ROMANIAN
COUNTRY COORDINATION MECHANISM
FOR HIV/AIDS AND TUBERCULOSIS

PROPOSAL

1 Proposal Overview

1.1 General information on proposal

Applicant Name	Romanian Country Coordination Mechanism for HIV/AIDS and Tuberculosis
Country/countries	Romania

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

- ☒ National Country Coordinating Mechanism
- ☐ Sub-national Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including small island developing states)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

Please tick the appropriate box or boxes below, to indicate components included within your proposal. Also specify the title for each proposal component chosen. For more information, please refer to the Guidelines for Proposals, section 1.1.

	Component	Title
☒	HIV/AIDS[1]	Towards Universal Access To HIV/AIDS Prevention, Treatment, Care And Social Support For Vulnerable And Underserved Population
☐	Tuberculosis[1]	Scaling up Tuberculosis Control in Romania By Focusing On Poor And Vulnerable Populations
☐	Malaria	

Currency in which the Proposal is submitted

Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.

- ☐ US$
- ☒ Euro

[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS and/or tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Proposal Overview

1.2 Proposal funding summary per component

Funds requested for each component (i.e. HIV/AIDS, tuberculosis and/or malaria) in table 1.2 below must be the same as the totals of the corresponding component budget in table 5.1.

Table 1.2 – Total funding summary

Component	Total funds requested (Euro)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV/AIDS	3,546,703	2,921,807	2,373,266	125,490	124,430	**9,091,696**
Tuberculosis	1,927,829	1,692,598	2,012,192	1,351,332	1,033,297	**8,017,248**
Malaria	0	0	0	0	0	**0**
Total	**5,474,532**	**4,614,405**	**4,385,458**	**1,476,822**	**1,157,727**	**17,108,944**

1.3 Previous Global Fund grants

Table 1.3 – Previous Global Fund grants

Component	Previous grants	
	Rounds	Current Amount* (US$)
HIV/AIDS	2	US$26.8 million
Tuberculosis	2	US$16 million

2 Eligibility

2.1 Technical eligibility

2.1.1 Country income level

Please tick the appropriate box in the table below. ***For proposals from multiple countries****, complete the referenced information separately for each country (see the Guidelines for Proposals, section 2.1).*

Country/countries		
☐	Low-income	➔ *Complete section 2.2 only*
☒	Lower-middle income	➔ *Complete sections 2.1.2, 2.1.3 and 2.2*
☐	Upper-middle income	➔ *Complete sections 2.1.2, 1.2.3, 2.1.4 and 2.2*

2 Eligibility

2.1.2 Counterpart financing and greater reliance on domestic resources

Table 2.1.2 – Counterpart financing

Component	Financing sources	(Euro)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
HIV/AIDS	**Total requested** from the Global Fund **(A)** [from table 5.1]	3,546,703	2,921,807	2,373,266	125,490	124,430
	Counterpart financing (B) [linked to the disease control program]	72,683,312	87,219,974	101,756,636	116,293,299	138,098,292
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	95.3%	96.8%	97.7%	99.9%	99.9%

Table 2.1.2 – Counterpart financing continued

Component	Financing sources	(Euro)				
		Year 1	Year 2	Year 3 estimate	Year 4 estimate	Year 5 estimate
TB	**Total requested** from the Global Fund **(A)** [from table 5.1]	1,927,829	1,692,598	2,012,192	1,351,332	1,033,297
	Counterpart financing (B) [linked to the disease control program]	5,300,000	5,300,000	5,300,000	5,300,000	5,300,000
	Counterpart financing as a **percentage** of total financing: **[B/(A+B)] x 100 = %**	73.3%	75.8%	72.5%	79.7%	83.7%

2 Eligibility

2.1.3 Focus on poor or vulnerable populations

*All proposals from Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or vulnerable population groups. Proposals may focus on both population groups but **must** focus on at least one of the two groups. Complete this section in respect of each component.*

Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these populations groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal *(Maximum half a page per component).*
This proposal is based on the latest reviews of the National HIV/AIDS Strategy (March 2006) and its recommendations for strengthening and expanding the scale and coverage of interventions targeting injecting drug users (IDUs), commercial sex workers (SWs), men who have sex with men (MSM), Roma communities, young people living with HIV/AIDS (YPLWHA), street children and prisoners. In the past few years, major progress has been made in these areas. Several pilot interventions were scaled up to significant coverage, many of them with support from the current GFATM grant. The current GFATM grant allows Romania to maintain existing interventions but not to expand them significantly. Despite the major progress there is still a significant gap to be addressed, and this gap will only increas as the size of the vulnerable populations increase and as new challenges arise. In the area of treatment and care, prevention among young people, and the prevention of mother to child transmission among the general population, Romania is supporting more interventions with its domestic resources and is rapidly approaching universal access. Unfortunately, however, this is not happening among the vulnerable populations. While the investments made in the past couple of years have helped develop the country's capacity for developing and implementing such interventions, there remains significant need to scale up these efforts in order to achieve meaningful health impact. This was the conclusion of intensive consultations between national and international partners for both the UNGASS reporting and for the mid-term review of the National HIV/AIDS Strategy 2004 – 2007 in the period November 2005 – March 2006. The review process involved all major stakeholders including organizations directly involved with the targeted populations. The present proposal is building on the current partnership established between government and nongovernmental organizations and between service providers and service beneficiaries. It will also have as a special focus the continuation of building capacity at the local level for implementing and sustaining long term effective interventions with the participation of all the stakeholders.

2.1.4 High disease burden

Proposals from Upper-middle income countries must also demonstrate that they face a very high current disease burden. Please enter such information in the section below in respect of each component. Please note that if the applicant country falls under the "small island economy" lending eligibility exception as classified by the World Bank/International Development Association, this requirement does not apply (see section C in Attachment 1 to the Guidelines for Proposals).

Confirm that the country(ies) is(are) facing a very high current disease burden, as evidenced by data from WHO and UNAIDS. *(Please see the Guidelines for Proposals, section 2.1.4 for more information on the definition of high disease burden.)*

2 Eligibility

2.2 Functioning of Coordinating Mechanism

2.2.1 Broad and inclusive membership

a) People living with and/or affected by the disease(s)

Provide evidence of membership of people living with and/or affected by the disease(s). *(This may be done by demonstrating corresponding Coordinating Mechanism membership composition and endorsement in table 3B1.2, and 3B.1.3 in section 3B of the Proposal Form.)*

People infected or affected by HIV/AIDS are members of the CCM through UNOPA, the National Union of Organization of People Infected and Affected, which holds the seat of vice-chair of the CCM. UNOPA is a large federation including 24 organizations of people infected and affected from throughout the country.

b) Selection of non-governmental sector representatives

Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.

(Please summarize the process and, for each sector, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the applicable annex number.)

The CCM in Romania was formed in early 2002 on the principle of equal participation. From the beginning, all NGOs, academia, private sector or other sector representatives that expressed interest were admitted. Furthermore, as the CCM Operation Book stipulates, the process of admitting new members remains open. In order for the body to cope with an ever increasing number of members (presently more than 55) and remain operational and effective, the CCM established an Executive Committee (with a maximum of 15 members). The EC continues the work of the CCM during the period between its meetings. An algorithm decides the make up of the EC membership by assigning a set number of seats for each constituency group represented in the CCM. EC members are elected through an open vote of the CCM members. (Please see Annex 1).

2.2.2 Documented procedures for the management of conflicts of interest

Where the Chair and/or Vice-Chair of the Coordinating Mechanism are from the same entity as the nominated Principal Recipient(s) in this proposal, describe and provide evidence of the applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest arising in regard to the applicant's operations or responsibilities.

(Please summarize and attach the policy as an annex. Please indicate the applicable annex number.)

The CCM Operating Book has a special chapter for the prevention and management of conflicts of interest (See Annex 2 for the revised and original Chapter VIII from the attached CCM Operating Book). One of the provisions in this chapter addresses the issue of a representative from the PR being a member of the CCM and prevents that CCM member from participating in any CCM decision making that refers to the selection of the PR or the relationship between PR and CCM. The president and vice-president and the PR are three different entities.

2 Eligibility

2.2.3 Documented and transparent processes of the Coordinating Mechanism

Please describe and provide evidence of the CCM's documented, transparent and established:

a) Process to solicit submissions for possible integration into this proposal.

The CCM solicits proposal in the daily newspaper "Romania Libera", (Announcement attached in Annex 3.), and through the electronic newsletter "Voluntarul" which has a significant circulation among NGOs. The CCM also posts such announcements and their supporting documents on the web page of the PR of the current grant and on the UN/Romania web page.

All the templates and guidelines for submission of proposals were prepared by the Executive Committee based on the mandate given by the CCM (See Annex 4). The table, including the areas to be covered by the proposals, were agreed upon by the CCM based on GFATM eligibility criteria and the existing national strategies and policies for interventions in each of the respective areas.

b) Process to review submissions received by the CCM for possible integration into this proposal.

The CCM has nominated a special selection committee that only includes technical experts from organizations that are not potential sub-recipients to screen and review the submissions for possible integration in the country proposal. The committee used well defined and specific selection criteria for their evaluation. (See Annex 5 for minutes from the CCM meeting.) The submissions that were approved by the selection committee were afterwards integrated into the country proposal by the working group established by CCM for writing the proposal. The first draft of the country proposal was again circulated to all CCM members and to all organizations that participated in the submission process for comments, suggestions and interventions. All the comments relevant to the scope of the application were integrated and the enhanced draft was again circulated widely for the final inputs prior to the CCM approval meeting organized on 13 July 2006.

c) Process to nominate the Principal Recipient(s) and **oversee** program implementation.

The CCM has solicited its members to apply for the PR position based on the criteria set forth by GFATM. The announcement included the selection criteria and process and was sent to all the CCM members on 30 June 2006. The applications were publicly presented at a CCM meeting on 18 July 2006. Each applicant presented a power point presentation to the CCM which included a question and answer period. The final decision was made by vote by the CCM members. CCM also approved its plan for overseeing the implementation of the current GFATM grant and of the potential future grants. (See Annex 6.)

d) Process to ensure the input of a broad range of stakeholders, including CCM members and non-CCM members, in the proposal development process and grant oversight process.

Proposals were solicited from potential subrecipients in the manner described in Section 2.2.3. The Technical Committee then wrote the proposal based upon these inputs, the mid-term evaluation of the National HIV/AIDS Strategy and the national 2010 targets for universal access to HIV/AIDS prevention, treatment and care. A draft proposal was circulated to the CCM for comments and edits. As explained later in Section 3A.2.1, this body represents a broad cross section of stakeholders. After comments were gathered, the Technical Committee then incorporated these comments and presented the final draft to the CCM for a vote. (Please see Annex 7 for the results of the evaluation process and proof the broad range of stakeholders involved.)

3A Applicant Type

3A.1 Applicant

Table 3A.1 – Applicant

Please tick the appropriate box in the table below, and then go to the relevant section in this Proposal Form, as indicated on the right hand side of the table.	
X National Country Coordinating Mechanism	➔*complete sections 3A.2 and 3B*
Sub-national Country Coordinating Mechanism	➔*complete sections 3A.3 and 3B*
Regional Coordinating Mechanism (including small island developing states)	➔*complete sections 3A.4 and 3B*
Regional Organization	➔*complete section 3A.5 and 3B*
Non-CCM Applicants	➔*complete section 3A.6*

3A.2 National Country Coordinating Mechanism (CCM)

For more information, please refer to the Guidelines for Proposals, section 3A.2, and the CCM Guidelines.

Table 3A.2 – National CCM: basic information

Name of national CCM	**Date of composition** (yyyy/mm/dd)
Country Coordination Mechanism for HIV/AIDS and Tuberculosis in Romania	2002/04/15

3A Applicant Type

3A.2.1 Mode of operation

Describe how the national CCM operates. In particular:

- **The extent to which the CCM acts as a partnership between government and other actors in civil society**, including the academic and educational sector; non-government and community-based organizations; people living with and/or affected by the diseases and the organizations that support them; the private sector; religious and faith-based organizations; and multi-/bilateral development partners in-country; and
- **How it coordinates its activities with other national structures** (such as National AIDS Councils, Parliamentary Health Commissions, National Monitoring and Evaluation Offices and other key bodies).

The Romanian CCM operates "based on partnership and consists of representatives of the organizations and institutions active in the area of HIV/AIDS and TB" (CCM Operating Book). This large partnership includes governmental and non-governmental organizations, donors and recipients, academic and community based organizations, service providers and service beneficiaries, people living with HIV/AIDS and people from vulnerable groups. The decision making process is focused on consensus. If consensus is not reached, the CCM proceeds to vote. All the members are " equal in their right to participate, to express themselves and to be involved in the decision making process" (CCM Operating Book). All the votes are equal. Moreover, to ensure the full participation of any institution interested, the CCM has an open admission policy and does not limit the number of members.

For operational reasons the CCM established an Executive Committee - EC, elected and reflecting the overall structure of the CCM. The EC meets between CCM meetings and ensures all the technical and professional input needed for adequate and efficient decision making by the CCM. The EC is not a substitute for the CCM and works only based on the mandate given by the CCM. During the past few years, the CCM met at least once every two months and more often during the preparation for the second phase of the current HIV and TB grants. The EC meets at least once a month.

The CCM is built on the existing National Inter-Sectoral Commission for Surveillance, Control and Prevention of HIV/AIDS, established by the Government Ordinance 330 of 20 March 2003 under the authority of the Prime Minister. It includes representatives of 16 Ministries and government agencies, eight NGOs and 20 permanent guest participants representing academia, civil society, the private sector, professional associations, UN Agencies, bilateral and multilateral donors. The CCM was expanded to include all the other relevant government and non-governmental institutions working in the area of HIV/AIDS and TB.

The National Inter-Sectoral Commission reports on the national HIV/AIDS situation and the status of the National HIV/AIDS Strategy implementation to the Government and Parliament. All the processes of the National HIV/AIDS Strategy implementation, including funding, are harmonized and fully coordinated with the current GFATM grant and with the present proposal. The National Inter-Sectoral Commission and the CCM have overlapping membership and have the same chair. The vice chairs of both represent people living with HIV/AIDS. This integration ensures that everything done under the current and proposed GFATM proposals is in line with national priorities and responds to national needs. (See Annexes 8 & 9)

➔ *After completing this section, complete section 3B.1.*

3B Proposal Endorsement

3B.1 Coordinating Mechanism membership and endorsement:

National Coordinating Mechanisms

3B.1.1 Leadership of Coordinating Mechanism

Table 3B.1.1 – National/Sub-national/Regional (C)CM leadership information
(not applicable to Non-CCM and Regional Organization applicants)

	Chair	Vice Chair
Name	Valentina Contescu,	Elena Traicu
Title	State Counsellor,	Board member,
Organization	Prime Minister Office	The National Union of Organizations of Persons Affected with HIV/AIDS - UNOPA
Mailing address	1 Victoriei Plaza, Sector 1, Bucharest	24 Nicolae Balcescu Blvd., Sector 1, Bucharest
Telephone	+40212602921	+40212109089
Fax	+40213149167	+40212109089
E-mail address	valentina.contescu@gov.ro	unopa@unopa.ro

3B Proposal Endorsement

3B.1.2 Membership information

Table 3B.1.2 – National CCM member information

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Prime Minister Chancellery	Website	www.cancelarie.ro
Type	government		
Name of representative	Valentina Contescu	CCM member since	2005
Title in agency/organization	State counsellor	Fax	+ 4 021 318 11 52
E-mail address	valentina.contescu@gov.ro	Telephone	+ 4 021 318 11 10
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	1 Victoria Square Sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNOPA	Website	www.unopa.ro
Type	non-governmental representing people living with HIV/AIDS		
Name of representative	Cristina Bucata	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 319 93 29
E-mail address	unopa@unopa.ro	Telephone	+4 021 319 93 29
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	24 Nicolae Balcescu Blvd sc C, ap. 7 sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Matei Bals Institute of Infectious Disease	Website	www.mateibals.ro
Type	government		
Name of representative	Adrian Streinu Cercel	CCM member since	2005
Title in agency/organization	General director	Fax	+4 021 318 61 19
E-mail address	strega@mb.rocknet.ro	Telephone	+4 021 318 16 00
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	1, Grozovici, sector 2 Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Marius Nasta Institute of Pneumophtisiology	Website	-
Type	government		
Name of representative	Elmira Ibraim	CCM member since	2005
Title in agency/organization	TB surveillance coordinator	Fax	+4 021 337 38 01
E-mail address	ielmira2000@yahoo.com	Telephone	+4 021 335 69 10
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	90, Sos Viilor sector 5, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Health	Website	www.ms.ro
Type	government		
Name of representative	Vlad Iliescu	CCM member since	2003
Title in agency/organization	State secretary	Fax	+4 021 337 38 01
E-mail address	viliescu@ms.ro	Telephone	+4 021 335 69 10
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	1-3, Cristian Popisteanu sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National School of Public Health and Healthcare Management	Website	www.incds.ro
Type	government		
Name of representative	Florin Sologiuc	CCM member since	2003
Title in agency/organization	General director	Fax	+4 021 252 30 14
E-mail address	fsologiuc@incds.ro	Telephone	+4021 252 78 34
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	31, Vaselor sector 2, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Global Fund and World Bank Project Management Unit	Website	www.pmu-wb-gf.ro
Type	government		
Name of representative	Antoanela Poenaru	CCM member since	2003
Title in agency/organization	Head of PMU	Fax	+4 021 312 35 88
E-mail address	antoanela.poenaru@pmu-wb-gf.ro	Telephone	+4 021 311 29 64
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	1-3, Cristian Popisteanu sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Public Finances	Website	www.mfinante.ro
Type	government		
Name of representative	Adrian Nan	CCM member since	2003
Title in agency/organization	Superior adviser	Fax	+4 021 336 63 85
E-mail address	adrian.nan@mfinante.gov.ro	Telephone	+4 021 410 34 00/1122
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	17, Apolodor sector 5, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Justice	Website	www.just.ro
Type	government		
Name of representative	Elena Melinda Stoica	CCM member since	2005
Title in agency/organization	Juridical adviser	Fax	+4 021 318 33 09
E-mail address	melindastoica@just.ro	Telephone	+4 021 318 33 23
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	17, Apolodor sector 5, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Justice, Prisons National Administration	Website	www.anp-just.ro
Type	government		
Name of representative	Afrodita Qaramah	CCM member since	2003
Title in agency/organization	PMU Coordinator	Fax	
E-mail address	aqaramah@dgp.ro	Telephone	+4 021 242 48 69
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	47, Maria Ghiculeasa sector 2, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Administration and Interior	Website	www.mai.gov.ro
Type	government		
Name of representative	Nicolae Stoicovici	CCM member since	2003
Title in agency/organization		Fax	
E-mail address	nicolae.stoicovici@mai.gov.ro	Telephone	+4 021 315 27 37
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	6, Mihai Voda sector 5, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National Agency against Drugs	Website	www.ana.gov.ro
Type	government		
Name of representative	Pavel Abraham	CCM member since	2005
Title in agency/organization	President	Fax	+4 021 326 67 27
E-mail address	ruxanda_iliescu@yahoo.com	Telephone	+4 021 326 44 00
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	37, Unirii Blvd sector 3, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Labor, Social Solidarity and Family	Website	www.mmssf.ro
Type	government		
Name of representative	Ioana Nedelcu	CCM member since	2003
Title in agency/organization	Deputy state secretary	Fax	
E-mail address	ioana.nedelcu@anpca.ro	Telephone	+4 021 310 07 89
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	2-4, Dem I Dobrescu sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National Authority for Protection of Children's Rights	Website	www.copii.ro
Type	government		
Name of representative	Ali Cranta	CCM member since	2003
Title in agency/organization	Adviser	Fax	+4 021 310 07 89
E-mail address	ali.cranta@anpca.ro	Telephone	+4 021 310 07 89
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	7, Magheru Blvd sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Transport, Construction and Tourism	Website	www.mt.ro
Type	government		
Name of representative	Gabriela Arnautu	CCM member since	2003
Title in agency/organization	Director	Fax	+4 021 212 61 42
E-mail address	dirmed@mt.ro	Telephone	+4 021 212 61 42
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	38, Dinicu Golescu Blvd sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of Education and Research	Website	www.edu.ro
Type	government		
Name of representative	Daniela Calugaru	CCM member since	2003
Title in agency/organization		Fax	
E-mail address	calugaru.daniela@gmail.com	Telephone	+4 021 313 79 56
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	28-30, G-ral Berthelot sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	General Secretariat of the Government	Website	www.sgg.ro
Type	government		
Name of representative	Adrian Comanescu	CCM member since	2003
Title in agency/organization		Fax	
E-mail address	adrian.comanescu@gov.ro	Telephone	+4 021 724 334 052
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	1, Victoriei Square sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National Authority for Persons with handicap	Website	www.anph.ro
Type	government		
Name of representative	Paulian Sima	CCM member since	2003
Title in agency/organization	Adviser	Fax	+4 021 212 54 43
E-mail address	paulsima@anph.ro	Telephone	+4 021 212 54 40
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	194, Calea Victoriei sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Ministry of National Defence	Website	www.mapn.ro
Type	government		
Name of representative	Gabriela Dutescu	CCM member since	2003
Title in agency/organization		Fax	+4 021 224 94 84
E-mail address	gabidutescu@yahoo.com	Telephone	+4 021 722 350 586
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	3-5, Izvor sector 5, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Presidential Administration	Website	www.presidency.ro
Type	government		
Name of representative		CCM member since	2005
Title in agency/organization		Fax	
E-mail address		Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National House of Health Insurance	Website	www.cnas.ro
Type	government		
Name of representative	Ioana Toncu	CCM member since	2003
Title in agency/organization	director	Fax	+4 021 302 62 88
E-mail address	programe@casan.ro	Telephone	+4 021 302 62 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	248, Calea Calarasilor sector 3, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	EC Delegation in Romania	Website	www.infoeuropa.ro
Type	multi-/bilateral development partners in country		
Name of representative	Iulia Deutsch	CCM member since	2003
Title in agency/organization	Project officer	Fax	+4 021 230 24 53
E-mail address	iulia.deutsch@cec.eu.int	Telephone	+4 021 203 54 45
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	18, Jules Michelet sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	World Bank Bureau in Romania	Website	www.worldbank.org.ro
Type	multi-/bilateral development partners in country		
Name of representative	Richard Florescu	CCM member since	2003
Title in agency/organization	Project officer	Fax	+4 021 210 20 21
E-mail address	rflorescu@worldbank.org	Telephone	+4 021 201 03 20
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	83, Dacia Blvd sector 2, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	World Health Organisation, Regional Office for Europe, Office for TB control in the Balkans	Website	www.who-tb.balkans.ro
Type	multi-/bilateral development partners in country		
Name of representative	Cassandra Butu	CCM member since	2003
Title in agency/organization	National professional officer	Fax	+4 021 307 26 68
E-mail address	cassb@cmb.ro	Telephone	+4 021 317 09 11
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	1-3, Cristian Popisteanu sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	World Health Organisation	Website	
Type	multi-/bilateral development partners in country		
Name of representative	Victor Olszavski	CCM member since	2003
Title in agency/organization	Head of country office	Fax	+4 021 201 78 89
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Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	48A, Primaverii Blvd sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	USAID Romania	Website	www.usembassy.ro/USAID
Type	multi-/bilateral development partners in country		
Name of representative	Cate Johnson	CCM member since	2003
Title in agency/organization	Director	Fax	+4 021 410 12 02
E-mail address	cate@usaid.gov	Telephone	+4 021 410 12 22
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	1-5, Costache Negri sector 5, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNICEF Romania	Website	www.unicef.org/romania
Type	multi-/bilateral development partners in country		
Name of representative	Tania Goldner	CCM member since	2003
Title in agency/organization	Program coordinator	Fax	+4 021 231 52 55
E-mail address	tgoldner@unicef.org	Telephone	+4 021 201 78 60
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	48A, Primaverii Blvd sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNFPA Romania	Website	www.unfpa.ro
Type	multi-/bilateral development partners in country		
Name of representative	Mihai Horga	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 201 78 40
E-mail address	horga@unfpa.ro	Telephone	+4 021 201 78 32
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	48A, Primaverii Blvd sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNDP Romania	Website	www.undp.ro
Type	multi-/bilateral development partners in country		
Name of representative	Alina Bocai	CCM member since	2003
Title in agency/organization	Project manager	Fax	+4 021 201 78 28
E-mail address	alina.bocai@undp.ro	Telephone	+4 021 201 78 22
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	48A, Primaverii Blvd sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	UNAIDS Romania	Website	
Type	multi-/bilateral development partners in country		
Name of representative	Eduard Petrescu	CCM member since	2003
Title in agency/organization	National officer	Fax	+4 021 201 78 28
E-mail address	eduard.petrescu@undp.ro	Telephone	+4 021 201 78 83
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	48A, Primaverii Blvd sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Health Aid Romania	Website	www.healthaidromania.ro
Type	non-governmental and community-based organisations		
Name of representative	Ernestina Rotariu	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 210 95 17
E-mail address	har@pcnet.ro	Telephone	+4 021 210 54 30
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	1, Dr Grozovici sector 2, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Romanian Association against AIDS - ARAS	Website	www.arasnet.ro
Type	non-governmental and community-based organisations		
Name of representative	Maria Georgescu	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 210 82 51
E-mail address	maria.georgescu@arasnet.ro	Telephone	+4 021 210 07 71
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	5, Intr. Mihai Eminescu sector 2, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Romanian Angel Appeal RAA	Website	www.raa.ro
Type	non-governmental and community-based organisations		
Name of representative	Silvia Asandi	CCM member since	2003
Title in agency/organization	General director	Fax	+4 021 323 24 90
E-mail address	silvia.asandi@raa.ro	Telephone	+4 021 323 68 68
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	52, Rodiei sector 3, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Youth for Youth Foundation	Website	www.venerix.ro
Type	non-governmental and community-based organisations		
Name of representative	Alexandru Negut	CCM member since	2003
Title in agency/organization	Director	Fax	+4 021 231 11 95
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Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	20B, Dionisie Fotino sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Association for contraceptive and sexual contraception SECS	Website	
Type	non-governmental and community-based organisations		
Name of representative	Borbala Koo	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 310 33 86
E-mail address	borbala.koo@secs.ro	Telephone	+4 021 310 33 14
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	3B, Dimitrie Racovita sector 2, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Save the children Romania	Website	www.salvaticopiii.ro
Type	non-governmental and community-based organisations		
Name of representative	Gabriela Alexandrescu	CCM member since	2003
Title in agency/organization	Executive president	Fax	+4 021 312 44 86
E-mail address	rosc@salvaticopii.ro	Telephone	+4 021 310 45 87
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	3, Intr. Stefan Furtuna sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Romanian Harm Reduction Network	Website	
Type	non-governmental and community-based organisations		
Name of representative	Catalina Iliuta	CCM member since	2003
Title in agency/organization	Project coordinator	Fax	+4 021 210 82 51
E-mail address	catalina.iliuta@arasnet.ro	Telephone	+4 021 210 07 71
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	5, Intr. Mihai Eminescu sector 2, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Population Services International - PSI	Website	www.psi.ro
Type	non-governmental and community-based organisations		
Name of representative	Clayton Davis	CCM member since	2003
Title in agency/organization		Fax	
E-mail address	cdavis@psi.ro	Telephone	+4 021 230 72 25
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	13, George Calinescu sector 1, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	John Snow Research and Training Institute - JSI	Website	www.jsi.com
Type	non-governmental and community-based organisations		
Name of representative	Merce Gasco	CCM member since	2003
Title in agency/organization	Executive director	Fax	+4 021 231 96 89
E-mail address	merce.gasco@jsi.ro	Telephone	+4 021 231 96 87
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	coordinating the proposal preparation	Mailing address	13, George Calinescu sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Accept Association	Website	www.accept-romania.ro
Type	non-governmental and community-based organisations		
Name of representative	Romanita Iordache	CCM member since	2003
Title in agency/organization	President	Fax	+4 021 252 16 37
E-mail address	romanita@accept-mail.ro	Telephone	+4 021 252 56 20
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	OP 34 CP 56 Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Center for Health Policies and Services	Website	www.cpss.ro
Type	non-governmental and community-based organisations		
Name of representative	Dana Farcasanu	CCM member since	2003
Title in agency/organization	Executive president	Fax	+4 021 212 06 29
E-mail address	dfarcasanu@buc.osf.ro	Telephone	+4 021 212 07 32
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	33 Caderea Bastiliei sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Close to you Foundation	Website	www.alaturidevoi.ro
Type	non-governmental and community-based organisations		
Name of representative	Angela Achitei	CCM member since	2005
Title in agency/organization	Executive director	Fax	+4 0232 313 214
E-mail address	advis@rdslink.ro	Telephone	+4 0232 275 568
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	10, Vovideniei Iasi

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Developing People Foundation	Website	www.fdpsr.ro
Type	non-governmental and community-based organisations		
Name of representative	Calin Pop	CCM member since	2003
Title in agency/organization	Director	Fax	+4 021 253 12 26
E-mail address	calin.pop@fdpsr.ro	Telephone	+4 021 253 00 76
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	2, Balciului sector 2, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Doctors of the World Romania	Website	
Type	non-governmental and community-based organisations		
Name of representative	David Berger	CCM member since	2005
Title in agency/organization	Project director	Fax	+4 021 252 32 74
E-mail address	david.berger@dowusa.org	Telephone	+4 031 401 63 69
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	35, Matei Voievod sector 2, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Merck Sharp & Dohme	Website	
Type	private sector		
Name of representative	Radu Vasilescu	CCM member since	2003
Title in agency/organization		Fax	+4 021 529 29 09
E-mail address	radu_vasilescu@merck.com	Telephone	+4 021 529 29 00
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	1A, Bucuresti-Ploiesti Sos sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Glaxo Smith Kline	Website	www.gsk.ro
Type	private sector		
Name of representative	Monica Amarie	CCM member since	2003
Title in agency/organization	HIV Brand manager	Fax	+4 021 202 82 09
E-mail address	monica.amarie@gsk.com	Telephone	+4 021 302 82 78
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	Opera Center 1, 1-5 Costache Negri sector 5, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	F. Hoffman La Roche	Website	
Type	private sector		
Name of representative	Daniel Andronache	CCM member since	2003
Title in agency/organization		Fax	+4 021 224 03 99
E-mail address	daniel.andronache@roche.com	Telephone	+4 021 224 03 96
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	9, Cpt. Av. N. Drossu sector 1, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Bristol Myers Squibb	Website	
Type	private sector		
Name of representative	Carmen Serban	CCM member since	2003
Title in agency/organization	Medical&Government Affairs Manager	Fax	
E-mail address	carmen.serban@bms.com	Telephone	+4 021 260 10 46
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Boehringer Ingelheim	Website	
Type	private sector		
Name of representative		CCM member since	2003
Title in agency/organization		Fax	
E-mail address		Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	College of Medicine Doctors of Romania	Website	www.cmr.ro
Type	private sector		
Name of representative	Petre Calistru	CCM member since	2005
Title in agency/organization	President of Infectious Diseases Commission of CMR	Fax	+4 021 413 77 50
E-mail address	vbabes@xnet.ro	Telephone	+4 021 321 49 54
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	15, Blvd Timisoara sector 6, Bucharest

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	Romanian Society of Pneumology	Website	www.srp.ro
Type	private sector		
Name of representative	Irina Strambu	CCM member since	2005
Title in agency/organization		Fax	+4 021 337 44 60
E-mail address	istrambu@yahoo.com	Telephone	+4 021 337 44 60
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	90, Viilor sector 5, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	National Commission of Pneumology	Website	
Type	government		
Name of representative	Miron Bogdan	CCM member since	2005
Title in agency/organization	President	Fax	
E-mail address	miron_a_bogdan@yahoo.com	Telephone	
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		Mailing address	

3B Proposal Endorsement

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	College of Pharmacists of Romania	Website	www.colegfarm.ro
Type	private sector		
Name of representative	Dumitru Lupuliasa	CCM member since	2005
Title in agency/organization	President	Fax	+4 021 314 79 55
E-mail address	office@colegfarm.ro	Telephone	+4 021 314 79 55
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	202 A, Splaiul Independentei sector 6, Bucharest

National/Sub-national/Regional (C)CM member details			
Member			
Agency/organization	International Orthodoxe Christian Charities	Website	
Type	non-governmental and community-based organisations		
Name of representative	Mark Ohanian	CCM member since	2005
Title in agency/organization		Fax	+4 031 405 77 94
E-mail address	ioccrom@xnet.ro	Telephone	+4 031 405 77 93
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	proposal preparation	Mailing address	

4 Component Section *Tuberculosis*

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

PROPOSAL FORM

1.1 General information on proposal

Applicant Name	CCM
Country/countries	Romania

Applicant Type

Please tick one of the boxes below, to indicate the type of applicant. For more information, please refer to the Guidelines for Proposals, section 1.1 and 3A.

- ☒ National Country Coordinating Mechanism
- ☐ Sub-national Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including small island developing states)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism Applicant

Proposal component(s) and title(s)

Please tick the appropriate box or boxes below, to indicate components included within your proposal. Also specify the title for each proposal component chosen. For more information, please refer to the Guidelines for Proposals, section 1.1.

	Component	Title
☐	HIV/AIDS	
☒	Tuberculosis[1]	**Scaling up Tuberculosis Control in Romania by focusing on poor and vulnerable populations**
☐	Malaria	

Currency in which the Proposal is submitted

Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.

- ☐ US$
- ☒ Euro

4 Component Section *Tuberculosis*

4.1 Indicate the estimated start time and duration of the component

Table 4.1.1 – Proposal start time and duration

	From	To
Month and year:	2007/07	2011/07

4.2 Contact persons for questions regarding this component

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Dr. Elmira Ibraim	Dr. Cassandra Butu
Title	NTP Romania TB Surveillance Coordinator	National Professional Officer
Organization	National Pneumology Institute Marius Nasta	World Health Organization
Mailing address	Sos. Viilor 86, Bucuresti, Romania	C. Popisteanu 1-3, Bucuresti, Romania
Telephone	+40726750637	+40726785380
Fax	+4021 3358201	+4021 3170911
E-mail address	ielmira2000@yahoo.com	cassandra@who-tb.balkans.ro

4 Component Section *Tuberculosis*

4.3 Component executive summary

4.3.1 Executive summary

Rationale: Despite recent efforts, including implementation of GFATM-funded programs, tuberculosis remains a serious public health issue in Romania. While epidemiological data demonstrates decline in overall incidence, TB remains widely disseminated throughout the country. In particular, nineteen counties, which comprise 9,462,757 persons (44% of the country population), reported TB rates exceeding national average of 126.5 per 100,000. In 2005, these counties experienced case rates ranging from 134.7 to a high of 203.2 per 100,000. Romania currently is ranked 42 out of 211 WHO reporting nations based on 2004 data. Within the WHO Euro region, Romania reported the second-highest TB incidence preceded only by Kazakhstan. Romania's TB caseload also overlaps with the nation's most vulnerable population defined as having the lowest income, highest unemployment, and low educational achievement. Another priority area for TB is within the prison population. TB incidence amongst inmates was reported as being 10 times the general population, while MDR TB (new cases) in prisons were 4.3% compared to 2.9% of the total country. While the government of Romania provides for free diagnostic and treatment services, there exist a number of critical gaps and uncovered areas including human resource development, patient support and outreach services, program management and operational research. In addition, Romania requires support to address and standardize treatment services within the large private-sector. Finally, given the large population of multi-drug resistant (MDR) TB patients (an average of 1,000 new patients each year), Romania needs to implement a DOTS Plus program. ***Strategy:*** In response to these needs, Romania has proposed a supportive and comprehensive strategy to scale up and sustain recent achievements and to reduce TB transmission, including national TB DOTS coverage, over the next five-year period (2007-2011). While services and activities will address national needs, this strategy will focus on nineteen high-priority counties along with the capital Bucharest which had the highest total number of cases. This strategy will consist of policy development, strategic planning, delivery of standardized training, and targeted interventions such as education and treatment incentives as well as implementation of DOTS plus. In addition, the proposal will address program innovation through implementation of operational research and via measures to better coordinate health care for patients (referral, notification, and discharge planning) and through new Advocacy, Communication, and Social Mobilization activities. ***Goals and Objectives:*** The overall goal of this proposal is to reduce the burden of TB in Romania through the following objectives: 1) Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers; 2) Protect poor and vulnerable populations from TB through targeted education and adherence interventions; 3) Scale up MDR TB control by implementation of DOTS plus; 4) Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment, and: 5) Develop community support and political commitment for TB control. 6) To ensure the efficient and effective implementation of the Global Fund grant. ***Expected Results:*** Romania expects the following results. Romania will reduce overall TB incidence (compared to 2005 value) by at least 10 percent by 2011, increase WHO case detection rates for new sputum smear positive TB cases from 76% (achieved in 2004) to 81% by 2011, and attain the WHO treatment success rate of 85% for new sputum smear positive TB cases. In addition, Romania will decrease the standardized death rate from TB, all forms, from 9.6 cases per 100,000 (2004) to 8.1 per 100,000 (2011). As part of this program, over 1,200 persons will be trained from the public sector providers on core TB components. An additional 2,500 private practitioners will be trained on the STOP TB strategy and adherence methods. Further, the program will enhance the skills of critical providers, such as 300 community nurses and occupational physicians, needed for case detection, contact investigation and treatment adherence. Enduring resources and targeted campaigns will be created for educating and supporting vulnerable populations. ***Main Activities:*** The program will address vulnerable populations and the public health work force through the following interventions: 1) provide and augment TB services to rural communities, roma, homeless, and prison inmate populations; 2) improve evaluation and treatment of contacts of TB cases, and 3) contribute to health systems strengthening through a human resource development (HRD) initiative to train staff working in TB units and laboratories and in areas not yet covered such as program management, epidemiology, surveillance, and financial management. In addition, Romania will implement innovative programs in line with the new STOP TB Strategy that will engage the private-sector, via a public-private mix (PPM) program, and contribute to health system strengthening by fostering operational research and Practical Approach to Lung Health (PAL) strategies. The PPM program will scale up training of family physicians to provide quality-assured TB care and adhere to international and NTP standards. Further, Romania will implement targeted advocacy, communication, and social mobilization (ACSM) activities to generate political commitment and community participation in TB control. The ACSM activities will also improve treatment adherence practices by educating vulnerable populations and reducing stigma. Finally, Romania will address the challenge of MDR by implementation of DOTS plus project.

4.3.2 Synergies

Although the proposal covers only TB its activities targeting poor and vulnerable populations will be integrated and coordinated with the HIV activities targeting the same populations. Further, Romania will have one Principal Recipient for both TB and HIV components. Together, with the Country Coordinating Mechanism (CCM), the PR will facilitate improved communication and sharing of best practices. The new PR, a non-governmental organization (NGO) with extensive experience in HIV/AIDS, capacity-development, and technical assistance, will also emphasize greater monitoring and evaluation and systems development to benefit the subrecipients and national TB and HIV programmes.

4.4 National program context for this component

4.4.1 Indicate whether you have any of the following documents (tick appropriate box), and if so, please attach them as an annex to the Proposal Form:

- ☒ National Disease Specific Strategic Plan (Annex 25)
- ☐ National Disease Specific Budget or Costing
- ☐ National Monitoring and Evaluation Plan (health sector, disease specific or other)
- ☒ Other document relevant to the national disease program context:
  Annex 26 (Romania NTP Review Report)

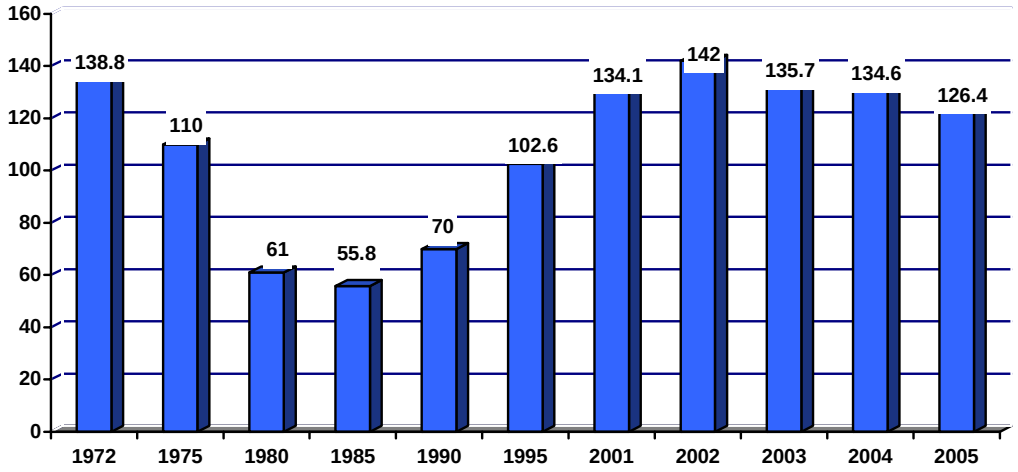
4.4.2 Epidemiological and disease-specific background

TB morbidity and mortality have increased markedly during the past 15 years in Romania resulting in TB notification rates that in 2004 were the second highest in the WHO European Region and 10 times higher than the average rate of the European Union. Between 2000 and 2005, there were 168,461 cases of TB. A total of 27,332 TB cases (new and relapsed) were notified in 2005 (126.4 cases per 100,000) with a total of 2,089 TB deaths reported in 2004 (9.6 per 100,000). This disease load makes TB a public health priority for the Romanian population and the government. Beginning in 2003, for the first time in 20 years, the country started to record decreases in TB incidence: 135.7 per 100,000 compared to 142 per 100,000 in 2002 (Graph 1). This decrease is a sign that the recent efforts are bearing positive results. Still, further decrease in incidence will be required to affirm this trend; in the interval, Romania must sustain and expand control interventions and activities.

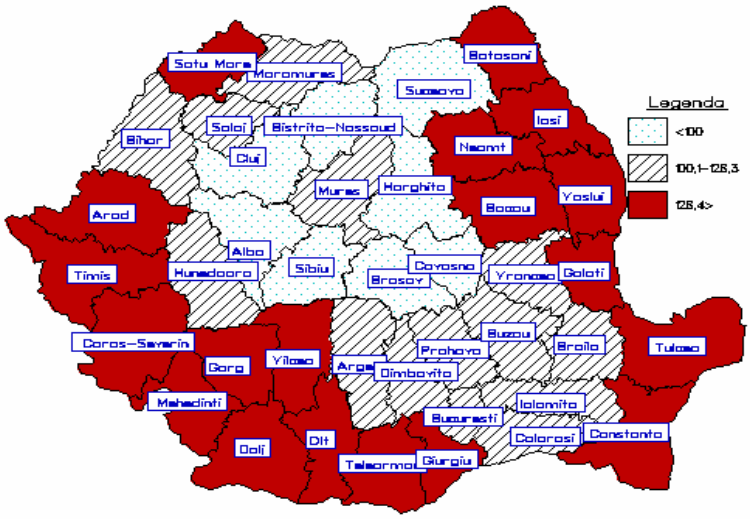
As noted above, the incidence of TB, while widespread throughout the country, has impacted nineteen counties, which comprise 9,462,757 persons, or 44% of the country population (Graph 2). The counties reported TB rates exceeding national average of 126.5 per 100,000. In 2005, these counties experienced case rates ranging from 134.7 to a high of 203.2 per 100,000.

4 Component Section *Tuberculosis*

Graphic 1: Global Tuberculosis incidence in Romania 1972 -2005 (Source: National Institute for Pneumology Marius Nasta)



Graphic 2: Global TB incidence in Romania 2005, by counties (Source: National Institute for Pneumology Marius Nasta)

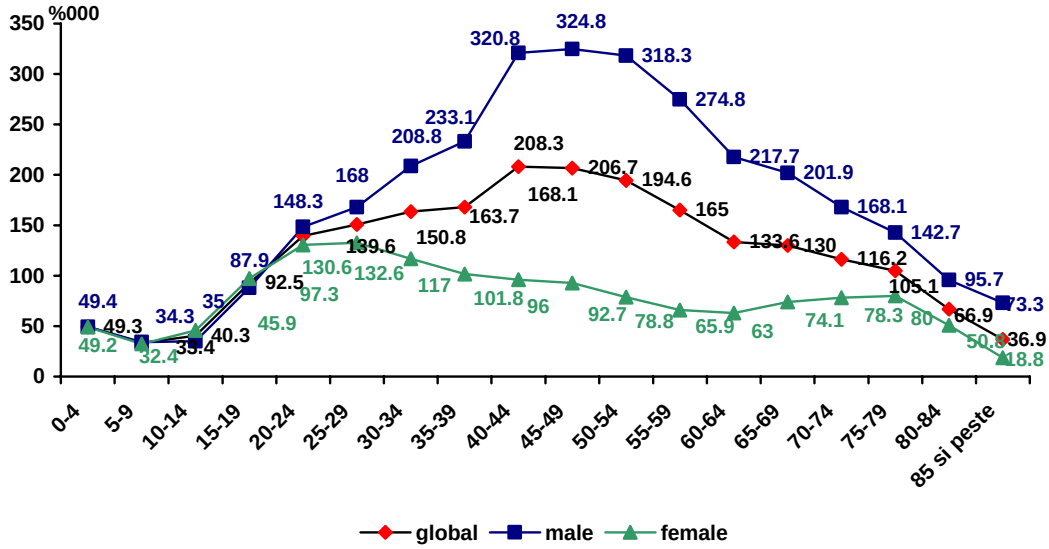


Counties with incidence higher than the average in Romania (126.4 per 100,000) in 2005 were: Arad, Bacau, Botosani, Constanta, Caras Severin, Dolj, Galati, Giurgiu, Gorj, Iasi, Mehedinti, Neamt, Olt, Satu-Mare, Teleorman, Timis, Tulcea, Vaslui, Valcea.

Age and Gender

Incidence rates were much higher at all ages in males and peaked at age 45-49 in males and at age 25-29 in females (Graphic 3). The overall incidence rate was 184.7 per 100,000 in males and 86.3 per 100,000 in females. The incidence rate in children was 41.2 per 100,000. A total of 62 cases of TB meningitis in children < 15 years old were reported in 2004.

Graphic 3: TB Incidence on age groups and sex, 2004 (Source: National Institute for Pneumology Marius Nasta)



Prisons inmates

Prison inmates are a well described risk group for TB. In Romania this group has a disproportionately high burden of TB. In 2005, the notification rate of TB in this group was 2,235 per 100,000, ten times higher than the rate in the total population.

Roma ethnic group

The Roma are an important minority ethnic group in Romania, representing 2.5% of the population (National Institute of Statistics – Census 2002). The socio-economic conditions of this group are disadvantaged with high unemployment rates (no data) and poor income. Tuberculosis is felt as a special problem in this ethnic minority, reported to have higher disease incidence and to be more frequently non-adherent to TB treatment, due to mobility and cultural barriers. However, no epidemiological data on TB in the Roma population have been published or have been made available during the visit.

Homeless

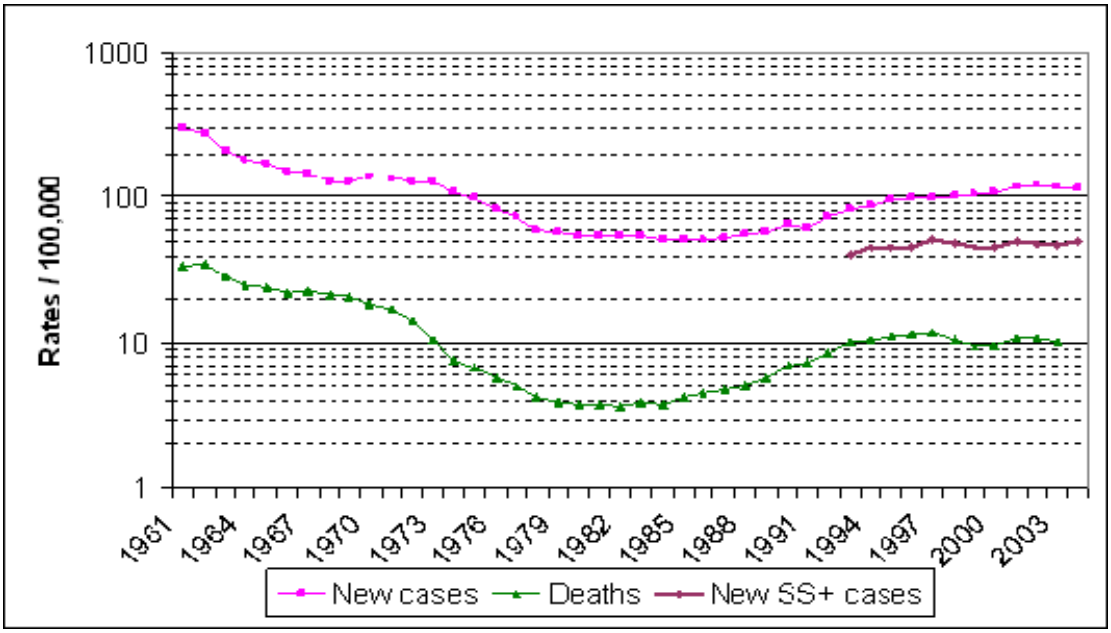
Homeless persons are one of the risk groups TB that are mentioned in the "The Stop TB strategy" and in other documents of WHO as a category that requires special attention. According to "European Observatory of Homelessness" the category of homeless persons includes persons without shelter, other subgroups such as those with a place to sleep, but temporary in institutions or shelters, and the people living in inadequate conditions (improvised shelters, in caravans on illegal campsites, in unfit housing, in extreme overcrowding). Most of them have no private and safe personal space for social relations and proper hygiene. In Romania, there is no data regarding TB incidence within homeless population (children or adults). Accordingly to one study conducted by Samu Social in 2005, the incidence of TB among homeless adults is increased from 33 cases in 1999, to more than 260 cases in 2005 among the NGOs beneficiaries.

TB mortality

In 2003 a total of 2,387 TB deaths were reported, with a total death rate of 10.3 per 100,000. Mortality rates were much higher in males (17.5) than in females (3.5) a male to female rate ratio of 5, much higher than the one observed in TB notification rates (Graph 4). Trends in mortality followed quite closely those

in disease notification with an earlier peak observed in 1997 (11.8 per 100,000) and relatively stable rates in more recent years. In treatment outcome monitoring data, the total number of reported deaths during treatment (all causes) among TB cases notified in 2004 was 1,782 and of these 1,461 was reported as deaths due to TB and 321 as deaths due to other causes. The higher numbers of TB deaths in general mortality statistics than in the TB outcome monitoring system might reflect definitional differences, underreporting of severe cases of TB, or over diagnosis of TB death by physicians, and needs to be further studied.

Graph 4: Tuberculosis trends in Romania, 1961-2004: new TB cases, new smear positive TB cases and total TB deaths per 100,000 population (semi logarithmic y scale)



Drug resistance

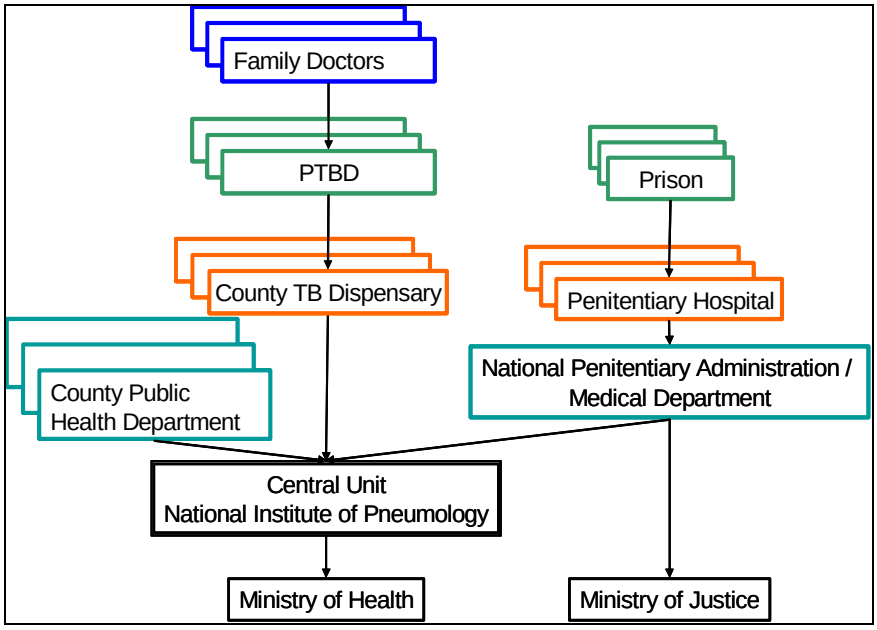
Preliminary data from a national survey held in 2003-2004 identified prevalence of resistance to any first line drug (INH, RMP, EMB and SM) of 19.2% among 918 new cases and 36.6% among 424 retreated cases included. The prevalence of any INH resistance and of multidrug resistance (MDR) was respectively 7.7% and 2.8% among new cases and 28.1% and 11.6% among retreated cases. These estimates are comparable to those obtained in a previous survey conducted in 1995 and 1999, for which however detailed study methodology has not been published. In an exhaustive survey of chronic TB patients in 2004, the prevalence of MDR-TB has been estimated at 32.7%.

4.4.3 Disease-control initiatives and broader development frameworks

a) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include all donor-financed programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships.)

Within Romania, the national response to TB is coordinated by the Public Health Department of MoPH and the National Commission of Pneumology, constituted by 10 members, who are nominated by the MoPH and meet at least twice a year. The National TB Program has a functional organizational framework (Figure 1). The Central Management Unit of the NTP is managed by the NTP manager and hosted by the National Pneumology Institute Marius Nasta in Bucharest; includes a TB surveillance Unit, one of the 3 NRLs, a Supervision and Monitoring Unit (10 of the 27 supervisors for the county-level NTP implementation). Outside the NTP central office there are also 50 TB managers including 41 county TB managers, 6 Bucharest Sector TB managers and one TB manager each within the Ministries of Justice, Defense and the Interior; their job descriptions are stipulated in the 2001-2005 National Programme for TB Control.

Figure 1: Organization structure of NTP in Romania



Source: WHO/Office for Tuberculosis Control in the Balkans, Pneumology Institute Marius Nasta – "First NTP Review in Romania, April 2005";
Abbreviation: PTBD = peripheral TB dispensaries

Each county has between three to six TB and other lung diseases dispensaries (a total of 196). These are the peripheral TB units responsible for implementation of the NTP. Each dispensary is manned by 1 to 5 lung diseases specialists (approximate 800 physicians) and a variable number of nurses and serve a territory of about 40,000 habitants. TB dispensaries perform TB diagnosis and treatment and are also responsible for preventive activities, and the surveillance and supervision of activities by GPs (family doctors).Treatment services, including diagnosis and provision of medications, is provided free of charge to all TB patients under the social health insurance budget. Access to first line drugs is provided by 190 pharmacies via a closed circuit.

A national network of bK laboratories function to ensure the necessary bacteriological services. The 165 laboratories, organized according to the complexity of the activity on three levels, are coordinated by NRL

and perform their activity integrated with NTP.

The total expenses from public sources (Social Health Insurances NHIH and MoPH) of NTP in 2005 were of 53.56 million euro (which represents 2.68% of the total public expenses for health). Between 2004 and 2006 the NTP received approximately US $18 million through the non-reimbursable financing program from the Global Fund for Fighting against HIV/AIDS, Tuberculosis and Malaria (GFATM).

Few financial and technical partners are supporting DOTS in Romania. The World Bank (WB) provided the most significant external financial assistance before the GFATM. Under the "Health Rehabilitation Project" (1992-99), the WB provided a loan of about US$5 million for the procurement of laboratory and radiological equipment, including a computed tomography (CT) scan. Under the "Health Sector Reform, Phase I" (2000-04) a loan of US$ 300 000 was provided to supply 19 TB facilities with laboratory equipment, including PCR equipment for the National Pneumology Institute Marius Nasta. The "Health Sector Reform, Phase II" (2005-2009) is pending the ratification of the Parliament. This last WB project is supporting the recently-approved Romania's Strategy for Health Care Reform that looks for more efficient and effective hospital care, expanding primary health care services (including family medicine and home care), introducing accreditation and quality control systems, increasing private participation, ensuring sustainable financing, providing social care outside the hospitals. WB considers very carefully the future streamlining of TB services into the health reform in Romania. Some of the main recommendations provided by the present review are very much in supporting this process.

Doctors of the World (DOW), a US-based non-governmental organizational initiated a TB program in Romania in 2003. Its project aims at improving TB treatment success in vulnerable populations (ex prisoners, Roma communities, the poor at large) and building the capacity of NTP to provide effective health education and community outreach services. DOW operates in the three main areas of: i) development of a health education and communication strategy for providers (family doctors, nurses) and vulnerable population such as Roma communities and ex prisoners (2004-07, US$ 1 million from USAID, partnership with Population Services International - PSI); ii) training of health mediators and peer health educators in Roma communities (2004-07, US$ 200 000 from Open Society Institute, partnership with the local NGO "Roma Center for Social Intervention and Studies" - Romani CRISS); iii) piloting and evaluating a system of incentives to TB patients in Bucharest Sector 5 and in the counties of Ilfov and Constanta (2004-07, US$ 86 000 from GFATM principal recipient, partnership with the Romanian Red Cross).

The Romanian Red Cross is part of the International Federation of Red Cross and Red Crescent Societies (ICRC). It is sub-recipient of the GFATM (2004-06, US$ 567 000) and was responsible of the distribution of food coupons used as incentive to TB patients for adherence to treatment. It is working partner of the DOW. Additional partners to NTP and sub-recipient of the GFATM grant are the Public Health Institute responsible of the accreditation process of the laboratories for TB bacteriology, the National Institute for Research and Development in Health responsible of developing the clinical guidelines for TB in children, the National Administration of Penitentiary for implementation of TB services in the prison sector.

The process of planning for and implementing the GFATM grant for TB facilitated largely the collaboration and coordination among different ministries and national and international organizations toward DOTS. However, beside the CCM of very large size and mainly dedicated to GFATM-related issues, a routine and TB-focused coordination among the present and potential stakeholders does not exist. Miscommunications occurred in the past, plans for TB interventions are sometime not synergetic for a stronger national plan.

In 2005, Romanian updated it TB control strategy. The newly proposed TB Control Strategic Plan (2006-2010) principal guidelines are:

1. Tuberculosis is a significant public health problem in Romania given its important economic and social consequences. The control of TB, therefore, shall become a priority of the Government as reflected in health policy and with the social-economic development programs that sustain and increase TB control

through medium and long term interventions and dedicated resources.

2. The state guarantees the right to health services for its citizens through universal and equal access to health insurance. TB is a disease that can be prevented and cured, and therefore, the provision of services, monitoring and surveillance and operational control shall be coordinated at national and local level.

3. The fight against TB requires a multi-disciplinary approach and, therefore, requires the provision of the human and financial resources both in the public sector and in the private sector. The partnership between public institutions, non-governmental organizations and international agencies is one of the key elements of the success of the fight against tuberculosis and shall be supported through sustained efforts and coordination.

4. The necessary prevention, diagnosis, and treatment services along psycho-social support required to ensure timely and successful completion of TB therapy, shall be made accessible, acceptable and efficient in all at-risk communities.

5. The strategy of directly observed treatment (DOT), which is universally recognized as a basic component in the fight against tuberculosis, and is a central part of the global strategy of tuberculosis control (DOTS), shall become an integral part of the Romanian strategy and standard of care.

6. Special attention shall be paid to primary and secondary prevention activities and to vulnerable population groups and affected communities.

7. The rights of the patients with tuberculosis shall include the free provision of TB diagnosis and treatment along with policies and procedures to ensure that confidentiality rights are observed by all the health services suppliers. The responsibilities of patients shall be established by specific regulations.

8. The strategic objectives and actions in the fight against tuberculosis in Romania are in accordance with the WHO principles and recommendations and with the EU directives regarding the control and monitoring of communicable diseases.

b) Describe the role of HIV/AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or Sector-Wide Approaches. Outline any links to international initiatives such as the WHO/UNAIDS 'Universal Access Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

As previously mentioned, Romania has undertaken a significant revision of its national TB strategy. The strategy elaborated with the technical assistance of the World Health Organization (WHO), is aligned on the Strategy recommended by the WHO for Tuberculosis Control – "DOTS" and the Global Plan to Stop TB. The central elements of Romania's DOTS strategy are the following:

1. Political involvement of the Government to support NTP.

2. Identification of cases by microscopic examination of the sputa of all the suspects of tuberculosis, thus identifying first of all the contagious cases.

3. Standard treatment regimens, short–course, administrated under direct medical observation.

4. Regulated and uninterrupted provision of essential anti-tuberculosis drugs.

5. A system of recording, reporting, supervision, monitoring and evaluation of NTP.

The DOTS strategy has proven on a global scale to be the most efficient way to control the tuberculosis endemic. The introduction of DOTS in Romania was originally proposed in 1997 when a series of actions were taken in order to create the organizational framework and a program capable to adopt the WHO

strategy. The implementation of the DOTS strategy was made by pilot-projects which consisted of intensive monitoring of all the aspects related to the application of NTP.

In Romania the implementation of the DOTS strategy was initially implemented in 1998 in Iasi county, and then was extended in 2000 to the counties Brasov and Constanta, as well as District 4 of Bucharest. In 2001, the counties of Calarasi, Giurgiu, Galati, Buzau, Harghita, Hunedoara, Sibiu, Mures, Cluj, and Timis were added, following by Neamt and Bucharest sectors 1, 2, 3, 5, 6 in 2002. By2005, the country achieved a DOTS coverage rate of 100% of the population.

In terms of larger governmental initiatives and policies targeted at vulnerable populations, to improve general health access, and reduce poverty, Romania has developed several strategies and programs. For instance, the government has become part of the ***Decade of Inclusion for Roma***. The ***Decade*** is meant to focus attention on the countries with the largest disadvantaged Roma populations. The Decade will address ***priority areas*** for Roma integration through coordinated efforts by Governments and international organizations in partnership with Roma communities. As participants in the Decade, Romania created a ***National Action Plans (NAPs)*** that outlines priority areas for integrating their Roma populations into mainstream society. These areas are education, employment, health and housing. The ***health component of Romania's NAP*** is focused on expanding the Roma Health Mediator program; child and family health; guaranteeing access to the primary medical and pharmaceutical services corresponding to EU standards; promoting intercultural education among medical personnel; and facilitating the ability of Roma to obtain health insurance. The governmental strategy specifically mentions TB as an area of focus for the Roma and supports *"organizing campaigns in order to trace the TB, HIV/AIDS, dermatological affections, sexually communicable diseases etc."*

4.4.4 National health system

a) Briefly describe the (national) health system, including both the public and private sectors, as relevant to reducing the impact and spread of the disease in question.

For four decades, from 1949 to 1989, health care in Romania was organized and delivered via a Semashko health system. Major reforms began in 1989; by 1998 Romania had transformed the centralized, tax-based system into a decentralized and pluralistic social health insurance system with contractual relationships between health insurance funds as purchasers and health care providers. The Health Insurance Law has already been modified, but still needs to be adapted to the changing political, social and economic context. The current reforms are focused mainly on the continuation of the decentralization process, the development of the private sectors and the establishment of clear relations between the health care and the social care system.

In terms of TB services, TB control services are coordinated by the Public Health Department of MoPH and the National Commission of Pneumology, constituted by 10 members. The National TB Program has a functional organizational framework. The Central Management Unit of the NTP is managed by the NTP manager and hosted by the National Pneumology Institute Marius Nasta in Bucharest; includes a TB surveillance Unit, one of the 3 NRLs, a Supervision and Monitoring Unit (10 of the 27 supervisors for the county-level NTP implementation). Outside the NTP central office there are also 50 TB managers including 41 county TB managers, 6 Bucharest Sector TB managers and one TB manager each within the Ministries of Justice, Defense and the Interior; their job descriptions are stipulated in the 2001-2005 National Programme for TB Control. Each county has between 3 to 6 TB and other lung diseases dispensaries (a total of 196). These are the peripheral TB units responsible for implementation of the NTP. Each dispensary is manned by 1 to 5 lung diseases specialists (approximate 800 physicians) and a variable number of nurses and serves a territory of about 40,000 habitants. TB dispensaries perform TB diagnosis and treatment and are also responsible for preventive activities, and the surveillance and supervision of activities by GPs (family doctors).Treatment services, including diagnosis and provision of medications, is provided free of charge to all TB patients under the social health insurance budget.

Patients with symptoms suggestive of TB are either referred directly to the TB Dispensary or they would be referred by their family doctor. Once the diagnosis of TB is confirmed by the TB Dispensary, majority of patients (regardless of their sputum smear status) are referred to a TB hospital for admission. On average, patients are admitted for 2 months (or until the smear conversion) to facilitate direct administration of the intensive phase of treatment. Within one week of patient admission the hospital is sending an announcement to the TB Dispensary (for registration purposes).

Public health services

The MoPH is the central authority in public health, responsible for setting organizational and functional standards, developing and financing national public health programmes, and collecting data and analyzing the population's health status. The MoPH funds the national health programmes, including the NTP, covering all the expenditures except drugs which are paid by the National Health Insurance House. The county-level Public Health Departments are responsible for public health in their counties, with their expenses financed by the MoPH. Communicable diseases are the responsibility of the Ministry, but diagnosis and treatment is covered by the Health Insurance Funds.

Private sector

Since 1998 patients are allowed to choose their dispensary/family doctor or general practitioner (GP). At the same time, GPs changed from being state employees to independent practitioners, contracted by the health insurance houses, and privately operating their medical offices. Access to outpatient specialty care and to hospital currently requires a referral by the GP. Family doctors or GPs are involved in NTP activities through identification of TB suspects in their territories and referring them to TB dispensaries. GPs also participate in epidemiological surveys, provide or supervise the directly observed treatment (DOT) for all ambulatory patients, especially in rural areas, participate in health education activities etc.

Secondary care

Ambulatory secondary care is delivered through a network of hospital outpatient departments, centres for diagnosis and treatment and private practices. Physicians working in private medical offices need a practice license and an authorization for the medical office, and private outpatient services may be accredited for all specialties including outpatient surgery.

Tertiary care

There are four main categories of hospitals in Romania: rural hospitals; town and municipal hospitals, county hospitals and specialized units for tertiary care, such as the central level institutes (Institute of Oncology, Cardiology, etc.) In terms of ownership, with the exception of a few small hospitals, all hospitals are publicly owned and under state administration. Hospital maintenance, treatment and staff salaries are financed from the Social Health Insurance Fund; the initial capital investment is currently financed by the state.

b) Given the above analysis, explain whether the current health system will be able to achieve and sustain scale up of HIV/AIDS, tuberculosis and/or malaria interventions. What constraints exist?

Romania's health care system is expected to continue its period of transition with the current reforms focused on the decentralization process, the development of the private sectors and the establishment of clear relations between the health care and the social care system. A series of new health insurance laws and public health measures were recently proposed. However, the impact of these on increase coverage, access and quality of services remains unclear. Despite this, since the adoption of the DOTS strategy in 1998, the Romanian National Tuberculosis Control Programme (NTP) has expanded to cover the entire country population in 2005, including the penitentiary system. Major progress in all core areas of TB control have allowed Romania to reach the global case detection rate target of 70% for new sputum smear (SS) positive patients in 2003. The treatment success rate of newly detected bacteriological confirmed

patients has reached 82% (2003 cohort) and is close to the 85% global target.

In terms of financing, public expenditure was 3.6% of GDP in 2004 for health care. Estimates of total expenditure are unavailable because private expenditure is not accurately calculated despite playing a significant role. Nonetheless, the country continues to spend a low proportion of GDP on health. Romania is classified by the World Bank as lower middle-income country. Funding for TB control, however, actually increased between 2005 and 2006 by about 20% and there is ongoing commitment for provision of basic diagnostic and treatment services.

c) Please describe national health systems strengthening plans as they relate to these constraints. If this proposal includes a request for resources to help overcome these constraints, describe how the proposal will contribute to strengthening health systems.

Reform efforts of the healthcare system, occurring at the present time, focus both on hospitals with the aim of improving their management and of public health issues by creating a National School of Public Health and a National Agency for Health Programmes. In the same time the National Health Insurance House is looking at improving cost-efficiency and, in this regard, is interested in the proposed PAL strategy implementation by the attached letters of support (Annex 27 and 28). The development and implementation of a comprehensive and systematic approach to manage patients with respiratory symptoms in primary health care (PHC) setting are likely to improve the quality of respiratory care and, subsequently, create conditions resulting in increasing TB case detection and improving the quality of TB diagnosis. Country experiences in PAL development and implementation suggest that PAL contributes to 1) improving the national health policy since PAL defines health policy and intervention for the 1st leading cause of care demand in PHC setting; 2) improving TB case detection, and the quality of TB diagnosis; 3) decreasing the referral of respiratory patients from PHC settings, and therefore improving the integration of respiratory care and TB control in PHC services; 4) reducing drug prescription, particularly antibiotics and adjuvant drugs; 5) improving the quality of the management of chronic respiratory patients within the district health system; 6) improving and strengthening the competency of PHC workers; and 7) improving health planning and formulation of resources needed within the health system.

Operational research is one of the strategic directions of the Global Plan to Stop TB, 2006-2015 in order to reduce the global burden of TB by 2015 in line with the Millennium Development Goals: "*For any public health activity, operational research is necessary to determine the best ways of implementing interventions and to monitor their impact. Operational research is thus crucial in determining how to increase access to accurate diagnosis and effective treatment through the DOTS strategy, and how to adapt the DOTS strategy to address the challenges posed by drug resistance and HIV. Operational research involves the evaluation of programme operations, aimed at improved policy-making, better design and operation of health systems, and more efficient methods of service delivery. Financial and technical support is required to enhance local capacity for operational research. National plans for TB control should include budgeted activities for operational research as a routine part of programme activities.*"

4.5 Financial and programmatic gap analysis

4.5.1 Overall needs assessment

a) Based on an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describe the overall **programmatic** needs in terms of people in need of these key services. Please indicate the quantitative needs for the 3-5 major services that are intended to be delivered (e.g. anti-retroviral drugs, insecticide-treated bed nets, Directly Observed Treatment Short-Course for TB treatment). Also specify how much of this need is currently covered in the full period of the proposal by domestic sources or other donors.

Despite recent efforts, including implementation of GFATM-funded programs, tuberculosis remains a

serious public health issue in Romania. While epidemiological data demonstrates decline in overall incidence, TB remains widely disseminated throughout the country. In particular, nineteen counties, which comprise 9,462,757 persons (44% of the country population), reported TB rates exceeding national average of 126.5 per 100,000. In 2005, these counties experienced case rates ranging from 134.7 to a high of 203.2 per 100,000. Romania currently is ranked 42 out of 211 WHO reporting nations based on 2004 data. Within the WHO Euro region, Romania reported the second-highest TB incidence preceded only by Kazakhstan. Romania's TB caseload also overlaps with the nation's most vulnerable population defined as having the lowest income, highest unemployment, and low educational achievement. Another priority area for TB is within the prison population. TB incidence amongst inmates was reported as being 10 times the general population, while MDR TB (new cases) in prisons were 4.3% compared to 2.9% of the total country. While the government of Romania provides for free diagnostic and treatment services, there exist a number of critical gaps and uncovered areas including human resource development, patient support and outreach services, program management and operational research. In addition, Romania requires support to address and standardize treatment services within the large private-sector. Finally, given the large population of multi-drug resistant (MDR) TB patients (an average of 1,000 new patients each year), Romania needs to implement a DOTS Plus program.

In 2005, the WHO conducted a program review of the National Tuberculosis Programme (NT) in Romania. The review team identified several areas for improvement including health systems coordination and policy as well as gaps in technical areas of the program. In addition, to this assessment, the NTP recently formulated a new Strategic Plan for 2006-2011. The findings and needs identified in these documents serve as the planning basis for the new GFATM proposal and other new initiatives. A summary highlight of these needs follows:

1. The current significant financial contribution provided by the GFATM grant will end in 2008. The future financial support of the NTP was cited as a common concern.

2. A number of important partners for the NTP are present in the country; however no national coordination is in place for ensuring synergy of interventions. There is need for a comprehensive joint planning of TB activities.

3. The link between the NTP and general health services is not clearly defined. NTP's roles and responsibilities at central and county levels are not formally recognized, many tasks are implemented on ad-hoc basis, there are no job descriptions, no enablers, nor are recognition or incentives provided for TB supervision and management.

4. The laboratory network needs to be reorganized and strengthened. There are too many laboratories performing culture and drug susceptibility testing (DST) with sub-standard quality and no biosafety standards for the staff (lack of biological safety cabinets). Shortage of media for bacteriological culture and DST is frequently reported. The bacteriological confirmation of pulmonary cases is too low (60%). Improvement of the laboratory performance and quality should contribute to increased confirmation of pulmonary cases. The three currently functioning NRLs (Bucharest, Iasi and Cluj) have not been officially recognized by the MoH, which hinders their mandate in supervision, training of laboratory personnel, supporting expansion of EQA activities and providing laboratory support for drug resistance surveillance and DOTS-plus activities.

5. Numerous groups of population are still unnecessarily screened for TB, such as army recruits, future employees, food industry workers, teachers, university students, and couples before marriage, parents of and their children enrolling in nurseries. In addition, tuberculin testing is repeatedly done in school children. TB screening in these population groups is proved to be not cost-effective. TB preventive chemotherapy is provided in many cases unnecessarily, it is not standardized and with inappropriate drugs. The impact of such practice is not evaluated.

6. Too many TB patients are hospitalized and for an excessive duration, with significant cost. Lack of TB infection control and universal Human Immunodeficiency Virus (HIV) precautions is often

observed. Boredom in hospitals and appalling physical conditions of inpatient facilities may contribute to the increase of defaulting. Lack of patients' support and mostly self-administered treatment in rural areas results in high death, default and failure (15% and 30% combined in new cases and relapses respectively).

7. Although centralized procurement of drugs results in no major drug interruptions reported at the peripheral level, the drug management system is precarious and vulnerable. Drugs are ordered monthly, which results in increased cost and insufficient buffer stocks.

8. Too many different data are requested to be collected and reported by the different administrative structures: NHIH, Public Health Directorate (PHD), and National Centre for Statistics etc. There is no culture of utilizing the data collected for monitoring of the programme performance at county and facility level.

9. Treatment of drug-resistant cases is widely implemented throughout the country by using second-line drugs of uncertain quality procured on the local market. Over-reliance in second-line drug susceptibility testing results in frequent treatment regime changes and sometimes unnecessary use of these drugs. Regimens are not always correct and do not reflect the international guidelines and policies. Second-line drugs are often given to patients for self-administration.

10. Collaboration between TB and Acquired Immunodeficiency Syndrome (AIDS) national programmes is not formally established for joint planning and implementation of the full package of internationally-recommended TB/HIV interventions. HIV testing is not extensively implemented and needs improvement for evaluating the rate of HIV prevalence among TB patients.

11. DOTS programme in prisons needs strengthening. Bacteriological confirmation of the TB cases in prisons is low and treatment outcome of patients discharged from hospital or released from prison is not reported.

12. A coherent national strategy and plan for information, education and communication (IEC) for TB control does not exist.

The quantitative needs for four major services that are intended to be delivered are presented in Annex 29.

In response, to the aforementioned needs, this GFATM proposal from Romania will improve the timeliness of diagnosis and quality of TB control, as well as strengthen coordination of care, via an innovative PPM and PAL program. Romania will address vulnerable population needs through targeted education and community-based strategies. Further, the needs of MDR patients will be improved via a DOTS Plus Strategy. Health system needs will be addressed by implementing specific training and policy and practice improvements through the use operations research. Finally, the need to foster political support will be generated through Advocacy, Communication and Social Mobilization strategies.

b) Based on an analysis of the national goals and objectives for fighting the disease component, describe the overall **financial** needs. Such an analysis should recognize any required investment in health systems linked to the disease. Provide an estimate of the costs of meeting this overall need and include information about how this costing has been developed (e.g., costed national strategies, medium term expenditure framework). *(Actual targets for past years and planned and estimated costing for future years should be included in table 4.5.1-3 [line A].)*

The NTP public funds are decided on a yearly basis through an Ordinance signed by both the MoPH and the president of the NHIH. The Ordinance approves among other national programs, the “Program 1.3.- TB Surveillance and Control”, where MoPH covers the interventions related to TB prevention and health promotion and the health insurance (NHIH) provides funds for inpatient and outpatient drugs. MoPH budgets are distributed to NTP through the County PHDs; MoPH funds go directly to the TB unites only for those directly subordinated to MoPH. At county level, there are often cases when the TB units can not easily access the MoH funds, due to either miscommunication with the authorities, lack of knowledge of

the NTP county managers on the flow of funds, lack of formal authority of the NTP county managers. TB drugs are procured at central level, and starting with this year, MoPH set up a procurement service subordinated directly to the Minister. According to the NHIH data, the TB drugs procured centralized have been distributed in 2004 to 187 TB units, and a total number of 63.059 patients have been treated with the procured drugs. The average cost/patient was around 60 euros (2.380.000 lei).

In addition, inpatient and outpatient services for TB patients are contracted by the county health insurance houses (CHIH) with the services providers (hospitals, other inpatient units – *preventorii*, *sanatorii* – and ambulatory practices). Moreover, there are several core components of an effective National Tuberculosis Program which remain unfunded or are not included explicitly in the MoPH budget (training, IEC, program monitoring and evaluation.)

An estimated of the costs and gaps is detailed in Table 4.5.1-3 - Financial contributions to national response. These costs were determined by NTP staff through a review of program activities and services.

4.5.2 Current and planned sources of funding

a) Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line B].)*

The total TB public expenditure in 2004 was 53.56 million euros (2.68 % of the total public health expenditure). The 2000-2004 evolution of NTP expenditure shows big yearly fluctuations, with a constant decrease of public funds each year. For 2005, it can be noticed an increase of the estimated budget for TB drugs compared to 2004. (*See Table 4.5.1-3 - Financial contributions to national response.)*

b) Describe current and planned financial contributions, anticipated from all relevant external sources (including existing grants from the Global Fund and any other external donor funding) relating to this component. *(Summarize such financial amounts for past and future years in table 4.5.1-3 [line C]*.)

The Global Fund grant added in 2004 only, to the NTP, around 10 million euros. **(**See *Table 4.5.1-3 - Financial contributions to national response.)*

4.5.3 Financial gap calculation

Provide a calculation of the gap between the estimated overall need and current and planned available resources for this component in table 4.5.1-3 and provide any additional comments below.

The estimated overall need was calculated based on the envisaged activities and their costs based on current staff salaries, drugs prices, materials prices etc. adjusted for inflation.

4 Component Section *Tuberculosis*

Please summarize the information from 4.5.1, 4.5.2 and 4.5.3 in the table below.

Table 4.5.1-3 - Financial contributions to national response

	Financial gap analysis (*please specify currency: millions Euro*)						
	Actual		Planned		Estimated		
	2004	2005	2006	2007	2008	2009	2010
Overall needs costing (A)	14.4	14.24	13.2	13	13	13	13
Current and planned sources of funding:							
Domestic source: Loans and debt relief (*provide donor name*)	0	0	0	0	0	0	0
Domestic source: National funding resources	4.72	4.4	5.36	5.3	5.3	5.3	5.3
Total domestic sources of funding(B)	4.72	4.4	5.36	5.3	5.3	5.3	5.3
External source 1 Global Fund Grants	1.52	6.4	1.36	1.36	0	0	0
External source 2 (*provide donor name*)	0.96 WB	0.6 DOW	0.7 DOW	0	0	0	0
External source 3 (*provide donor name*)	0	0.11 WHO	0.02 WHO	0	0	0	0
Total external sources of funding (C)	2.48	7.11	2.08	1.36	0	0	0
Total resources available (B+C)	7.2	11.51	7.44	6.66	5.3	5.3	5.3
Unmet need (A) - (B + C)	7.2	2.73	5.76	6.34	7.7	7.7	7.7

4.5.4 Additionality

Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this will continue to be true for the entire proposal period.

The resources requested from Global Fund are planned to cover partially the programmatic gaps identified in the program analysis. The analysis involved an inventory of all resources, national and international available and their destination. The services paid from domestic resources will be maintained and strengthened over the life time of the proposal as it is shown in the financial contribution to the national response table.

4.6 Component strategy

4.6.1 Goals, objectives and service delivery areas

Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

The TB project proposal overall goal is to scale up the TB control efforts by introducing innovative aspects, while continuing other activities that have proven to be effective, in order to reduce the burden of TB in Romania. By the end of the project (2011) it is expected that Romania will reduce overall TB incidence by at least 10 percent, increase WHO case detection rates for new sputum smear positive TB cases from 76 % (achieved in 2004) to 81% , and attain the WHO treatment success rate target of 85% for new sputum smear positive TB cases. In addition, Romania will decrease the standardized death rate from TB, all forms, from 9.6 to 8.1 percent of total cases.

The program objectives are:

1) Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers;

2) Protect poor and vulnerable populations from TB through targeted education and adherence interventions;

3) Scale up MDR TB control by implementation of DOTS plus;

4) Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening, and

5) Develop community support and political commitment for TB control.

6) To ensure the efficient and effective implementation of the Global Fund grant.

Objective 1: Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers

Service delivery area(s):

SDA 1. TB: PPM (Public Private Mix)

The health literature shows that TB care offered by private and public health care providers working outside National TB Programmes (NTPs) is often of uneven standards. At the same time, it is

acknowledged that the global TB control targets will not be met unless all private and public sector care providers become actively involved in DOTS implementation. Ways to productively engage the non-NTP private and public providers in TB control have been developed over the last few years through various Public-Private Mix for DOTS (PPM DOTS) initiatives. The feasibility and effectiveness including cost-effectiveness of PPM DOTS have been demonstrated. PPM has also been shown to improve access to the poor and reduce the financial burden of TB care on the patients. Within Romania, the role of the private practitioner is increasing rapidly. However, national KAP studies have shown deficiencies in knowledge and practice needed to positively impact TB control. The proposed interventions will deliver standardized training and improve operational and health system functioning with medical practioners. Through knowledge and skills development, and better coordination of services, the intervention will contribute to more timely referrals and improve treatment outcomes.

Objective 2: Protect poor and vulnerable populations from TB through targeted education and adherence interventions

SDA 1. TB: Social assistance and psychological counseling

While the majority of patients adhere to therapy; in 2004, 6.2% of patients were reported to default, 4% failed therapy, and the outcome for nearly 2.1% patients was unknown. Treatment default can contributed to ongoing transmission of the TB disease, lead to drug resistance, and may ultimately result in the death of the patient. While many defaulters eventually restart, an unacceptable number abandon treatment. Given the health risks of defaulting, there is a need to better understand factors contributing to treatment non-adherence for TB. There is also a need to develop cost-effective and sustainable models for improving treatment outcomes. Numerous studies have shown the positive contribution of incentive and enabler programs can have on reducing default and improving treatment results. Funding will be used to implement an incentives and enablers program aimed at vulnerable TB patients to encourage adherence and to reduce barriers to care such as lack of transportation resources.

SDA 2. Prevention: BCC - community outreach

In the national and sub-national context, social mobilization is a process of generating public will by actively securing broad consensus and social commitment within civil society to fight stigma and eliminate TB as a public health threat. That is, social mobilization seeks to convert knowledge into demonstrable action. In terms of vulnerable population, homeless adults and families are often at high risk for TB due to the social and personal conditions. This program will address the tuberculosis burden among homeless children, their families and other at-risk communities, by increasing awareness about the disease and supporting early and timely diagnosis. At the same time, the program will address the social needs of the TB positive homeless persons/suspects.

SDA 3 TB: Timely detection and quality treatment of cases

Within Romania, there is a growing number of homeless persons that are amongst the most vulnerable community members. Health and homelessness relate to each other in a multifaceted way. Homelessness gives rise to many health problems, both mental and physical. The environment can lead to severe physical ailments and respiratory problems. Homeless children, in particular, remain quite vulnerable given threats such as substance abuse and lifestyle threats such as AIDS and other diseases transmittable through intravenous drug use. In Romania, there are is no data regarding TB incidence within homeless population (children or adults). Accordingly to a sociological study conducted by Samu Social in 2005, the incidence of TB among homeless adults is increasing at an alarming rate (33 cases in 1999, more than 260 cases in 2005 in Bucharest among their beneficiaries). This intervention will improve the surveillance, identification and treatment of homeless persons with TB.

SDA 4. Supportive Environment: Human Resources

Within Romania, TB disease rates within prisons far exceed national rates, and remains a serious public health threat for those detained or working correctional facilities as well as communities following release

of inmates with active disease. In particular, late diagnosis or untreated TB can become a life-threatening disease for inmates and will contribute to infecting other inmates as well as correctional staff and people in the community at large. This project will improve prison staff and prisoner knowledge about TB disease and transmission in order to control TB infection, improve the timely detection of case of TB and support treatment adherence. Reducing TB infection reservoir is expected to reduce over time the overall TB notification rate.

Objective 3: Scale up MDR TB control by implementation of DOTS plus

Service delivery area(s):

SDA 1. TB: MDR TB

Addressing management of multi drug-resistant tuberculosis (MDR-TB) is one of the six components of the new WHO Stop TB strategy. There is evidence that improper use of second-line anti-TB drugs can result in further resistance to second-line drugs and may, ultimately, lead to incurable forms of tuberculosis. Romania identifies, on average, around 1000 new MDR TB cases among the new cases and among the previously treated cases. The most recent national survey of TB drug resistance, conducted in 2003- 2004, found that MDR TB incidence in TB patients not previously treated, was 2.9%, but in TB patients previously treated resistance was 10.7%. Given these figures, the treatment and management of MDR TB patients remains a significant challenge and priority of the NTP. MDR TB patients are currently treated in the two MDR TB centers in Bucharest and Bisericani, which were established under the previous GFATM grant. After discharge from the hospital, the MDR patients continue to receive treatment either from the pneumology dispensary or the family physician under strict pneumology dispensary supervision. Under the new program, Romania will institute a DOTS Plus strategy to meet the Green Light Committee (GLC) requirements and ensure the proper utilization of second-line drug regimens.

In addition, funds will be used to conduct a new national anti-tuberculosis drug resistance surveillance (DRS) survey to assess resistance to second-line medications. This will study will be implemented in collaboration with the supranational laboratory in Sweden and with the WHO EURO office, to build upon the survey conducted in 1994. A well-designed drug resistance survey will provide current sensitivity data and allow the program to evaluate recent interventions. The study will also contribute to strengthening the national reference laboratories and MDR management activities in the country.

Objective 4: Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment

Service delivery area(s):

SDA 1. Supportive environment: human resources

Romania has made significant strides in training and developing capacity for TB specialists. Nonetheless, there remains a need to improve capacity and coordination of human resource development (HRD) for public and private sector health care personnel (physicians, nurses, laboratorians and allied health care workers). As noted in a 2005, WHO report, *"the NTP does not have a comprehensive middle to long term HRD plan or a clearly defined training strategy. Furthermore, there is not a NTP training coordinator or local/regional training coordinators…the majority of people involved in training activities are currently doing this work on an ad hoc basis. Training activities are done by county managers, but they are not part of the terms of reference or job descriptions of them."* Through this initiative, Romania will develop a comprehensive HRD strategic process for TB control and expand the creation and use of training materials to build program and personnel capacity. Training materials will be developed based on a needs assessment report on areas not yet covered by previous projects and recommended by the last NPT Programme Review lead by WHO in 2005: management, surveillance, economics and financial management. Modular training courses will be provided to the medical personnel from the TB control network (County TB managers, physicians and nurses from TB hospitals/ departments, TB dispensaries, TB laboratories, etc).

SDA 2. PAL strategy implementation

The development and implementation of a comprehensive and systematic approach to manage patients with respiratory symptoms in primary health care (PHC) settings will improve the quality of respiratory care and, subsequently, create conditions to increase timely TB case detection with appropriate diagnosis tools. The PAL strategy is also able to improve the management of TB, with respect to the other respiratory illnesses, and to manage non-tuberculosis respiratory conditions related to TB. The experience of PAL development and implementation in other countries suggest that this strategy contributes to 1) improving the national health policy; 2) integrating respiratory care and TB control in PHC services; 3) reducing inappropriate or ineffective drug prescriptions, particularly antibiotics and adjuvant drugs; 4) increasing quality of care for the management of chronic respiratory patients within the district health system; 5) improving and strengthening the competency of PHC workers; and 6) improving health planning and formulation of resources needed within the health system.

SDA 3. Information system & operational research

An essential component for development of effective national TB programme is ongoing monitoring and evaluation based on quality data collection and review. This information is vital to understand the function and needs of the programme and to plan for improvements. Periodic programme reviews can be of great benefit for the NTP, particularly during periods of leadership changes or significant shifts in the programme's mandate. Its main purposes are to examine the function and capacity of the TB programme through a review of policies and procedures, human resources, and systems for the detection, diagnosis, and management of TB morbidity and mortality. The review can identify and recommend strategies, methods, and resources to promote administrative, technical and organizational improvements. A comprehensive International Review of the NTP in Romania was undertaken by a team of international and Romanian reviewers in April 2005. A second Programme Review led also by a WHO team is proposed to be organized at the end of the second year of the program. Its recommendation can be of great value for the second phase of the GFATM Round 6 programme.

A related and important component of monitoring and evaluation is to build the capacity of the programme itself to conduct and carry-out operational research. As noted in the Stop TB Strategy, programme's need to be able to plan and improve decision-making through programme-based operational research. Strengthening capacity for operational research within NTPs can contribute to improvements in the program activities and contribute to rationale use of limited resources. The project will focus on identifying unmet needs and impact of TB interventions, practices and procedures in counties with the highest TB incidence and with significant high-risk populations. The project's main activities will involve developing capacity to design and implement operational research and targeted assessment activities. Through partnership with professional association of specialists working in the pneumology network and primary care are (pneumology physicians, laboratory staff, family physicians, epidemiology physicians and nurses) as well as other researchers interested in the subject from different counties, specific operational research will be proposed and undertaken. Operational research will be used to advocate for improvements in NTP implementation by evaluating interventions, monitoring activities and adjusting policy based on data-driven decisions.

Objective 5: Develop community support and political commitment for TB control

SDA 1. Empower people, ACSM

The new Stop TB Strategy identifies implementation of an Advocacy, Communication and Social Mobilization (ACSM) plan as an essential component in TB control. ACSM activities aim to create demand, spur health seeking behavior and combat stigma. Within Romania, there remains an ongoing gap regarding national commitments for TB control; there is now an urgent need to intensify communication efforts and engender greater civil society engagement in TB control and elimination. Two recent surveys

conducted by the Health Communication Partnership of ACSM activities in Peru and Vietnam (two countries that have achieved the case-detection targets of 70% and the cure rate of 85%) illustrate the potential impacts that a sustained, well-integrated ACSM component can have on improving cast detection and treatment adherence. In both cases, a strategic ACSM effort allowed the countries to surpass the TB control targets. The proposal will result in the development of a national ACSM strategy and implementation of targeted activities to develop decision-maker commitments and community involvement with TB in vulnerable and at-risk populations.

SDA 2. Prevention: BCC - Mass media

Engaging members of the media to build awareness of TB and to appropriately cover the impact of TB within the local, national, and global TB situation can increase public and community participation through awareness of TB, reduce stigma, and affect political will. This effort can influence successful implementation of scaling up of the DOTS strategy. The proposed activities for Round 6 are designed to create a pool of knowledgeable and engaged journalists who can act as advocates and draw attention to the problem of TB at a local and national level.

Objective 6: To ensure the efficient and effective implementation of the Global Fund grant.

SDA 1. Program Management by Principal Recipient (PR): aiming to ensure the financial and technical management of the Global Fund grant by providing technical assistance to SRs and coordinating M&E activities.

Romania has chosen an exceptionally strong PR for this round who has extensive experience both as an implementer and as a manager of funds from various donors. The PR is focused on quality management and communication as well as on working in partnership with NGOs and governmental stakeholders. The PR has already developed and tested an innovative web-based management system suitable for large programmes with various SRs and will configure a similar one for the GFATM program. This objective will be accomplished by the PR and the CCM providing the SRs with technical assistance in order to increase their capacity to achieve the expected indicators.

SDA 2: Strengthen CCM Capacity: by monitoring and evaluation, CCM oversees grant implementation and integration with National TB Programme, to prevent any gap, duplication or premature termination of activities; facilitating integration GFATM funded activities with the National Strategy on TB; developing and implementing a communication strategy aiming to increase visibility of the program; and coordinating national advocacy to ensure government funding for the continuation of activities after the GFATM grant finishes.

4.6.2 Link with overall national context

The present application was developed based on the gaps resulting from the analysis of the national context done in the process of Programme Review 2005 and proposed National TB Control Strategy for 2006-2010 along with input and consultation among the CCM membership.

The reviews showed that activities targeting poor and vulnerable groups still to be expanded to make the necessary impact on the overall TB incidence trend registered in the last years and to sustain recent achievements. Other prevention activities, treatment and care activities are already developed and implemented at national scale with proven impact.

The SDAs proposed are the ones that already proved both internationally and in Romania to be efficient in targeting the poor and vulnerable groups and the present proposal wants to respond to the need of expanding and scaling up.

4 Component Section *Tuberculosis*

As noted in the new STOP TB strategic plan (2006-2015), mobilizing political support is crucial to sustain priority activities. Romania has had some success in this arena of outreach and materials development, but additional strategizing, action and creation of education materials for vulnerable populations is required. The 2005 WHO NTP Review report recognized the need for a *"coherent national strategy and plan for information, education and communication (IEC) for TB control."* The authors noted that "although some video and audio materials have been developed…they have not reached the counties to be disseminated. A number of Knowledge, Attitude, and Practice (KAP) studies have been conducted among vulnerable populations and providers, but need to be integrated into an effective strategy for creating effective messages, materials and ACSM strategies.

4.6.3 Activities

The proposed activities were developed by the CCM members, including governmental, academic, private-sector and non-governmental organizations. While this application was submitted by the CCM, if Romania is successful in Round 6, the CCM and the PR will undertake a tender process according to Romanian laws and regulations in order to select the final subrecipients. Therefore, if there is not a specified agency involved or identified below, the activity will be tendered.

Objective 1: Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers

SDA 1. TB: PPM (Public Private Mix)

Activity 1. Develop training curricula for providers focused on DOTS strategy and working with vulnerable: NTP and the subrecipients (to be tender following the finalization of Round 6 contract*)* will establish agreements and terms of reference with training partners. The partners will conduct a task analysis of the role and responsibilities of private-sector GPs for TB control along with a meta analysis of KAP studies on providers. The findings of task analysis and KAP surveys will be used to establish training targets, and the curricula design process. The partners will convene a task force of key stakeholders from the medical community along with TB control network personnel at an initial workgroup meeting. The partners will initiate the process for vendor selection to produce the 2,500 participant guides and faculty materials. The NTP and partners will assemble a curricula design team utilizing a process previously implemented for curriculum development using an interdisciplinary team for content design. Following workshop #1, a standardized training curricula and train-the-trainer (TOT) materials will be developed. The revised materials will be presented at a second workshop. Final production of training material which occur after this.

Activity 2. Develop HRD capacity through faculty recruitment and training: NTP and the subrecipient will establish terms of reference with training partners including recruitment, roles of institutions, and final deliverables. Following the initial workshop, the partners will develop train-the-trainer materials and develop the monitoring and evaluation process for trainers. The partners will recruit and train faculty from high-incidence regions of the country. The trainers will include those previously involved with the NTP, Doctors of the World and Centre for Health Services and Policies (CPSS) trainings. The trainings will take place via a series of TOT workshops.

Activity 3. Strengthen and develop the knowledge and skills of 2,500 private-sector practitioners to communicate and support patients in completing TB treatment: The partners will develop a schedule for trainings and secure continuing educations credits. After the final TOT, subrecipients will market activities to attract target participants and finalize provider selection. Starting in year 2, the subrecipients will implement training workshops in year 2 and 3. Monitoring of the workshops will occur by collection of registration and signature sheets, course evaluations and pre/post tests. In addition, the subrecipient will survey participants six months post-workshop to assess knowledge and practice changes.

Activity 4. Develop provider educational resources in support of private practioner patient management and quality of care: The subrecipient will conduct task analysis on private practitioner role in TB care and review TB KAP studies related to private practitioners. Based on this information, and consultations with the NTP, the subrecipient will create and distribute posters with NTP definitions, treatment regimens, dosages and correct abbreviations for TB drugs to 4,000 medical offices treating TB patients (for DOTS and DOTS PLUS)

Activity 5. Improve the coordination of care between the TB dispensaries and private practitioners: In order to enhance the PPM system, the subrecipient will work with the NTP, pneumology network, local public health department (LPHD), and physician representatives to review guidelines and practices

related to notification and referral system and coordination of care for TB patients during the discharge and continuation period. A research/advocacy coordinator will be hired to manage this project. The initial quarter will involve a review of literature on notification and discharge issues and initial partner meetings. Based on this meeting, the subrecipient will further investigate referral and notification issues in the country through an assessment and key informant process. Based on these findings, the partners will design a strategy to foster and enhance communication, referral, and co-management relationship between GPs and TB Dispensary Networks. The partners will also examine options to revise and monitor the current notification system, and to implement strategies to overcome current barriers in communication between TB patients, GPs and Pneumologists. This may include policy development or revisions, strengthen development of tools, such as notification forms for Pneumologists and GPs, and recommending outreach strategies to improve communication.

Objective 2: Protect poor and vulnerable populations from TB through targeted education and adherence interventions

SDA 1. TB: Social assistance and psychological counseling

Activity 1. Develop a targeted incentive and enabler program for high-burden jurisdictions: The subrecipient will draft agreements and terms of reference with partners and authorities to design a targeted incentive and enabler program in high-burden regions of the country. Following the draft design of the protocol, the subrecipient will conduct workshop #1 with stakeholders to establish targets and design protocols including eligibility criteria and distribution of incentives and enablers. The subrecipient will then prepare for the final protocol production and conduct workshops with implementers and with local authorities

Activity 2: Distribute incentives and enablers to high-risk health districts: TB patients will be provided with incentives in the form of food vouchers and, to reduce barriers, the subrecipient will distribute transportation vouchers to patients to travel to and from the dispensary where they receive directly observed treatment.

SDA 2. Prevention: BCC - community outreach

Activity 1. Develop a national health education (HE) strategy for vulnerable populations: The NTP and the subrecipients will establish an agreement and terms of reference with the MoPH and partners to elaborate a national health education (HE) strategy during year. To contribute to devising this plan, the subrecipients will collect and review existing educational documents and resources, conduct a Meta analysis of KAP surveys. The subrecipients will develop new KAP surveys with the innovative programs such as those targeting homeless children and youngsters. The partners will convene a work group with partners and international experts to review this information and draft a written HE strategy and implementation plan with multi-year targets. The strategy will be elaborated and presented to the work group for final approval. The final plan will be printed and disseminated nationally. Ongoing work group meetings will be conducted to review and elaborate a strategy

Activity 2. Implement health education activities for poor and vulnerable population: The subrecipients will elaborate information campaigns and health education activities that address the vulnerable and poor population (rural areas, homeless people, roma population, inmates, HIV+ persons, and TB patients.) The subrecipient will organize 200 caravans to educate the groups from remote areas and the roma population. In addition, the subrecipient shall implement 10 education contests with TB patients and students to raise awareness about TB.

A series of health education sessions for 1,500 homeless children (and the parents or other relatives living with them) by the subrecipient. Informative meetings will be sustained by the social workers and peers (mediators) in the beneficiaries' environment (street, different settings, communities) and in the day/emergency centers of the partner institutions. Different messages for children and youngsters will be formulated in a simple and accessible language. Beside the knowledge about tuberculosis, the accessibility to diagnosis and treatment even in their condition (the lack of medical insurance, of identity papers) will represent one of the topics. Furthermore, informative sessions will be provided to the beneficiaries by

professionals from other institutions trained within the program.

Activity 3. Develop TB educational materials or the poor and vulnerable population and TB patients to strengthen TB knowledge and adherence: The subrecipient will create health education materials for vulnerable populations based on the findings of KAP studies and through the collaboration of a series of working groups that will consist of experts and representatives from different target groups. The subrecipient will develop and distribute patient educational resources targeted at vulnerable groups including 10,000 patient education flipbooks on TB disease (diagnosis and treatment), 20,000 brochures, and 4000 TB posters to TB dispensaries, hospitals, and private clinics. Along with this, the subrecipient will develop three patient educational videos for vulnerable populations to be distributed to 189 TB dispensaries and 60 TB hospitals and 1000 rural clinical offices. The videos will address TB disease and treatment, adverse reactions, and adherence.

Activity 4. Conduct partner meetings to monitor and evaluated health education programs: The NTP will coordinate a series of partners meeting with the subrecipients and decision makers at country and national levels to review the various health education programs. An annual regional meeting with stakeholders will be held to support these activities.

SDA 3. TB: Timely detection and quality treatment of cases

Activity 1. Map vulnerable homeless communities: The subrecipient will work with the NTP to identify and map the communities/locations where the program will be implemented (service points). The communities will be selected based on the assessment of the NTP and the subrecipient including an assessment of the needs. This will be followed by the development of partnerships with local authorities, NGOs, policy and other institutions, including medical service providers that offer services for homeless children/youngsters.

Activity 2. Deliver health education for homeless families: The subrecipient will develop educational materials (36,500 units) for 1,500 homeless families and children along with materials for professionals. These materials will be developed based on a KAP study that will occur during year one of the project. Health education sessions for children/youngsters (and the parents or other relatives living with them) will be delivered in years 1-3. Informative meetings will be sustained by the social workers and peers (mediators) in the beneficiaries' environment (street, different settings, communities) and in the day/emergency centres of the partner institutions. Different messages for children and youngsters will be formulated in a simple and accessible language. Beside the knowledge about tuberculosis, the accessibility to diagnosis and treatment even in their condition (the lack of medical insurance, of identity papers) will represent one of the topics. Furthermore, informative sessions will be provided to the beneficiaries by professionals from other institutions trained within the program.

Activity 3. Provide homeless children with medical care by family doctors: 550 homeless children/youngsters will be referred toward medical services The persons without medical registration will be registered at the medical individual units – general practitioners (Bucharest) and other communities.

Activity 4. Identity TB suspects (homeless): The subrecipient will identify 160 TB cases through training 100 social workers and healthcare professional to recognize TB symptoms and conduct risk assessments in the street or shelters. The subrecipient and volunteer staff of project will identify the children/youngsters at risk of contacting tuberculosis. A medical assistant will accompany the social workers' team. The social workers will refer and accompany the suspected persons toward medical individual units (in Bucharest - The medical individual units Dumitrescu and Vlaicu. After the general assessment, the medical individual units will refer the suspected persons toward pneumoftiziology units - the Pneumoftiziology Outpatient Department of sector 6 in Bucharest. If the person is identified as TB positive, the social workers will also refer the persons that are usually in contact with him them toward medical services (including homeless adults). Further, the professionals and mediators trained within the program will follow the same procedure for referral of persons suspected of TB.

Activity 5. Treat homeless TB cases: The subrecipient will ensure that at least 140 homeless TB cases

successfully complete treatment. The subrecipient social workers and mediators trained will provide DOT treatment support during the continuation phase of treatment . Together with the patient's family members that will be selected and trained, the subrecipient staff will observe the treatment and counsel the patient to attend the medical unit at the established terms. All the treatment supporters will be regularly monitored by the project's staff. They will receive regular support, motivation and instruction.

SDA 4. Supportive Environment: Human resources

Activity 1. Organize workshops and round tables for the penitentiary system: The National Administration of Penitentiaries (NAP) will implement a series of TB training workshops for 660 prison providers and staff (general Practioner, administrative personnel, security staff, specialists in TB laboratories and pneumologists).

Activity 2. Develop a TB infection control manual: The NAP will collaborate with TB infection control and representatives of prison system to elaborate and produce a TB infection control manual in prisons.

Activity 3. Monitor and evaluate of TB control practice in prisons: The NAP will organizes a review of TB control practices in Romanian penitentiaries.

Activity 4. Produce education kit for penitentiaries: The NAP will produce TB educational kits for prison staff consisting in posters and other educational materials to illustrate schemes of searching TB cases contacts, case definitions, standard TB regimens, treatment monitoring, and treatment results definitions.

Activity 5: Train prison health educators: The NAP will train teams of three representatives of each prison and prison hospitals through an annual training workshops. The training will consist of TB strategies, adult learning skills. Additional education will be delivered via distance learning modules. Competitive tender will be organized for procurement of six distance-learning modules to be used in health education session in prisons.

Activity 6: Conduct KAP surveys: Two KAP surveys will be performed to evaluate prisoner knowledge and attitude after introducing E-learning platform and health education sessions.

Objective 3: Scale up MDR TB control by implementation of DOTS plus

All the activities under Objective 3 will be implemented by an MDR TB Center.

SDA 1. TB: MDR TB

Activity 1. Procure MDR TB drugs: Second-line anti-tuberculosis medications will be procured through the Green Light Committee at an annual cost of US$ 50,000/40,000 EURO. The estimated cost for a full course of medications, including shipment, storage and distribution totals 3200 EURO/patient.

Activity 2. Provide psychological support services for MDR TB patients: Psychological support will be provided to address the information, education, material and emotional barriers that prevent the patient to be adherent to treatment.

Activity 3. Elaborate MDR TB patient guides: The MDR TB Center will develop and distribute 2000 educational guide for MDR TB patients.

Activity 4. Support GLC monitoring visits: The project will support for three Green Light Committee monitoring visits to Romania to review the project implementation. The visits will assist the program by providing its comments and recommendations.

Activity 5. Conduct drug resistance survey for second-line anti-TB drugs: The national reference laboratories will work with the NTP and the supranational laboratory in Stockholm to design and conduct a survey on second-line anti-TB sensitivities and resistance patterns. Sample specimens will be collected

from the country as a whole, and/or from the district where the potential DOTS-Plus project will be implemented.

Objective 4: Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment;

SDA 1. Supportive Environment: Human resources

Activity 1. Develop TB curricula and training materials for the public health sector to strengthen TB surveillance, epidemiology, program management and case management practices: The subrecipient will design and develop a series of curricula and training materials focused of the following topics:

- Leadership module
- Human resources development (including team-building, motivation, communication, etc) module
- Quality and performance in TB patient case management (including patient rights) module;
- Basics of epidemiology and the management information system (MIS) module;
- Program management and evaluation module;
- Health system reform and TB control services planning module

Activity 2. Develop e-learning courses: In order to ensure broader access of the target group to the modules developed, the subrecipient will developed distance learning delivery methods based on the curricula and training materials using existing e-learning platforms.

Activity 3. Provide training of trainers (TOT) and training for the NTP network personnel: Accredited trainers will be identified and trained by the subrecipient according the approved curricula, materials and methods; experiential training will be used combining different training methods as appropriate for the target population. It is estimated that four modules will be deliver to 300 persons (for a total of 1,200 persons trained) from the TB control network. These sessions will be delivered in partnership with academic programs. As such, an efficient coverage of the entire country will be achieved. It is estimated that at least 50% of the TB control network personnel will take part to at least one training module, and around 20% to attend more than one module.

Activity 4. Monitor and evaluate trainings: The trainings will be monitored and evaluated by M&E experts who will review the training curricula and methodology, attend training sessions, and conduct key informant interviews with the programme personnel. Conduct annual meetings with trainers will be conducted to develop skills and review program. An extensive mid-term evaluation will be carried out with the support of the WHO experts or other external expert in order to make the needed adjustment in program implementation. A final evaluation study will be carried out after training will be completed, in order to assess the results and the changes in target group activity following the participation in these courses. It is estimated that these final evaluation will make also recommendations regarding the next steps to be made.

Activity 5. Attend TB and Health Management international conferences for best practices sharing and project promotion: Program visibility component (PR component) – in order to increase the TB control activities' visibility both at national and international level a strong PR component is needed. The PR component will involve a PR strategy to get TB control in the centre of public and policy makers' interest, and also increase visibility at international level by attending international conferences focused on TB control and on Health Management, by organizing national conferences with international attendance for best practice sharing, by organizing study tours for Task Force members and for TB control network staff members.

SDA 2. PAL strategy implementation

Activity 1. Establish national working group on PAL: A national working group (NWG) on PAL adaptation and development will be created in country. The NWG will involve NTP and other key partners at country level such as Romanian College of Physicians, Ministry of Public Health, National Health

Insurance House, HIV/AIDS control program, PHC services and professional organizations, national health academic institutions, HMIS department, health resource planning department, etc.

Activity 2. Provide WHO Technical assistance: WHO TA will be assured in key points of the project (to initiate the PAL process, PAL guidelines elaboration, PAL feasibility test, PAL implementation).

Activity 3. Elaborate PAL guideline: The NWG has the responsibility to develop the PAL guidelines. They should be based on the international standards of clinical care for respiratory illnesses that have gained general acceptance. They should focus on the priority respiratory conditions encountered within the district health system. They should be adapted to the national conditions and health policy priorities while taking into account the organization of the district health services and the skills of the existing health professionals (general practitioners, nurses, etc.) who have to use them.

Activity 4. Develop PAL training materials: It will be developed by the NWG. It should target the implementation and the appropriate utilization of PAL guidelines by health workers in their daily tasks. The training materials will include: 1) a document explaining the concept and rationale of PAL strategy; 2) PAL guidelines; 3) a training module for health worker including case studies which cover all the content of the guidelines; 4) documents on how to use, clean and maintain equipment such as peak flow meter, inhalation chamber, nebulizer, spirometry and oxygen supply; and 5) a facilitator module.

Activity. 5. Conduct PAL feasibility test: It will be undertaken by the NWG. The objectives of this test is to assess the impact, in the short term, of PAL on the health care delivery to patients with respiratory symptoms in PHC settings, particularly in terms of: i) patient referral; ii) quality of the process of TB identification among respiratory patients; iii) quality and cost of drug prescription. The feasibility includes two surveys: the first before PAL implementation and the second after PAL implementation.

It include two studies: a baseline study and an impact study that:
- uses the same protocol on the basis of the WHO model
- enrolls patients, aged 5 years and over, who attend PHC facilities for respiratory symptoms
- involve a high number of GPs (80 to 100) who should be the same in both studies. The GPs will be 80 from the existing sentinel dispensaries. The sentinel dispensaries will receive pick flow meters and upgrading of their computers for data collection.

Activity 6. Procure pick flow meters (PAL) and PC units for the sentinel dispensaries for data collection for PAL feasibility test: Competitive tender will be organized for both procurements.

Activity 7. Exchange PAL implementation international experience: Representatives of the NWG will visit a country advanced in PAL implementation for on site experience exchange.

Activity 8. Provide training for PAL feasibility test and for implementation: Training will be organized for PAL implementation and data collection in the sentinel dispensaries.

Activity 9. Provide monitoring and evaluation for PAL implementation: M&E visits will be organized in the counties were PAL will be implemented.

Activity 10. Elaborate national PAL implementation plan: It will be developed by the NWG. It will be developed for, in a first phase, 5 counties of the country. It should be multi-year, stepwise and in line with the long term strategic plan of the NTP. The plan will be developed in coordination with Ministry of Public Health, National Health Insurance House, and discussed with the other relevant stakeholders dealing with national health issues.

Activity 11. Publish and disseminate PAL experience: The project final report will be published and distributed in the country. The project will advocate PAL implementation to be included within the national health planning process.

SDA 3. Information system & operational research

Activity 1. Prepare Operational Research (OR): Conduct a situation analysis on operations research (OR) capacity based on the WHO framework to plan and build OR capacity and OR network at county level. The subrecipient will develop OR plans according to the needs and areas identified by the programme during the situation analysis.

Activity 2. Provide OR Training: The subrecipient will provide four trainings (1 annually) to develop OR skills, including operational research design and reporting, and knowledge regarding OR methodology for pneumology staff from selected counties.

Activity 3. Implement OR: OR studies proposals will be elaborated by selected counties. Proposals will be selected and research protocols concluded. Technical assistance, supervise and monitor of the OR implementation will be provided.

Activity 4. Assure policy change based on OR and disseminate the experience: The subrecipient will conduct an annual review meeting to review the experience and findings of OR activities with national stakeholders.

Activity 5. Evaluate OR: The subrecipient will evaluate the results of the OR activities on policy.

Activity 6. Conduct a TB programme review: The subrecipient will organize one Programme Review with WHO technical assistance, based on WHO Programme Review Guidelines. At least 25% of the counties will be visited and the findings and recommendations will be presented to policy decision makers.

Objective 5: Develop community support and political commitment for TB control

SDA 1. Empower people, ACSM

Activity 1. Develop an Advocacy, Communication, and Social Mobilization (ACSM) strategy for policy makers: The subrecipient will review international and national activities related to ACSM including communicating with the STOP TB and IUALTD work groups. An ACSM working group will be established and a workshop conducted. The workshop will result in an initial draft ACSM strategy, which will then be revised and elaborated by the subrecipient. A second workshop will be conducted to finalize ACSM strategy. Following this, the subrecipient will develop policy briefing materials, fact-sheets and a short video about the impact (social/financial) of TB along with recommended policy actions.

Activity 2. Identify TB patient needs and facilitate patient advocacy: To identify and respond to patient needs, the subrecipient will hire a halftime patient advocate coordinator that will interview patients, identify and train patients willing to serve as spokespersons for TB, and coordinate patient advocacy activities working with local care providers. The coordinator will review existing models and design appropriate data collection methods. This will be followed by implementation of data collection and identification of local partners including representatives from religious and social institutions. During the media outreach activities, the coordinator will facilitate opportunities for patients to voice their perspective on TB control needs.

Activity 3. Develop advocacy media video for TB: The subrecipient will develop a short video about the impact (social/financial) of TB along with recommended policy actions.

Activity 4. Organize legislative meetings: The subrecipient will conduct briefings with decision-makers on TB will be conducted to support policy development supportive of TB.

SDA 2. Prevention: BCC - Mass media

Activity 1. Implement World TB Day Events: To increase awareness about TB, the subrecipient and partners will develop and plan for World TB Day activities. The subrecipient will create and disseminate resources to be used by local partners, TB dispensaries, and hospitals nationwide.

Activity 2. Conduct media trainings: As part of this initiative, the subrecipient will implement a series of media trainings with at least 40 Romanian journalists. The subrecipient will also facilitate TB patient media and advocacy interviews and support patient advocacy activities.

Objective 6: To ensure the efficient and effective implementation of the Global Fund grant.

SDA 1. Program Management by Principal Recipient (PR)

Activity 1. Provide Technical assistance to PR (M&E, legal, studies, TB expert etc): The PR will require technical assistance in some specific areas and will purchase it by a competitive tendering process.

Activity 2. Financial and Technical management activities: The PR, according to its stated roles, responsibilities and functions will enter in financial relations with subrecipients and providers and also will manage technically the programme (trainings, coaching/work sessions, retreat meetings). The PR will design Web-based financial and programmatic management system and maintain it in order to monitor & evaluate subrecipients performance activities and provide technical assistance to subrecipients as needed.

SDA 2: Strengthen CCM Capacity: monitoring, evaluation, oversees grant implementation and integration with National Programme for TB Control

Activity 1. Provide CCM Secretariat and M&E Technical Group operations: by assuring communication between CCM members and between CCM and other stakeholders, assisting the CCM president and vice-presidents and Executive Committee, providing administrative functions, translations, register and multiplication of documents etc.

Activity 2. Implement M&E Plan by CCM: by providing the administrative arrangements (travel, accommodation, communications etc.).

4.6.4 Performance of and linkages to current Global Fund grant(s)

a) Provide an update of the current status of previous Global Fund grants for this disease component, in the table below.

Table 4.6.4. Current Global Fund grants

	Grant number	Grant amount*	Amount spent
GF Grant 1	ROM-202-G02-T-00	USD 16,743,641	11,882,953**

* *For grants in Phase 1, this is the original two year grant amount. For grants that have been renewed into Phase 2, this is the total amount, inclusive of Phase 1 and Phase 2. For unsigned Round 5 grants this is the two year TRP approved maximum budget.*

** According to Round 2 Principal Recipient's Annual Report (January 1st – December 31st 2005).

b) Please identify for each current grant the key implementation challenges and how they have been resolved.

There are a number of reasons to explain the slow financial implementation of the GFATM grant for TB, including the complex procurement procedures required of the PR, the prolonged process for procurement of second-line drugs, and the need to modify some of the planned activities. Despite this, TB programme performance has progressively improved throughout the Phase 1 period, mostly during the second year of implementation. Despite initial delays, the grant achieved the majority of the targets set for its second year. To date, targets were exceeded in 11 of the 17 achieved performance indicators in Phase 1.

Transition to Phase 2 was also marked by a significant delay in the disbursement of funds to sub-recipients, but at the moment all sub-recipients participating in Phase 2 have been contracted and activities are on track.

c) Are there any linkages between the current proposal and any existing Global Fund grants for the same component? (E.g. same activities, same targeted populations and/or the same geographical areas.)

☒ Yes *complete d)*

☐ No *go to 4.6.5.*

d) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided under current Global Fund grants.

Training During the GFATM round 2 phase 1, Marius Nasta Institute has spent 911.575 USD for implementing the Strengthening the national capacity of implementing the DOTS national strategy project, where 2,537 GPs/FDs, 660 pneumologists and 8,018 nurses have been trained in DOTS activities. In the phase 2 these activities are planned to continue, reaching a total of 17,461 persons trained till January 2008 (family physicians, pediatricians specialized in TB, epidemiologists, pneumologists and laboratory staff). These training courses are short courses mostly focused on DOTS, and having only a small communication component designed to improve the communication between the TB patients and their families and the staff from the TB facilities and between the partners involved in TB control. The Round 6 proposal steps forward and proposes courses to improve the managerial skills of the medical personnel involved in the TB control network as pointed out also by the Romanian National strategy of Tuberculosis Control 2006-2010, as well as by the WHO, in its First Review of the National Tuberculosis Programme in Romania "*create a HR development team, which implies training selected staff to become training coordinators; to support staff at the NTP central office to acquire leadership skills; to improve the management/leadership capacity of county TB managers by organizing training in leadership and management issues; to continue training for family doctors and nurses, with a plan for training organized*

from county level."

IEC During the GFATM round 2, phase 1 and 2, several sub-grants included IEC activities to improve patient adherence and a number of IEC materials were developed. The targets till the end of Round 2 programme are: 1) 22,800 (58,46%) prisoners receiving IEC sessions in TB; 2) 282,291 roma population from selected communities (4 counties) and school children receiving TB education; 3) 65% of roma people (in a representative sample) able to identify basic characteristics of TB. The current proposal builds upon this experience. The ACSM activities proposed are a scale up of the previous round activities.

PAL During NTP 2000-2005 treatment regimens have been standardized with the introduction of national guidelines. During the phase one of GFATM projects different guidelines have been elaborated and disseminated (guidelines for TB control in penitentiary health facilities; guide on TB control for primary health providers, nurses and pulmonologists, guide for diagnosis and treatment of pediatric TB, guidelines for MDR-TB management, epidemiologic surveillance guide, TB drugs management guide). These projects are successfully finalized. PAL strategy is a natural continuation and scale up of the previous activities in this area, both under NTP and GFATM.

MDR TB The GFATM round 2, phase 1 and 2 cumulative target, by the end of January 2008 is 1) 400 MDR TB patients on treatment in 2 regional MDR TB centers; 2) 60% of MDR TB patients successfully treated. The current proposal adds on the existing DOTS Plus project.

Incentives The GFATM round 2, phase 1 and 2 cumulative target is 12,900 TB patients receiving incentives. The round 6 proposal for incentives refers to a specific category of TB patients receiving incentives and enablers (homeless, remote rural, inmates).

4.6.5 Linkages to other donor funded programs

a) Are there any linkages between the current proposal and any other donor funded programs for the same disease	☒ Yes *complete b)* ☐ No *go to 4.6.6.*

b) If yes, clearly list such linkages and describe how this proposal builds on, but is not duplicative of the funding provided by other donors, including in respect of health system strengthening activities.

Benefiting from additional funding from the United States Agency for International Development (USAID) and the Open Society Institute (2004-05), Doctors of the World (DOW) coordinated a training program for GPs and nurses in Neamt and Constanta counties. A total of 259 general practitioners and 261 nurses have been trained in DOTS strategy and BCC strategies (patient communication, interviewing skills, as support for adherence behaviors and communication for a group of vulnerable population –rroma people) via four one-day intensive trainings and eight two-day workshops.

The Round 6 project proposal intends to make a country profile regarding the distribution of vulnerable areas and their coverage with GPs and DOT services. According to regional and training needs identified, an appropriate training program will be developed; it will expand DOW initiatives to additional counties and extend it within current program counties (where vulnerable areas are identified). In addition to the training initiatives, the proposed project seeks to raise public awareness (general population and policy-makers) as regards the burden of TB disease and the main barriers that prevent the achievement of a high rate of completed and successful TB treatment (both at the national level and among vulnerable TB patients).

With additional funding from the United States Agency for International Development (USAID) and from the Open Society Institute (2004-05), DOW coordinated a series of working group meetings with MoPH and other partners to develop a national health education strategy and resources for different target

populations. These activities will provide a foundation for the scaling up of educational materials production and assist with proposed advocacy and social mobilization events.

4.6.6 Activities to strengthen health systems

a) Describe which health systems strengthening activities are included in the proposal, and how they are linked to the disease component. *(In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. See the Multi-Agency M&E Toolkit.)*

The proposal includes several health systems strengthening activities including human resource development, operation and epidemiological research and PAL strategy.

b) Explain why the proposed health systems strengthening activities are necessary to improve coverage to reduce the impact and spread of the disease and sustain interventions.
(When completing this section, applicants should refer to the Guidelines for Proposals, section 4.6.6.)

The 2005 WHO report noted that, *"the NTP does not have a comprehensive middle- to long-term HR development plan or a clearly defined training strategy. Furthermore, there is not an NTP training coordinator or local/regional training coordinators…the majority of people involved in training activities are currently doing this work on an ad hoc basis. Training activities are done by county managers, but they are not part of the terms of reference or job descriptions of them."* The authors recommended that training for family doctors should be consistent with a training plan organized at the county level. Based on previous training experience, a number of barriers to involve private practitioners in ongoing training programs were. For example, to participate in trainings GPs have to find a colleague to replace them for the missing day, which can be nearly impossible in rural areas where there is a lack of human resources. In addition, while family doctors are required to complete continuing medical education programs, there is limited support or incentive by the National Health Insurance House (NHIH) for participating in continuing medical education trainings. Moreover, to enhance the PPM role, other issues need to be addressed such as notification and coordination of care during the continuation phase of treatment. For example, private practitioners report that they are not notified of the outcome of evaluations after they refer suspects to the TB dispensary.

As noted by the 2005 WHO report, the NTP public funds are designated on an annual basis through an Ordinance signed by both MoPH and the NHIH President. At the county level, TB units can not easily access the funds. In addition, there are activities that are part of the NTP, but are not explicitly included in the MoPH budget, including for IEC and health education activities. While the GFATM funded targeted educational activities, there has not been an analysis on the impact, replicability or sustainability of these interventions. Furthermore, programmatic and financial gaps remain for scaling up IEC efforts and to meet coverage gaps.

c) Describe how activities to strengthen health systems, integrated within this component, will have positive system-wide effects and how it is designed in compliance with the surrounding context and aligned with government policies.

Developing a targeted PPM strategy will help to ensure continuity of care and address health systems issues related to coordination between the growing private sector and the public health system. By working with the College of Physicians and the National Health Insurance House, the NTP and its partners will develop a systematic approach to resolve these outstanding issues.

Development of a national ACSM strategy will guide future national and targeted education and training activities and increase the likelihood that the materials developed will be disseminated to a wider patient audience. In addition, media training will develop systemic capacity regarding health reporting, which can contribute to sustained and enhanced political commitment to TB control. The development of educational

and audiovisual resources will provide important resources for the next 5 years at least. The project will contribute to the development of standardized TB education materials for national use.

The expected outcomes of OR are in line with NTP, the proposed National Strategy for TB Control and healthcare reform in Romania: to improve national health policy, since it defines health policy and interventions; to improve the competency of pneumology network staff; and to improve health planning and resource mobilization needed within the health system.

d) Are there cross-cutting health systems strengthening activities integrated within this component that will benefit any other component included in this proposal?	☐ Yes *complete e) and f)* ☒ No *go to g)*

e) If you answered yes for d), describe these activities and the associated budgets and identify and explain how the other components will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

f) If you answered yes for d), confirm that funding for these activities has not also been requested within the other component. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

g) Is this component reliant on any cross-cutting health systems strengthening activities that have been included within other components of this proposal?	☐ Yes *complete h)* ☒ No *go to 4.6.7.*

h) If you answered yes for g), describe these activities and the associated budgets and identify and explain how this component will benefit. *Please refer to the Round 6 HSS Information Sheet on http://www.theglobalfund.org/en/apply/call6/documents/ before completing this section.*

4.6.7 Common funding mechanisms

This section seeks information on funding requested in this proposal that is intended to be contributed through a common funding mechanism (such as Sector-Wide Approaches (SWAP), or pooled funding (whether at a national, sub-national or sector level).

a) Is part or all of the funding requested for the disease component intended to be contributed through a common funding mechanism?	☐ Yes *answer questions below.* ☒ No *go to 4.8*

b) Indicate in respect of each year for which funds are requested the amount to be funded through a common funding mechanism.

c) Describe the common funding mechanism, whether it is already operational and the way it functions. Identify development partners who are part of the common funding mechanism. Please also provide documents that describe the functioning of the mechanism as an annex.

(This may include: The agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)

d) Describe the process of oversight for the common funding mechanism and how the CCM will participate in this process.

e) Provide an assessment of the incremental impact on projected targets as a consequence of the funds being requested for this component, which are to be contributed through the common funding mechanism.

f) Explain the process by which the applicant will ensure that funds requested in this application, that are contributed to a common finding mechanism, will be used specifically as proposed in this application.

4.6.8 Target groups

This proposal was developed in collaboration with members of the CCM. This diverse group represents stakeholders, governmental agencies, and beneficiary representatives and advocates. A technical team reviewed the initial proposals, which was followed by an open review of the proposal draft by the entire CCM membership.

4.6.9 Social stratification

Table 4.6.9 **Social stratification**

	Estimated number and percentage of people reached who are:			
	Women	Youth (<18)	Living in rural areas	Other*
OBJECTIVE 1: Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers				
SDA 1: TB PPM	2000 women GP/FPs		2000 family practitioners/2000 medial offices/clinics	500 family practitioners/2000 medical offices/clinics
OBJECTIVE 2: Protect poor and vulnerable populations from TB through targeted education and adherence interventions				
SDA 1: TB: Social assistance and	250 TB patients to receive incentives		500 TB patients in	500 TB patients in

psychological counseling	and enablers		rural areas	urban settings
SDA 2: Prevention: BCC - community outreach	Enduring products (video, TB posters, etc.) will reach 120,000 women	1500 homeless children	20,000 rural residents to receive TB education (caravans); enduring products (video, TB posters, etc.) will reach 120,000 persons	Enduring products (video, TB posters, etc.) will reach 120,000 person
SDA 3: Timely detection and quality treatment of cases	500 homeless women provided with TB education for early detection and treatment	Refer 550 homeless children to medical care; identify at least 160 homeless children and families; Completion of Therapy (COT) for 140 persons	2000 rural providers seeing 5 TB patients per yr. over 5 yrs.= 50,0000 patient beneficiaries	500 urban providers seeing 5 TB patients per yr. over 5 yrs.= 12,500 patient beneficiaries
SDA 4: Supportive environment: Human resources	240 women prison staff educate 3,000 women prisoners educated regarding TB symptom			660 prison staff educated 10,560 prisoners educated regarding TB symptoms
OBJECTIVE 3: Scale up MDR TB control by implementation of DOTS plus				
SDA 1: TB: MDR TB	96 women MDR patients provided with DOTS Plus		240 rural MDR patients with DOTS Plus	240 urban MDR patients provided with DOTS Plus
OBJECTIVE 4: Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment				
SDA 1: Supportive Environment: Human resources	1000 women public health providers trainer		600 public health providers trained	600 public health providers trained
SDA 2: PAL strategy implementation	250 women GPs trained serving 625,000 patients		240 rural GPs trained serving 600,000 patients	340 urban GPs trained serving 850,000 patients
SDA 3: Information system & operational research	160 female public health practitioners and researchers trained		50 rural public health practitioners and researchers trained	200 public health practitioners and researchers trained
OBJECTIVE 5: Develop community support and political commitment for TB control				
SDA 1: Empower people, ACSM	100 decision-makers (legislative			400 decision-makers (legislative

	representatives)			representatives)
SDA 2: Prevention: BCC - Mass media	20 female journalists trained			40 journalists trained

4.6.10 Gender issues

In all the major areas of intervention proposed in this component, gender issues have been carefully considered. All planned activities consider gender issues and will determine interventions appropriate for both female and male roles, and will look at responsibilities and opportunities from a social, cultural, and political perspective. Various instruments for monitoring, evaluation, and surveillance will be designed accordingly to provide gender disaggregated data and to determine gender focused interventions.

4.6.11 Stigma and discrimination

In order to address stigma, this proposal will develop a comprehensive IEC strategy along with ACSM and educational interventions to increase both awareness and knowledge. Effective and targeted messages and materials will be developed for vulnerable and at-risk population to: increase awareness of the symptoms of TB and the benefits of completing the treatment process; clarify or correct any misconceptions about the transmission, symptoms, and treatment of TB, and; create a clear association in the minds of the vulnerable groups between the symptoms of TB, its affordable treatment, and cure.

4.6.12 Equity

Within Romanian, access to diagnostics and treatment services is provided free-of-charge. There are, however, some access issues related to distance and primary care services. Through the new National TB Control Strategy (2006-2011), a commitment will be made to address or improve upon the following:

- The state guarantees the right to health insurance for its citizens through universal and equal access to health services.
- Necessary prevention, diagnosis, and treatment services for psycho-social support required to ensure timely and successful completion of TB therapy shall be made accessible, acceptable, and efficient in all at-risk communities.
- Special attention shall be paid to primary and secondary prevention activities as well as to vulnerable population groups and affected communities.
- The rights of the patients with tuberculosis shall include the free provision of TB diagnosis and treatment along with policies and procedures that ensure confidentiality rights are observed by all health service providers.

4.6.13 Sustainability

All proposed activities include plans for ensuring sustainability by ensuring national ownership from the beginning and through the gradual transfer of the programme from the Global Fund resources to domestic resources.

The pneumology network staff is relatively stable with low turnover rates. It is very likely that the staff who will be trained for the project will remain in the same workplace, thus enabling the continual

application of skills and knowledge acquired during the project. The dissemination components of project results will increase the visibility of the different components and support their import in evidence-based decision making, subsequently increasing their ability to attract and obtain funding from additional sources (government, local, EU, international agencies, etc.)

4.7 Principal Recipient information

4.7.1 Principal Recipient information

Table 4.7.1: Nominated Principal Recipient(s)

Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☒ Single
	☐ Multiple

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone, fax numbers and e-mail address**
Romanian Angel Appeal Foundation	HIV&TB	Silvia Asandi, Executive Director	52 Rodiei Street 030956, Sector 3 Bucharest, Romania

4.8 Program and financial management

4.8.1 Management approach

The CCM has the overall role of coordinating the implementation of the Proposal within the general framework of the National AIDS Strategy implementation. The CCM designated its Executive Committee (EC) to coordinate the elements related to implementation, to determine what actions are required and to eliminate obstacles that hinder the progress of implementation. The CCM Executive Committee includes the key stakeholders of the CCM (President and Vice Presidents, Principal Recipient (PR), NGO and international organization representatives). The EC will receive and analyze the reports from the PR, deal with implementation issues that might occur and make adjustments, as needed.

The designated Principal Recipient is Romanian Angel Appeal (NGO). The designated PR will be responsible for managing the funds and ensuring efficient disbursement to the subrecipients. In the period of time before that grant is awarded/signed, the PR (as part of the CCM) will act as a Project Preparation Unit. As such, it will facilitate the proper preparation of project implementation. UN Agencies have expressed their intention of assisting the PR during this preparation period. Once the grant agreement is approved, additional staff will be contracted to fulfill the requirements of PR responsibilities, including procurement, disbursement, accounting, and internal control. This assistance will reinforce the legal framework and transparency of all proposed procedures with respect to international and national legislation.

The PR will fully handle the management of the project, and will make recommendations on adjustments to the plans of sub-recipients, based on achievements or lack of progress. Sub-recipients will be responsible for driving implementation for each component, and for developing and updating a detailed implementation plan and timetable for their component. Based on the program proposal, the PR, together with the Executive Committee and technical partners, as needed, will proceed to finalize the programmes,

budgets, and a disbursement plan for the first year. They will also ensure a timely, transparent and efficient process of sub-recipient selection. Sub-recipients which are Ministries or other government institutions will designate, by ministerial order, the official entities within the Ministries that will be responsible for implementation. Specific existing procedures will be used to contract with the NGOs. All the sub-recipients will have contractual arrangements with the PR.

4.8.2 Principal Recipient capacities

a) Describe the relevant technical, managerial and financial capacities for each nominated Principal Recipient. Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

Romanian Angel Appeal Foundation (RAA) is one of the largest Romanian NGOs. It has 15 years experience in the HIV/AIDS sector, both as implementer (34 medical and social services for PLWHA, including large prevention programs, partner and founder of various health institutions and NGOs), as well as technical and financial administrator of international grants. These grants include the following: EU (PENTA clinical trials on ARV efficacy in children), pharmaco-funded project (SEYPA www.seypa.net), partner and work-package leader in the EU funded TEDDY international network of excellence www.teddyoung.org. For more information on RAA activity, please consult www.raa.ro and the Annex 14: RAA Activity report 2005.

RAA is a sustainable organization and it has a coordination team with relevant competencies on technical and administrative aspects of the GFATM grant implementation. It is managed by a motivated managerial team (Quality Management Standards ISO 9001:2001 implemented) with a strategic development plan for 2006-2010 and it has the capacity to merge technical assistance for SRs with appropriate grant administration.

"RAA is a resource organization for Eastern European region in HIV/AIDS and other chronic illnesses with major risk for discrimination and social exclusion, that offers training, research and consultancy, advocacy and lobby and multidisciplinary services for those affected, specialists and stakeholders". (Source: Report on RAA Assessment and Strategic Planning 2006-2010, EuroSucess Consulting, 2005 – see Annex 15).

RAA has invested more than 7 million USD during 1991-1999 in pioneering services for PLWHA and attracted more than 5 million USD during the last 4 years for programs aiming to respond to National HIV/AIDS Strategy (including GF funded programs).

RAA Technical Capacity rely on:

- the competencies and skills within the coordination team (See annex 16 RAA application for PR with list of technical and managerial competencies included.);

- the expertise in M&E: RAA has offered technical consultancy to UNAIDS on Evaluation of National HIV/AIDS Strategy implementation (See attached letter from UNAIDS.);

- accreditations from national authorities and professional bodies: Ministry of Labor and Social Protection (as provider of social services for PLWHA); Romanian College of Physicians, Romanian College of Biologists and Biochemists Working in the Health Sector, Romanian College of Dentists (as provider of Continuing Medical Education); and

- academic partnerships with three national HIV/AIDS clinics and 11 European international clinics/research institutes.

RAA Managerial capacity:

- Competent Managerial team who implemented the Quality Management Standard ISO 9001:2001. The Quality Manual was designed and approved, procedures and working instructions are implemented and include: quality management design and development, service provision, relationship with stakeholders, procurement, suppliers' evaluation, risk management, management and control of documents and records, internal audit, preventive and corrective actions, management analysis, human resources management, etc.

- Evaluation performed every five years, followed by Strategic Planning Process involving all stakeholders, including beneficiaries. (See RAA 2005 Evaluation and Strategic Planning Report attached.)

- RAA has proven capacity to adjust to various changes and challenges (including massive expansion of staff and programs in 2004 due to the GF funded activities, external challenges due to various political changes affecting health system, social protection, funding, etc.).

- RAA management is based on communication (internal and external) and important decisions are taken by consultation with stakeholders.

RAA financial capacity:

- Relevant Financial team competencies (See Annex 16 RAA application for PR, with list of financial competencies included.)

- RAA has demonstrated ability to comply with diverse financial reporting obligations of multiple donors & countries: Romanian financial institutions, EU, World Bank, Phare, Regional Administrative Authorities in Italy, Donors in Romania, UK, Italy, etc: RAA has had a wide range of donors, especially outside Romania, including the EU, World Bank, FFM, the Elton John AIDS Foundation, Glaxo Smith Kline – diverse funding contracts and ability to comply with very varied reporting and auditing requirements.

- RAA has expertise in establishing and maintaining contract service agreements including the funding of Romanian state institutions. It also has international experience managing network programs (i.e.. five countries, two yrs): 116 legal contracts with 40 beneficiary entities during 2000-2006 and over 775,000 Euro disbursed in cash/in kind (procurement and distribution) to 35 legal entities (hospitals and public health authorities) during 2004-2005; RAA has coordinated (on behalf of European Forum for Children, Young People and Families Affected by HIV/AIDS) the management of 100,000 Euro disbursed to five NGOs in Italy, Spain, Portugal and Russia (2003-2005).

- RAA has customized financial (accounting) networked software in place, allowing for financial data management, quick release of financial reports on different projects, types of expenditures, funding sources, etc; including periodic reports requested by the Ministry of Finance.

- RAA complies with the accounting principles according to Romanian legislation issued by the Ministry of Finance (OMF 1829/2003) re: accounting regulations for non-profit legal entities.

- RAA developed an innovative web-based user-friendly management and financial management system. The system is able to: track SRs results and achievements; track SRs expenditure rate/progress; generate correlated reports; make SRs achievements visible to stakeholders (donors, beneficiaries, general public); offer an interactive forum for free communication among parties.

- RAA's capacity in the technical, managerial and financial areas was evaluated / audited by various donors and independent consultants: FDSC (EU-Phare grant), FRDS (EU-Phare grant), PMU-MoH –GFATM and JSI consultant (GFATM fund), International Public Health consultant Katinka de

Vries (implementation of VCT and PMTCT GFATM funded programs), Ministry of Finance (quarterly, since 2001), independent auditors 2004, 2005 (GFATM funds).

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☐ Yes ☒ No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☐ Yes ☒ No

d) If you answered yes for b) or c), provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous grants (Global Fund or other donor).

RAA is one of the SRs of phase I and II GFATM in Romania. Total budget of the project implemented by RAA (five yrs) is 3,871,460 USD (2,900,000 already spent in phase I). RAA's performance as SR of GFATM was excellent, both technically as well as financially, and this statement is endorsed by the M&E and financial reports of PMU-MoPH-GFATM and audit reports for 2004 and 2005. RAA has not only achieved (and exceeded) the indicators but has also demonstrated a good capacity to comply with all challenges generated by difficult implementation conditions. RAA is constantly preoccupied with ensuring sustainability for continuation of the programs after Phase II (persistent lobbying to Government and MoPH still ongoing).

Examples of grants (other than GF) administrated by RAA since 2002:

- 400,000 Euro for SEYPA project (Combating Social Exclusion of Young People Affected by HIV/AIDS), funded by GlaxoSmithKline Corp. (2002-2004)

- 230,000 Euro for PMTCT, Diagnosis Disclosure in young PLWHA "Right to Adolescence" Project, funded by "Partners for Life" Foundation (2002-2004)

- 350,000 Euro for PENTA clinical studies on ARV efficacy in children, EU funded (2003-2010)

- 440,000 Euro for TEDDY Taskforce in Europe for Drug Development for the Young" (2004-2010)

- 110,000 USD for PMTCT Grassroots Interventions in Rural Area, Development Marketplace World Bank funded (2004-2005), etc.

See the endorsement letters for RAA capacity in Annex 17.

e) If you answered yes for b) or c), describe how the PR would be able to absorb the additional work and funds generated by this proposal.

RAA has a flexible structure and a strategic development plan that includes clear objectives, methods and deadlines with regard to strengthening RAA's capacity to absorb both programs and funds. In addition, RAA's Quality Management System has prepared the organization to cope successfully with quality management requirements in various situations.

RAA already has the adequate infrastructure and information systems to support proposal implementation, including monitoring the performance of SRs and outsourced entities in a timely and accountable manner:

- Developed IT infrastructure: optic fiber Internet network (within and between the two offices), firewall hardware router, Microsoft Windows 2000 Network and Server, Microsoft Exchange Server, all IT system is anti-virus & Spam protected, the network can accommodate up to 60 working stations – Windows 2000 & Windows XP
- Project Management & Accounting software systems

- Two offices owned by RAA and adequate office equipment
- Five vehicles suitable for M&E site-visits

RAA has adequate health expertise and cross-functional expertise (finance, procurement, legal, M&E):

- Competencies existing within RAA coordination team and collaborators as per RAA application for PR. (See section 4.8.2.A.)
- Legal department - outsourced
- TB Competencies needed: TB consultants to be recruited
- RAA has been working for more than two years within the frame of GF procurement policies (national and international procurement). The previous annual financial audits proved the fact that RAA has appropriately applied the GF procurement policies.
- RAA can collect and record programmatic data with appropriate quality control measures.
- Data Collection: web based management system which allows for communication among different databases
- RAA Quality Control Measures involve the following: desk research, quality control tools designed and applied, site visits and feedback from beneficiaries (focus groups, questionnaires, meetings).
- RAA is capable to support the preparation of regular reliable programmatic reports, due to the competent human resources which are backed by an efficient web-based Management System that will be customized according to GFATM proposal: SRs, activities, indicators, work plans, M&E plans, technical and financial reporting requirements, etc.

4.8.3 Sub-Recipient information

a) Are sub-recipients expected to play a role in the program?	☒ Yes *complete the rest of 4.8.3*
	☐ No *go to 4.9*
b) How many sub-recipients will or are expected to be involved in the implementation?	☐ 1 – 5
	☒ 6 – 20
	☐ 21 – 50
	☐ more then 50
c) Have the sub-recipients already been identified?	☒ Yes *complete 4.8.3. d) -e) and then go to 4.9*
	☐ No *go to 4.8.3. f) – g)*

d) Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.).

The sub-recipients were **partially** identified. The governmental subrecipients have been identified: a pneumology hospital MDR TB Center – for MDR TB treatment, and the National Administration of Penitentiaries – for the TB control in the penitentiary system component. They were selected on the basis that they are the only entities in the country dealing with the specific area of TB control.

e) Where sub-recipients applied to the Coordinating Mechanism, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal.

See f, below.

f) Describe why sub-recipients were not selected prior to submission of the proposal.

CCM decided not to select the sub-recipients prior to the submission of the proposal (See Annex 18 CCM EC decision). The decision was based on the limited time available for receiving and evaluating fully-fledged project proposals from potential sub-recipients. Alternatively, the process approved by the CCM was to publicly solicit contributions to the proposal from all the possible national partners. Thirty-five organizations sent their contributions. These contributions were evaluated by a special committee established by the CCM against a set of criteria and against a framework approved by the CCM in line with the national HIV/AIDS Strategy and the criteria set by GFATM for low-middle income countries. The admitted contributions formed the base for developing the country proposal. If the proposal is approved by GFATM, the Romanian CCM will organize a selection process for sub-recipients, according to its manual of operations. The fact that the activities in the country proposal are based on proposals received from potential sub-recipients will ease the selection process of the sub-recipients.

g) Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process.

CCM will use its previously developed mechanism, which is based on the CCM manual of operations, to select the sub-recipients. (See Annex 5) The process of sub-recipient selection was performed in the past with good and timely results.

4.9 Monitoring and evaluation

4.9.1 Plans for monitoring and evaluation

Describe how the targets and activities indicated in the Targets and Indicator Table (attached as Attachment A to this proposal, see section 4.6) will be monitored and evaluated. Please identify any surveys to which this proposal is contributing.

M&E activities for this proposal will be coordinated by the proposed PR and implemented by the proposed PR in partnership with the selected subrecipients. For the period when the activities of this proposal overlap with the activities under the current GFATM grant (2007 and 2008), all M&E activities will be closely integrated and coordinated under the leadership of CCM to ensure clarity and transparency of the results achieved with the resources from each grant. Considering that the majority of the activities proposed target populations that are hard to reach, the implementing organizations and the target groups will be closely involved in designing the monitoring and evaluation instruments and in carrying out the M&E activity.

Upon approval of this proposal, an integrated plan for M&E will be produced. It will indicate clearly what will be the main M&E activities and from which grant they come (e.g., current GFATM grant, newly approved grant or other resources).

4.9.2 Integration with national M&E Plan

Describe how performance measurement for this program is proposed to contribute to and/or strengthen the national Monitoring and Evaluation Plan for this component. If a national Monitoring and Evaluation strategy exists, please attach it as an annex to the proposal, and provide a summary of key linkages with the national Monitoring and Evaluation Plan and data collection methods.

Targets and indicators for the activities proposed are included in the current plan for monitoring and evaluating the implementation of the National TB Strategy 2006-2010. Proposed PR will establish its own capacity for M&E the results of the activities directly funded from this proposal and will liaise with the PR of the current grant and with the M&E structure established for the implementation of the overall National TB Control Strategy.

4.10 Procurement and supply management of health products

4.10.1 Organizational structure for procurement and supply management

Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

4.10.2 Procurement capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?	☐ Principal Recipient only
	☐ Sub-recipients only
	☒ Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency.

The selected PR (Romanian Angel Appeal Foundation) has procedures in place regarding national and international procurement as well as supply management according to RAA ISO Quality Management Manual and procedures attached. RAA's procurement rules are following GFATM procurement policies promoting cost-effectiveness, transparency and rapid implementation and complying with the legal framework and transparency of all procedures in regard to international and national legislation. RAA procurement policy includes open and competitive process used to select suppliers and prepares the most adequate technical specifications of products (in cooperation with recognized experts from UN agencies – i.e. for health products). The assessments of the suppliers take into consideration the results of need analysis and market research to identify the most cost-effective products. RAA procedures require technical specifications for each type of product and documented evidence of the conformity of the goods and services with international standards of quality.

RAA has demonstrated expertise in procurement under the GFATM grant phase one by successfully conducting procurement on 40% of RAA total GFATM funding (total RAA budget 2.9 million), as follows:

- national and international shopping for pharmaceutical and other health products (HIV rapid tests, medical consumables), and for non-health products (stationery, vehicles and other equipments)
- selections based on consultant qualification (for consultants, trainers)
- direct contracting (for insurance, fuel, and communications), etc.

During 2001-2004, RAA has organized and managed procurement of over 500,000 from non-GFATM sources for various goods and products: HIV testing and viral load kits, drugs, health products, equipment, and software and food supplies.

The National Administration of Penitentiaries has demonstrated expertise in procurement under the GFATM grant phase one by successfully conducting procurement of about 1 million USD, as follows:

- national shopping for civil works, health products and for non-health products
- selections based on consultant qualification (for consultants, trainers)
- direct contracting (for insurance, fuel, and communications), etc.

Regarding the other sub-recipients that are not yet identified: at the moment of selecting them their procurement capacity will be evaluated and a decision will be made at that time about whether they will have procurement activities or the PR will procure for them.

4.10.3 Coordination

a) For the organizations involved in section 4.10.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc

RAA procurement expenditure 2004-2005 represented 40% of 2.9 million budget (RAA total GF funding) including: 139,800 USD for medical consumables and HIV rapid tests and 34,000 for medical equipment.

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal.

4.10.4 Supply management (storage and distribution)

a) Has an organization already been nominated to provide the supply management function for this grant?	☐ Yes *continue*
	☒ No *go to 4.10.5*
b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. If more than one of the boxes below is ticked, describe the relationships between these entities.	☐ National medical stores or equivalent
	☐ Sub-contracted national organization(s) *(specify which one(s))*

	☐ Sub-contracted international organization(s) *(specify which one(s))*
	☐ Other *(specify)*

c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.

d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.

4.10.5 Multi-drug-resistant TB

Does the proposal request funding for the treatment of multi-drug-resistant TB?	☒ Yes
	☐ No

In GFATM Round 2 Romania had a successful application to Green Light Committee of the Stop TB Partnership. The DOTS Plus Project is continuing in phase 2.

UNIFARM is the National Company that is importing, storing and distributing the second line TB drugs procured from GLC in the Round 2 GFATM DOTS Plus project. It has the required storage conditions and capacity. It has the capacity to expand to cohorts of 160 patients added in three years of the project proposal.

4.11 Technical and Management Assistance and Capacity-Building

4.11.1 Capacity building

Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.

Romanian partners are already successfully implementing a large GFATM grant. Most of the activities proposed in the current application will expand on activities already carried out under the existing grant. Potential sub-recipients exist and they have proven capacity to scale up and expand to other geographic areas. A plan to enhance capacity building will be prepared immediately after the possible announcement that the grant was approved by the technical assistance agencies, which are members of the CCM, together with the PR. The PR has already included in its budget some capacity building activities to make the implementation smooth and coordinated.

The Nominated PR will be responsible for day-to-day management and monitoring of the grant in relationship with GFATM and CCM. The PR will ensure technical assistance and coaching to SRs in order to improve their planning and implementation capacity and will manage M&E in respect with GF requirements. At the same time, CCM will oversee the grant implementation, including PR performance,

through: regular dedicated meetings as well as impromptu meetings, decisions concerning plans for improvement/adjustment or preventive measures aimed to avoid risk in grant implementation. Additionally, the web-management system of the PR will provide a "helicopter view" of technical and financial implementation progress, This will allow CCM members to monitor at any point the evolution of grant implementation and to have access to all documentation supporting the activities. An M&E package to be used by CCM in assessing the grant implementation and PR performance is already being developed by the CCM technical work-group that will also produce two evaluation reports/year. Risk management plans will be developed by PR and presented to EC and CCM for approval. In addition, the PR will develop and implement a Communication Strategy aiming to: increase the visibility of the program's results and maintain its momentum; increase the SR's compliant to the program, maximize integration of GF activities into the National Strategy and strengthen advocacy for domestic co-funding.

4.11.2 Technical and management assistance

Describe any needs for technical assistance, including assistance to enhance management capabilities. *(Please note that technical and management assistance should be quantified and reflected in the component budget section, section 5.6)*

The PR will provide permanent assistance to the SR in management matters throughout the implementation process. RAA benefits from the experience of being a SR of GF itself and, thanks to this experience and lessons learned, is now capable to figure out the expectations of the SRs in terms of technical assistance. RAA's coordination team is also qualified in project management and financial management. Additionally, RAA's strategy in the capacity of PR includes trainings and retreat meetings with SRs in order to provide them with the necessary technical assistance.

The Nominated PR (RAA) has demonstrated good management capacity. However, due to the complexity of the program and the crucial importance of the quality performance in GF grant implementation, RAA in its turn requires some technical assistance in management on specific areas such as: Legal, M&E and Procurement:

- Legal consultancy to the PR will ensure that all legal aspects are met both in relationship with GF as well as SRs

- M&E consultancy (provided by JSI, UN) will represent added value to RAA's current M&E expertise and will enhance the national response

- Procurement consultancy for health products (provided by UN) will enhance PR's capacity of purchasing good quality, lowest price products in a reliable and timely manner.

WHO technical assistance will be requested for Programme Review, PAL strategy component and DOTS Plus Project.

PLEASE NOTE THAT THIS SECTION IS TO BE COMPLETED FOR EACH COMPONENT.

In this section, applicants will need to provide summary budget information for the proposed duration of the component. Applicants are also required to provide a more detailed budget as an annex to the proposal. For more information on budget requirements, please refer to the Guidelines for Proposals, section 5.

If part or all of the funding requested for this component is to be contributed through a common funding mechanism (consistent with section 4.6.7), **applicants should provide:**

3 Compile the Budget information in sections 5.1 – 5.6 on the basis of the anticipated use, attribution or allocation of the requested funds within the common funding mechanism; and

4 Provide, as an annex, the available annual operational plans/projections for the common

funding mechanism and explain the link between that plan and this funding request.

5 Component Budget *Tuberculosis*

5.1 Component budget summary

Table 5.1 – Funds requested from the Global Fund

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	513324	518944	526144	400012	376012	2334436
Infrastructure and equipment	329092	64149	12644	10694	10694	427273
Training	364235	340875	388155	219180	190785	1503230
Commodities and products	29300	27000	27000		37500	120800
Drugs		307200	512000	512000	204800	1536000
Planning and administration	691878	434430	546249	209446	213506	2095509
Total funds requested from the Global Fund	1927829	1692598	2012192	1351332	1033297	8017248

5.2 Detailed Component Budget

The Component Budget Summary (section 5.1) must be accompanied by a more detailed budget covering the proposal period, attached as an annex to the proposal. The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Component Budget is attached as file **"Romania TB Att.E_Budget.xls".**

5 Component Budget *Tuberculosis*

5.3 Key budget assumptions

Without limiting the information required under section 5.2, please indicate budget assumptions for year 1 and year 2 in relation to the following:

5.3.1 Drugs, commodities and products

Please use Attachment B (Preliminary Procurement List of Drugs and Health Products) in order to compile the budget request for years 1 and 2 in respect of drugs, commodities and health products. Please note that unit costs and volumes must be fully consistent with the information reflected in the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Please complete table B.1 in Attachment B to the Proposal Form.)*

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. *(Please complete table B.2 in Attachment B to the Proposal Form.)*

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Please complete table B.3 in Attachment B to the Proposal Form.)*

For example: *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs*, Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org); *First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (*http://www.stoptb.org/GDF/drugsupply/drugs.available.html*).)*

See "TB Romania Att. B Procurement Plan.xls".

5.3.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over. *(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)*

Human resources represent more than a quarter from the total budget because most of the activities proposed under this application are human labour intensive because they are focused on outreach and interpersonal activities. The salaries as all the activities will be sustained after the proposal period is over from domestic resources that will be attracted through the advocacy efforts and the transition to domestic funding strategy that is included in the current proposal.

5.3.3 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years. *(Maximum half a page. Please attach an annex and indicate the appropriate annex number.)*

Computers will be procured for PAL implementation (80) and for penitentiary system (44) for training, health education and program management activities.

5.4 Breakdown by service delivery area

Table 5.4: Estimated budget allocation by service delivery area and objective.

		Budget allocation per SDA (in Euro/US$)				
Objectives	**Service delivery area**	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
OBJECTIVE 1: Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers	SDA 1: TB PPM (Public Private Mix)	187250	133475	126575	49000	49000
OBJECTIVE 1 TOTAL		187250	133475	126575	49000	49000
OBJECTIVE 2: Protect poor and vulnerable populations from TB through targeted education and adherence interventions	SDA 1: TB: Social assistance and psychological counseling	27000	82750	82750		
	SDA 2: Prevention: BCC - community outreach	457558	224279	348529	75854	89854
	SDA 3: TB: Timely detection and quality tratment of cases	4000	5000	4000		
	SDA 4: Supportive Environment: Human resources	396705	233038	232692	231918	220623
OBJECTIVE 2 TOTAL		885263	545067	667971	307772	310477
OBJECTIVE 3: Scale up MDR TB control by implementation of DOTS plus	SDA 1: TB: MDR TB	106400	371600	581400	576400	234200
OBJECTIVE 3 TOTAL		106400	371600	581400	576400	234200
OBJECTIVE 4: Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment	SDA 1: Supportive Environment: Human resources	149525	114050	86550	106550	131550
	SDA 2: PAL strategy implementation	190300	111600	221800	84400	100900
	SDA 3: Information system & operational research	122000	176000	112800	112800	91200
OBJECTIVE 4		461825	401650	421150	303750	323650

TOTAL						
OBJECTIVE 5: Develop community support and political commitment for TB control	SDA 1: Empower people, ACSM	32250	10750			
	SDA 2: Prevention: BCC - Mass media	104350	84300	80050	14700	17200
OBJECTIVE 5 TOTAL		136600	95050	80050	14700	17200
OBJECTIVE 6: PR & CCM	SDA 1: Program management by PR	123641	122056	111946	80210	79270
	SDA 2: Strengthen CCM Capacity: monitoring, evaluation, oversees grant implementation and integration with National Programme for TB Control	26850	23700	23100	19500	19500
OBJECTIVE 6 TOTAL		150491	145756	135046	99710	98770
Total:		1927829	1692598	2012192	1351332	1033297

5.5 Breakdown by implementing entities

Table 5.5 – Allocations by implementing entities

Note: Except for subrecipients for MDR TB and penitentiaries (Governmental) and the Principal Recipient (an NGO) the other subrecipients are not yet selected. A tender will be organized if the application will be successful and any entity (academic/educational sector, government, nongoverment/community based, organizations representing people living with tuberculosis, private sector, religious/faith-based organizations etc.) will have the opportunity to participate in the tender and win.

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector					
Government	32.4	36.9	31.0	46.2	60.4
Nongovernmental / community-based org.	7.8	8.9	7.5	11.1	14.6
Organizations representing people living with tuberculosis					
Private sector					
Religious/faith-based organizations					
Multi-/bilateral development part.					
Total	40.2	45.8	38.5	57.3	75.0

5 Component Budget *Tuberculosis*

5.6 Budgeted funding for specific functional areas

Table 5.6 – Budgets for specific functional areas

	Funds requested from the Global Fund (in Euro/US$)					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and Evaluation	135122	107080	117250	70422	122702	552576
Procurement and Supply Management	36875	74840	72630	67040	27040	278425
Technical and Management Assistance	265374	162886	150186	123568	125628	827642

5 Component Budget *Tuberculosis*

Section 4 (Component specific): Component Strategy		
4.4.1	Documentation relevant to the national disease program context, as indicated in section 4.4.1.	Annex 26
4.6	**A completed Targets and Indicators Table**	Attachment A to the Proposal Form
4.6	**A detailed component Work Plan** (quarterly information for the first year and indicative information for the second year).	Annex 30
4.6.7 c) *(if common funding mechanism)*	Documentation describing the functioning of the common funding mechanism.	
4.8.3 e) *(where SRs applied but were not selected)*	Name and type of all Sub-Recipients not selected, the proposed budget amount and the reasons for non-selection.	
4.9.2	National Monitoring and Evaluation strategy (if exists)	Annex 25
Section 5 (Component specific): Component Budget		
5.2	**Detailed component Budget**	
5.3.1	Preliminary Procurement List of Drugs and Health Products (tables B1 – B3)	Attachment B to the Proposal Form
5.3.2	Human resources costs.	Not necessary – explanation given within proposal.
5.3.3	Other key expenditure items.	Not necessary – explanation given within proposal.
5.1 - 5.6 *(if common funding mechanism)*	Available annual operational plans/projections for the common funding mechanism, and an explanation of any link to the proposal.	
Other documents relevant to sections 4-5 attached by applicant:		
	Letters of support for PAL	Annex 27, Annex 28
	Programmatic gap analysis	Annex 29

4.6.9 Social stratification

Table 4.6.9 **Social stratification**

	Estimated number and percentage of people reached who are:			
	Women[1]	Youth (<18)	Living in rural areas	Other*
OBJECTIVE 1: Provide high-quality TB diagnosis and patient-centered care through training of public and private-sector providers				
SDA 1: TB PPM	2000 (44.4%) women GP/FPs		2000 (44.4%) family practitioners	500 (11.1%) family practitioners urban areas
OBJECTIVE 2: Protect poor and vulnerable populations from TB through targeted education and adherence interventions				
SDA 1: TB: Social assistance and psychological counseling	250 (1.7%) TB patients to receive incentives and enablers		500 (3.4%) TB patients in rural areas	500 (3.4) TB patients in urban settings
SDA 2: Prevention: BCC - community outreach	Enduring products (video, TB posters, etc.) will reach 120,000 (2.5%) women	1500 (30%) homeless children	20,000 (0.4%) rural residents to receive TB education (caravans); enduring products (video, TB posters, etc.) will reach 120,000 (2.5%) persons	Enduring products (video, TB posters, etc.) will reach 120,000 (2.5%) persons
SDA 3: Timely detection and quality treatment of cases	500 (9.1%) homeless women provided with TB education for early detection and treatment	Refer 550 (11%) homeless children to medical care; identify at least 160 (3.2%) homeless children and families; Completion of Therapy (COT) for 140 (2.8%) persons	2000 (44.4%) rural providers seeing 5 TB patients per yr. over 5 yrs.= 50,0000 (69%) patient beneficiaries	500 (11.1%) urban providers seeing 5 TB patients per yr. over 5 yrs.= 12,500 (17.2%) patient beneficiaries

[1] Percentages were calculated from total populations of each category (professional, homeless, general population from the target counties) because population number by gender was not available for all categories.

SDA 4: Supportive environment: Human resources	150 (1.3%) women prison staff educated during project			660 (5.5%) prison staff educated during project
	900 (2.7%) women prisoners educated regarding TB symptom			9680 (24.9%) prisoners educated regarding TB symptoms per year
OBJECTIVE 3: Scale up MDR TB control by implementation of DOTS plus				
SDA 1: TB: MDR TB	96 (9.6%) women MDR patients provided with DOTS Plus per project		240 (24%) rural MDR patients with DOTS Plus per project	240 (24%) urban MDR patients provided with DOTS Plus per project
OBJECTIVE 4: Expand capacity of the NTP to manage and coordinate national and local TB control activities through health systems strengthening and increase political commitment				
SDA 1: Supportive Environment: Human resources	1000 (83.3%) women public health providers trained		600 (50%) public health providers trained	600 (50%) public health providers trained
SDA 2: PAL strategy implementation	250 (5.5 %) women GPs trained serving 625,000 (13%) patients		240 (5.3%) rural GPs trained serving 600,000 (12.5%) patients	340 (7.5%) urban GPs trained serving 850,000 (17.6%) patients
SDA 3: Information system & operational research	160 (40.2%) female public health practitioners and researchers trained		50 (12.6%) rural public health practitioners and researchers trained	200 (50.3%) public health practitioners and researchers trained
OBJECTIVE 5: Develop community support and political commitment for TB control				
SDA 1: Empower people, ACSM	100 (21.4%) decision-makers (legislative representatives)			400 (85.5%) decision-makers (legislative representatives)
SDA 2: Prevention: BCC - Mass media	20 (16.7%) female social and health journalists trained			40 (33.3%) social and health journalists trained

4.8.2 Principal Recipient capacities

…

b) Has the nominated Principal Recipient previously administered a Global Fund grant?	☐ Yes
	☒ No
c) Is the nominated PR currently implementing a large program funded by the Global Fund, or another donor?	☒ Yes
	☐ No

…

5.5 Breakdown by implementing entities

Table 5.5 – Allocations by implementing entities

Note: Except for subrecipients for MDR TB and penitentiaries (Governmental) and the Principal Recipient (an NGO) the other subrecipients are not yet selected. A tender will be organized if the application will be successful and any entity (academic/educational sector, government, nongoverment/community based, organizations representing people living with tuberculosis, private sector, religious/faith-based organizations etc.) will have the opportunity to participate in the tender and win.

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector					
Government	32.4	36.9	31	46.2	60.4
Nongovernmental organization nominated as Principal Recipient for Round 6	7.8	8.9	7.5	11.1	14.6
Nongovernmental organizations that contributed to the proposal	59.8	54.2	61.5	42.7	25
Organizations representing people living with tuberculosis					
Private sector					
Religious/faith-based organizations					
Multi-/bilateral development part.					
Total	100	100	100	100	100