintegrated amount to $2.8m. The total budget saving resulting would be $1.5m (8% of the lifetime budget).

The CCM proposed to use the Phase 1 amount to increase coverage (beyond that planned in the proposal approved by the Board in 2002), in four areas:
(i) additional patients to receive anti MDR-TB treatment;
(ii) additional bacteriological laboratory rehabilitation;
(ii) additional TB in-patient facilities for rehabilitation; and
(iv) additional IEC materials developed beyond the high risk groups identified.

The Secretariat strongly recommends funding the additional 200 patients proposed to receive anti MDR-TB treatment, since the initial proposal included sufficient funds for this purpose and delays with the Green Light Committee approval and International Dispensary Association procurement processes prevented this cohort commencing Phase 1. However, the Secretariat does not support additional rehabilitation capital works in either bacteriological laboratory or in-patient facilities, as clearly falling outside the scope of the initial proposal, and of questionable merit given findings of the WHO Review of the NTP in April 2005. (A key recommendation was that hospitalization for smear negative and extra-pulmonary patients should be limited to severe cases, while the duration of hospitalization for smear positive patients on DOTS be shortened). The Secretariat also did not support the development of ad hoc IEC materials for remote communities and the general population, since this did not address the fundamental need for a coherent national IEC strategy, as identified by the WHO Review of the NTP.

2. Is the budget within the permitted maximum?

☒ Yes ☐ No

In the CCM Request for Continued Funding, the CCM has requested an amount of USD5,347,578 which is within the Phase 2 upper limit.

3. Is the budget in line with:

3.1 Usage of funds in Phase 1?	☒ Yes ☐ No	As at end Q6 the PR had expended 52% of the Phase 1 grant. However, as yet unverified expenditures in Q7 indicate that the PR has been able to increase this to 61%. Currently the PR seems to have achieved the majority of aims for TB detection, DOTS coverage and cure rates during Phase 1. Additional activities are in line with general objectives but are questionably linked to increasing stated aims.
3.2 Anticipated program realities for Phase 2?	☒ Yes ☐ No	Uncertainties remain in relation to the national TB budget allocation to be committed under the National TB Strategy for 2006-2010. (The Romanian budget process is still underway). The Board approved proposal was a means to extend NTP coverage and contribute to achieving WHO defined TB goals. This has evidently been achieved. The key focus moving into Phase 2 should therefore be to fully integrate these Phase 1 activities back into the NTP while ensuring sustainability. Therefore GF financing of additional infrastructure (beyond the scope of the initially approved proposal) would not seem appropriate. However, extension of MDR-TB treatment would seem consistent with the original Board approved proposal.
4. Do the budget and workplan show sufficient detail (including key budget assumptions)?	☐ Yes ☒ No	General budget and workplan detail is sufficient. However a key gap is the lack of transparency in the PR budget. The PR should address this as a priority. Additionally the general increase in human resources costs and the breakdown of M&E costs require further information.
5. Are there any other comments on the budget?	☒ Yes ☐ No	Importantly the proposal and associated budget, reduce the term of Phase 2 from 3 to 2 years on the basis that activities can be undertaken within the shorter period. The Secretariat recommends this reduced time frame and recommends funding: (i) those activities provided for under the original proposal: AND (ii) extending the coverage of treatment for MDR-TB; (iii) extending IEC Roma activities (in line with the approved proposal); (iv) providing incentives for TB DOTS patients into Phase 2 (not included in the CCM Request); and (v) finalizing Phase 1 activities not provided for in the CCM Request,(ie accreditation costs for bacteriological laboratories). However, the Secretariat does not endorse CCM proposed: (i) additional bacteriological laboratory rehabilitation;(ii) additional TB in-patient facilities for rehabilitation; and (iii) extending additional IEC activities to the general population.

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

The CCM Request has not proposed any changes to implementation arrangements.

C. PROGRAM DESCRIPTION AND GOALS

1. Program Description Summary

The Program aims to enable the Government of Romania to reduce TB mortality, morbidity and disease transmission, while preventing the development of drug resistance.

The goal is to achieve the WHO Recommended TB Control targets to cure 85% of newly detected cases of sputum smear positive TB and to detect 70% of the estimated incidence of sputum smear positive by expanding DOTS coverage to 100% of the country by the end of the project.

In addition, DOTS plus protocols for Multi-Drug Resistant (MDR) TB are to be incorporated into the DOTS strategy and 80% of the MDR TB patients are to receive treatment.

After two years, more than 10,000 professionals will be trained and involved in DOTS programming and the foundations will be laid to meet the World Health Organization targets for reducing TB mortality rates and stopping the increased rate of incidence.

Key strategies focus on:
· Ensuring DOTS expansion and prevention programs in order to halt the increasing rate of TB incidence;
· Strengthening the implementation of the National Strategy and Control of TB among the most vulnerable groups by working in close collaboration with specialist networks in pulmonology and epidemiology, all levels of health professionals and community members;
· Strengthening the national health care system for TB patients by improving the bacteriological laboratory network and functionality of the quality control system and using a patient-centered approach to improve both access to and use of health services; and
· Improving TB supervision/monitoring and strengthening the TB surveillance system within the National Communicable Disease Surveillance network.

Program Goals and Impact Indicators

Goal 1	Expand DOTS to reduce TB incidence	Baseline		Target				
		Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5
Impact Indicator	Reduced number of smear-positive cases per 100,000 population per year	TBD						TBD
Impact Indicator	Reduced TB incidence in children (per 100,000)	47.1	2000					40
Impact Indicator	Percentage of population living in areas covered by DOTS	25%	2001		100%			100%
Impact Indicator	Detection rate of new ss+ cases	TBD						70%
Goal 2	Improve care for TB patients	Baseline		Target				
		Value	Year	Year 1	Year 2	Year 3	Year 4	Year 5
Impact Indicator	Reduced number of deaths from TB (all forms) per 100,000 population per year	TBD						TBD
Impact Indicator	TB specific mortality rate	9.5%	2000					7%
Impact Indicator	Cure rate for new smear-positive pulmonary TB cases	55%	2001					85%
Impact Indicator	Success rate for new smear-positive pulmonary TB cases	76%	2001					93%
Impact Indicator	Percent of MDR-TB patients on treatment with high-quality, second-line anti-TB drugs	0%	2000		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
1	Expand Directly Observed Treatment, Short-course (DOTS) strategy nationwide to reduce increasing rate of Tuberculosis (TB) incidence	1
2	Strengthen the National Healthcare for TB patients	2
3	Strengthen the supervision/monitoring and surveillance system within the National Communicable Diseases Surveillance Network	2

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	Supportive Environment: Health systems strengthening	0	1	2	A	The program has overachieved both targets (training and number of dispensaries with DOTS implemented) to be reported in Q6.
1	Prevention: Behavioral Change Communication - Community Outreach	2	1	2	B1	All 5 indicators have exceeded targets leading to significantly increased coverage of the Roma and prison populations. However, there is a need to take into account WHO review comments of lack of IEC strategy. Results for Roma population only in %.
1	Supportive Environment: Advocacy and increased political commitment to DOTS	0	0	0	Select	This indicator is not required to be reported until Q8.Coperation with the Penitentiary system is good and the target is anticipated to be reached.
1	Prevention: Infection control in health care	1	1	0	B1	Coverage of TB patients counselled and tested for HIV has exceeded the target by almost 50%. However the L2 indicator, establishing isolation and sputum collection rooms is lagging behind.
1	Care and Support: Supporting patients through direct observation of treatment	1	0	0	A	The number of TB patients receiving incentives is exceeding targets and contributing to the increased treatment success rate reported (April 2005 WHO Review). However, treatment success rate is not yet optimal at international standards.
1	Supportive Environment: Coordination and partnership development (national, community, public-private)	0	1	0	A	While the uptake of new TB curricula by medical schools has exceeded targets, the actual contribution to improved medical treatment received by patients will take some time to be demonstrated.
1	Prevention: Identification of Infectious Cases	0	0	0	Select	Both impact indicators are not due to be reported on until Q8.
2	Supportive Environment: Procurement and supply management capacity and building	0	1	1	B2	At Q6, one target was almost achieved, while the other (training of pharmacists) has lagged significantly behind. This should be caught up with rapidly. The program expects to catch up by Q8.

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	Supportive Environment: Health systems strengthening	0	2	0	B2	One indicator is yet to be reported (Q8) however, due to issues surrounding the operation of the Romanian accreditation authority, it is anticipated that while all necessary quality control preparatory work is undertaken, actual accreditation will not be achieved.
2	Treatment: Control of drug resistance	1	1	1	A	While initially slow, achievements for indicators for control of MDR-TB, including patients reached, are on track. Savings reached.
3	Supportive Environment: Monitoring and evaluation and operations research	0	1	0	B1	Quality control visits have been exceeded. Phase 2 emphasis should be on sustainability and integration with the NTP.
3	Supportive Environment: Health systems strengthening	0	1	1	B2	Significant over-achievement of targets is seen for training, however the target for number of dispensaries using the centralised data collection system is lagging significantly behind. This is anticipated to be achieved by end Q8.

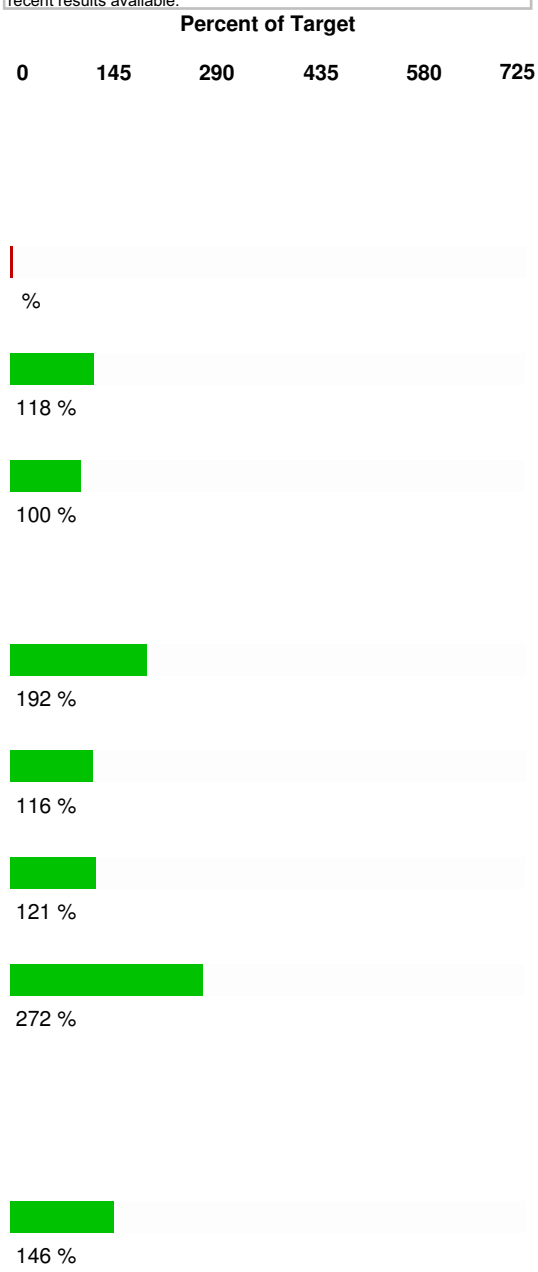
Level 1: No. of people trained indicators.
Level 2: No. of service points supported indicators.
Level 3: No. of people reached indicators.

3. Indicator level Performance

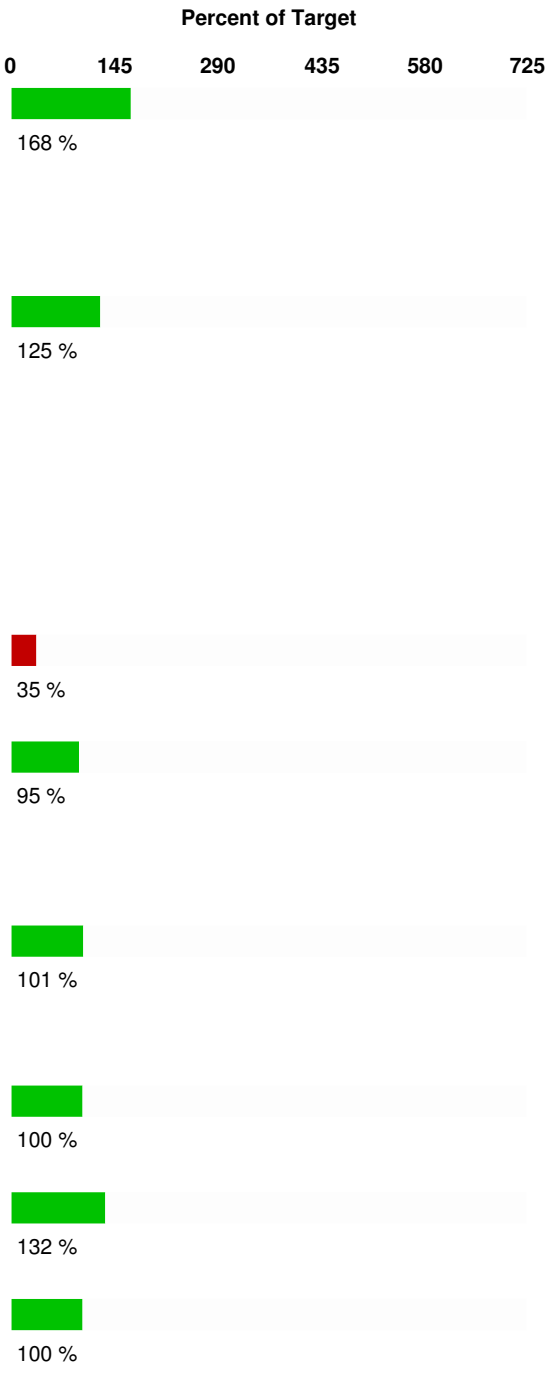
The numbers to the left of the indicators refer to their coverage level: Level 3, people reached; Level 2, service points supported; and Level 1, people trained.

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.

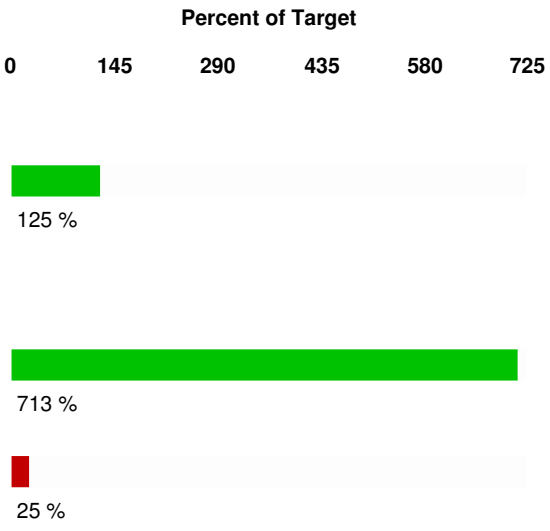
Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results		Period	Target	Actual	Percent of Target
Objective 1	**Expand Directly Observed Treatment, Short-course (DOTS) strategy nationwide to reduce increasing rate of Tuberculosis (TB) incidence**				
Service Delivery Area 1	**Health systems strengthening**				
1	Number and percentage of specialists in TB in children trained in new guidelines for TB diagnosis and treatment in children	Period 6	-	-	
2	Number and percentage of TB dispensaries with DOTS implemented	Period 6	163	192	118
1	Number of medical staff (pneumologists, epidemiologists, family doctors, nurses from the TB and the family doctors network.	Period 6	9100	9127	100
Service Delivery Area 2	**Prevention: Behavioral Change Communication - Community Outreach**				
1	Number of medical and prison staff trained for IEC sessions in prisons	Period 6	75	144	192
3	Number and percentage of prisoners receiving IEC sessions in TB	Period 6	2200	2552	116
1	Number of Roma medical mediators trained for IEC sessions in TB	Period 6	52	63	121
3	Number and percentage of Roma population from selected communities with implemented IEC program in TB	Period 6	20%	54.47% 14991	272
Service Delivery Area 3	**Supportive Environment: Advocacy and increased political commitment to DOTS**				
Service Delivery Area 4	**Prevention: Infection control in health care**				
3	Number and percentage of new TB patients counseled and tested for HIV	Period 6	5000	7312	146
Service Delivery Area 5	**Care and Support: Supporting patients through direct observation of treatment**				



Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results						
		Period	Target	Actual	Percent of Target	
3	Number of TB patients receiving incentives	Period 6	3000	5049	168	
Service Delivery Area 6	**Supportive Environment: Coordination and partnership development (national, community, public-private)**					
2	Number and percentage of medical schools with new curricula in TB implemented	Period 6	4	5	125	
Service Delivery Area 7	**Prevention: Identification of Infectious Cases**					
Objective 2	**Strengthen the National Healthcare for TB patients**					
Service Delivery Area 8	**Supportive Environment: Procurement and supply management capacity and building**					
1	Number and percentage of TB pharmacists trained in the new drug management system	Period 6	240	83	35	
2	Number and percentage of selected laboratories with proper equipment	Period 6	22	21	95	
Service Delivery Area 9	**Supportive Environment: Health systems strengthening**					
2	Number and percentage of laboratories receiving quality control visits	Period 6	174	177	101	
Service Delivery Area 10	**Treatment: Control of drug resistance**					
2	Number of facilities for Multidrug-Resistant Tuberculosis (MDR-TB) treatment receiving support (infrastructure, equipment,	Period 6	1	1	100	
1	Number and percentage of health staff (from the 2 MDR centres) trained in MDR-TB case management	Period 6	40	53	132	
3	Number and percentage of MDR-TB eligible patients under treatment in regional centers	Period 6	90	90	100	
Objective 3	**Strengthen the supervision/monitoring and surveillance system within the National Communicable Diseases Surveillance Network**					



Program Objectives, Service Delivery Areas (SDAs), Indicators, Targets and Results						
			Period	Target	Actual	Percent of Target
Service Delivery Area 11	**Supportive Environment: Monitoring and evaluation and operations research**					
2	Number and percentage of TB dispensaries with two supervision visits received annually		Period 6	77	97	125
Service Delivery Area 12	**Supportive Environment: Health systems strengthening**					
1	Number and percentage of people (including TB specialists from dispensaries, TB county managers and laboratory staff) trained in		Period 6	60	428	713
2	Number and percentage of TB dispensaries using centralized system for data collection		Period 6	39	10	25



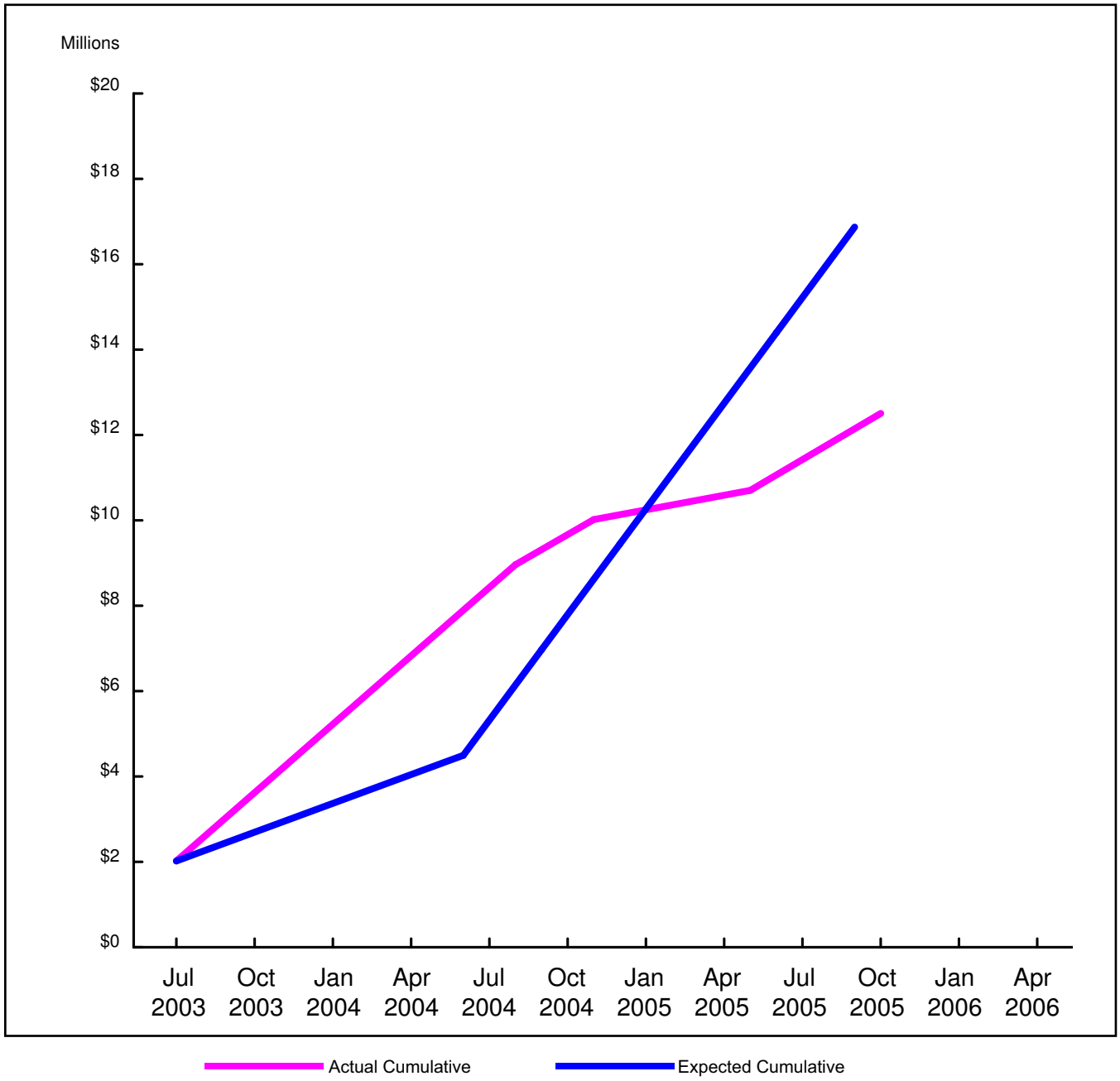
4. Disbursement History

***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	2020000	2020000	2020000	2020000
2	15-Jun-2004	04-Aug-2004	2475000	6942030	4495000	8962030
3	15-Sep-2004	19-Nov-2004	2475000	1056475	6970000	10018505
4	16-Dec-2004	--	2475000	0	9445000	10018505
5	15-Jun-2005	31-May-2005	4950000	683900	14395000	10702405
6	15-Sep-2005	06-Oct-2005	2475000	1802195	16870000	12504600

Expected vs. Actual Disbursements



5. Estimated under-disbursement in Phase 1

Estimated under-disbursement in Phase 1	Amount (in USD)	Amount (in %)
Phase 1 grant agreement amount	16,870,000	100 %
Less: actual disbursed to date	12,504,600	74 %
Less: expected additional disbursement until the end of Phase 1 grant agreement	0	0 %
Expected undisbursed amount at the end of Phase 1	4,365,400	26 %

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)?

24

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

If yes, please comment:

☒ Yes ☐ No

According to the program budget, the PR should have requested and received $16,870,000 by mid Q7 representing the cumulative budget to the end of Phase 1. However, actual disbursement #7 represents the receipt of 74% of Phase 1 budget. When considering the progress of the program overall, the PR was generally on track with disbursements up to the end of Q5 (actual $10,018,505 v. expected $10,800,645), but fell behind schedule in Q5-7. This resulted from a slow disbursement rate and an overestimation of cash needs leading to a zero disbursement in Q5 and the PR conducting a more rigorous assessment of the real cash needs of the SRs for Q6 and 7.

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

No additional comment.

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 significant Phase 1 undisbursed amount of USD 4,365,400 is due to:
(i) savings in procurement of MDR-TB drugs achieved early in Year 1 (USD 2,172,305). These were then available as un-allocated funds (requiring CCM endorsement prior to consideration of reasonableness. Options for use of these funds were not strategically developed by the PR during Phase 1.);
(ii) slow disbursement due to procurement delays (construction and refurbishment), slower implementation than expected for a number of activities e.g. construction works;
(iii) additional small budget savings.

Of these amounts the PR requested USD 3,935,438 to be reallocated to Phase 2.

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)	12,504,600	100 %	06-Oct-05
Less: Direct payments for PR Expenditures	392,436	3 %	
Less: PR disbursements to sub-recipients	8,424,536	67 %	
PR cash-balance	3,687,628	30 %	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

Importantly, the cash balance above reflects an erroneous picture of current PR liquidity. The table records the last disbursement made (6 October 2005 of USD1,802,195). However LFA verification was undertaken on 30 June 2005, with total disbursements at that time of USD10,702,405. Therefore, at 30 June 2005, PR Cash balance was USD1,954,325 (18% of disbursements). Given the intervening time between June and Phase 2 consideration, the LFA verified PR cash balance again at 30 September (again prior to receipt of the last disbursement). Cash balance at this time was USD516,873 (representing 4.8% of disbursements). Current PR commitments consist of procurement of PCs for dispensaries, multifunctional vehicles, SR audit, TB drugs and laboratory equipment) (total $991,833). All are expected to be paid and utilized in Q7.

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

As at 30 June 2005, the PR cash balance represented 18.26% of total disbursements received from the Global Fund. This was due to slower implementation during the first year of the program, due to the relatively low spending rate. Additionally, the PR did not receive any disbursement in Q5. (This is reflected in the expenditure 'burn rate' demonstrated. At 30 June 2005 the incurred amount was USD9.8 million representing 58% of the Phase 1 amount in 71% of the elapsed time). During Q6, the PR and the Sub Recipients (SRs) recovered activities rescheduled from previous quarters and the PR is disbursing funds to SRs as needed. This is reflected in the cash balance reported at end September 2005.

E. CONTEXTUAL CONSIDERATIONS

1. Have there been significant adverse external influences (force majeur)?	☐ Yes ☒ No	Significant widespread flooding occurred in the summer of 2005, placing strain on national systems and causing disruptions to implementation of training schedules training pharmacists in the new drug management system. Training is anticipated to have caught up targets by Q8. Currently, a significant focus for the Government of Romania is accession to the European Union which is anticipated to occur at end 2007.
1.1. If yes, have they been (or are they being) alleviated?	☐ Yes ☐ No	No additional comment.
2. Are there any unresolvable internal issues?	☐ Yes ☒ No	The change in Government in December 2004, led to a period of transition in early 2005 involving changes at the highest level in the MoH and a restructuring of the PMU. This led to the appointment of two new heads and a new financial coordinator. It also led to a period of intense focus on PMU previous management practice in order to deliver the external audit. The appointment of a new Minister in August 2005, ultimately resolved the issue. A new CCM chair was nominated in April 2005 and new members admitted to the CCM. With the exception of faith based organizations (FBOs), the CCM membership is representative of all constituencies, and Vice-Chairs represent the academic, HIV/AIDS and TB sectors. It should be noted that the CCM incorporates greater HIV representation (85%), leading to more strategic involvement in HIV/AIDS grant oversight than with the TB grant program. The CCM Executive Committee has maintained regular interactions with the PR since program commencement.
3. Are there financial and program management issues (e.g., slow or incomplete disbursements to sub-recipients or issues with the PR)?	☒ Yes ☐ No	A slow spending rate was demonstrated in the early stages of program implementation due to delayed procurement and delays associated with GLC approval and subsequent MDR-TB treatment. This was reflected in reduced disbursements. Significant savings achieved in the procurement of MDR-TB drugs also led to a reduced level of spending. While experiencing a recovery over the past 3 quarters, the spending rate has remained sub-optimal. The PR's capacity to provide leadership in securing timely strategic implementation decisions has been lacking, particularly in utilizing unallocated budget (derived from the savings described above) and in coordinating SRs in the development of the Request for Continued Funding. This may reflect the coincidence of a number of events around the same period, specifically, change in PMU management, change in Minister, change in CCM Chair and significant attention directed to an internal audit of the previous PMU management. The PR needs to address its principal role of coordination and management as a priority. Further refinements to the financial system including internal accounting controls and appropriate segregation of finances between the HIV and TB grants (as highlighted by the Audit process) need to be undertaken.

4. Are there any systemic weaknesses in:

4.1. Monitoring and evaluation?	☒ Yes	☐ No	The M&E budget for Phase 2 activities appears to be restricted to M&E provided by the PMU. Generally SR data collection and reporting is systemmatic although not always timely, so further systems strengthening is recommended. As at end September 2005, the position of the M&E Coordinator remained vacant. Increased M&E at the activity level is required in order to ensure an integrated approach with NTP systems. It may be more appropriate to strengthen the M&E function of the key SR, Marius Nasta, (the central TB unit for the National TB Program). The PR should develop an M&E plan that demonstrates better integration with the National TB program in order to address some of the key findings of the WHO Review Mission of April 2005 and longer term sustainability of activities.
4.2. Procurement and Supply Chain Management?	☒ Yes	☐ No	The PR has experienced several delays in its centralized procurement processes conducted on behalf of the SRs, that could have been avoided with better procurement planning (e.g. by outsourcing procurement). The position of Procurement Coordinator has been vacant since June 2005. The PR should strengthen its PSM capacity by hiring a competent Procurement Coordinator. The PR has also been urged to streamline the cumbersome national procurement processes applicable to the GF funded program in order to ensure timely procurement and spending. It is probable that most SRs from Phase 1 will continue to operate in Phase 2. Therefore, the PR should be in a position to benefit from lessons learned and minimize delay. In the instance of MDR-TB drug procurement with IDA this already seems to be demonstrated, as negotiations in September 2005 suggest early resolution and drug delivery.
4.3. Any other areas?	☐ Yes	☒ No	No additional comment.
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. The PR should ensure adequate M&E capacity and systems at the SR level so that results are consistently reported on a timely basis.
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	The implementation of the program has generally strengthened partnerships with NGOs (DOW, Rromani Cris, Romanian Red Cross) and government, including the penitentiary system. In September 2005, the new Minister of Health announced a major health sector reform initiative, pledging 5% GDP for the health budget, and the intention to move to multi-year budgeting for all public health programs, including TB. While the National TB Strategy 2006-2010 has yet to receive government budget allocation, the Minister of Health has provided assurances that, at a minimum, the current funding level would be maintained for 2006 and 2007. Romania is also poised to join the EU end 2007, which is also expected to provide a major incentive for further domestic funding. The WHO Office for TB Control in the Balkans has been a key technical partner throughout the program, also supporting the National TB Program. Such technical assistance has focused on strengthening the bacteriological laboratory network and on improving communication among the main stakeholders involved in TB control activities.

7. Has the program demonstrated significant improvements in implementation over the last 6 months?	☒ Yes ☐ No	Program implementation has accelerated over the past three quarters, resulting in reaching and exceeding most targets in quarter 6. The PR has overcome the slow start experienced at program launch due to the lengthy administrative procedures, extended processes for completing SR agreements, and delays in procurement. Overall spending rate, while increased over the past 6 months, remains sub-optimal.
8. Have there been any changes in disease trends?	☒ Yes ☐ No	The number of TB cases has been decreasing over the past three years since proposal submission. After 15 years of steady increase in overall incidence, this is now slowly decreasing (from 142.2% in 2002 to 134.6 in 2004). The number of new cases has also decreased (from 25,237 in 2003 to 24,779 in 2004), as well as the number of TB cases in children (1,608 in 2003 to 1,442 in 2004). In 2004 the prevalence of MDR-TB was estimated at 32.7%. According to the WHO NTP Review Report, April 2005, the WHO global target for TB control related to case detection has been achieved, and DOTS strategy is available for 100% of the population. The treatment success rate of newly detected bacteriologically confirmed patients has reached 80% (on track to achieving the 2007 target of 85% in the initial proposal)

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	The program has strengthened partnerships with NGOs (Doctors of the World, Rromani Cris, Romanian Red Cross), and engaged with the academic sector (National Institute for Research and Development in Health, Romanian Society of Pulmonary and Romanian medical schools). Strong links exist with the National TB Program, Pharmaceutical Department (MOH), National Health Insurance House and the penitentiary system. WHO Office for TB Control in Balkans has been actively involved in the provision of technical assistance and overall support through engagement with the NTP and CCM. Additional WHO partnership has been commenced through the Intensive Support and Action for Countries (ISAC) (one of 7 countries world wide to undertaken this partnership).
9.2. Promote sustainability and national ownership through use of existing systems and linkages with related strategies and programs?	☐ Yes ☒ No	The Global Fund TB grant focuses on using existing systems and building on the national TB program capacity to create ownership and sustainability. This is achieved through close relationship with the NTP. One of the main objectives of the program is to improve TB supervision/monitoring and strengthen the TB surveillance system within the National Communicable Diseases Surveillance network. This collaboration aims to ensure the additionality of activities and funds and sustainability of the program.
9.3. Provide additional resources?	☐ Yes ☒ No	See comments provided under Item E.6. Over the the life of the program, GF funding support has comprised a high of 54% of total financial contributions (with heavy investment in training and infrastructure in 2004) to 28% in 2005. External funding sources have increased by four fold since program commencement. Domestic funding contributions have fluctuated, increasing since 2003 but with a lower level funding (USD 0.5 million) demonstrated between 2004 and 2005. A number of international organizations (DOW, USAID) have provided assistance since 2003, however exact figures beyond 2005 have not been received. National government contribution, in the form of the National TB Strategy for 2006-2010 is not anticipated to be approved until November 2005. Ministerial assurances have been given to maintain (at a minimum) the current level of USD 5.5 million in 2006 and 2007.
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 HIV/AIDS Proposal was also approved in 2002. The PR's PMU also manages the Global Fund HIV/AIDS 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 TB program and the national program enable effective expansion of prevention and treatment, together with strengthening of the national surveillance network across Romania.