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The Global Fund

To Fight AIDS, Tuberculosis and Malaria

CCM Request for Renewal

April 2012

CCM Request for Renewal Outline

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SECTION 1: SUMMARY OF REQUEST

1.1 General Program Information

Applicant	Country Coordination Mechanism of National HIV/AIDS/STI Prophylaxis and Control and TB Control and Prophylaxis Programs	
Country	Republic of Moldova	
Component	Tuberculosis	
Component Implementation Period	01 January 2013 – 31 December 2015	
Cut-off date	31 December 2011	
Renewal date	30 April 2012	
Current Phase/Implementation Period Currency:	EUR	
Next Phase/Implementation Period Currency:	EUR	

Principal Recipient (PR) Name	Grant/SSF Number	Grant/SSF start date
PR 1: Public Institution "Coordination, Implementation and Monitoring Unit of the Health System Restructuring Project" (PI "CIMU HSRP")	MOL-T-PCIMU	October 01, 2010
PR 2: Center for Health Policies and Studies (PAS Center)	MOL-809-G05-T	October 01, 2010

1.2 CCM Approval of Request for Renewal

Role	Title / Organization	Name	Signature
CCM Chair	Minister of Health of the Republic of Moldova	Andrei USATÎL	
CCM Vice Chair	Head of Social Development Department, State Chancellery of the Republic of Moldova	Iurii BUCINSCHI	
CCM Vice Chair	Ministry of Education, Deputy Minister	Tatiana POTÂNG	
CCM Vice Chair	Chairman of the League of PLWHA	Igor CHILCEVSHI	
CCM Focal Point	CCM Secretariat Responsible	Oleg BARBĂ	
CCM Secretary	Apparatus of the Government of the Republic of Moldova	Snejana ȚURCANU	
CCM member	Deputy Minister of Health	Mihai MAGDEI	
CCM member	Deputy Minister of Youth and Sport	Octavian BODIȘTEANU	
CCM member	Deputy Minister of Finances	Victor BARBĂNEAGRĂ	
CCM member	Deputy Minister of Justice	Vladimir GROSU	
CCM member	Deputy Minister of Internal Affairs	Dumitru URSACHI	

CCM member	Deputy Minister of Labor, Social Protection and Family	Sergiu SAINCIUC	
CCM member	Head of the National AIDS Center	Ștefan GHEORGHÎĂ	
CCM member	Country Director, UNDP Moldova	Kaarina IMMONEN	
CCM member	Country Coordinator, UNICEF Moldova	Alexandra YUSTER	
CCM member	Head, Country Office of the WHO in Moldova	Jarno HABICHT	
CCM member	Coordinator, UNAIDS Moldova	Gabriela IONAȘCU	
CCM member	Coordinator, UNFPA Moldova	Boris GÂLCĂ	
CCM member	Project Manager, Social Protection, Health, Education and Youth, EU Delegation to Moldova	Cornel RÂȘCANU	
CCM member	Chairperson, AIDS Network	Antonița FONARI	
CCM member	Head, Health Department, Gagauzia	Uzun SIDOR	
CCM member	Executive Director, Soros Foundation	Victor URSU	
CCM member	Executive Director, Center PAS	Andrei MOȘNEAGA	
CCM member	Executive Director, CPU	Victor VOLOVEI	
CCM member	Chairperson, Red Cross Moldova	Larisa BÂRCĂ	
CCM member	Executive Director, Regional Centre for Community Policies	Alexandru CURAȘOV	
CCM member	Coordinator, GenderDocM	Veaceslav MULEAR	
CCM member	Chairperson, UORN	Ala IAȚCO	
CCM member	Chairman, National Confederation of Employers	Leonid CERESCU	
CCM member	Chief physician, TB Control Department, Transnistria Region	Petru DERMENJI	
CCM member	Coordinator, HIV/AIDS Control Department, Transnistria Region	Alexandru GONCEAR	

1.3 Summary of CCM Request for Renewal

1.3.1 Summary of Request

Please provide a brief overview of the current progress toward goals and objectives of the proposal as well as main observations, the recommendations and the rationale for the Request for Renewal.

This application represents a Request for Renewal of two TB grants from the Global Fund in the Republic of Moldova and covers the period of 3 years between 01 January 2013 – 31 December 2015:

1. Grant MOL-T-PCIMU (Principal Recipient 1: Public Institution “Coordination, Implementation and Monitoring Unit of the Health System Restructuring Project”, PI CIMU HSRP)
2. Grant MOL-809-G05-T (Principal Recipient 2: Center for Health Policies and Studies, PAS Center).

Both programs have been previously consolidated into Single Stream of Financing (SSF) projects from TGF TB grants obtained in Rounds 8 and 9 (in case of PR-1, Round 6 grant as well). At the stage of consolidation, the start dates and cycles were aligned across the two SSF grants. The projects are parts of one program application, implemented by two entities representing governmental sector and non-governmental sector.

The proposal is built to support the key priorities of the National TB Control Program 2011-2015, namely MDR-TB management and adherence support through multisectoral and multidisciplinary patient-centered approaches. The Government of the Republic of Moldova faces continuing fiscal constraints, exacerbated by the consequences of the global financial crisis during the last three years that have resulted in the need to reduce the overall public expenditures and reorient them towards strictly defined priority interventions, e.g. in the health sector. Nevertheless, the Government has demonstrated commitment to TB control, including sustaining and expanding financing of TB interventions.

At the same time, domestic funding resources remain insufficient to cover all costs of costly DR-TB management interventions, and the mechanisms are not yet in place to channel public resources for important community-based actions for TB, which are best implemented by the non-state actors. Therefore, the need of external funding for TB control remains important in Moldova, and the current application aims at obtaining additional resources from the Global Fund and channelling them effectively towards priorities not covered by domestic funds.

The interventions included in the proposal for Period 2 have focus on strengthening the programmatic management of drug resistant TB, supporting patients and communities and consolidating health service’s capacities for successful TB case management, with special focus on groups at high risk. The application is built to uphold the goal, scope and key directions of the ongoing TGF-financed TB program. At the same time, it complies with current TGF requirements (including 10% mandatory budget reduction for lower-middle income countries); for this purpose, the activities implemented through both Principal Recipients during the previous phase of the consolidated grants, have been re-organized under three main **Objectives**:

1. To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis;
2. To strengthen community involvement and foster partnerships for effective TB control;
3. To ensure successful TB case management through patient support and strengthening health system capacities.

Objective 1. To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis

The project will continue to support programmatic management of MDR-TB as the main priority. The proposal aims at maintaining universal access to diagnosis and treatment of DR-TB cases in the country, with enrolment of a higher number of patients in second-line treatment as required. This coverage extends to both civilian and penitentiary sectors including Transnistria region.

Activities:

- 1.1. Strengthening national capacities for management of drug-resistant tuberculosis
- 1.2. Drug resistance surveillance, diagnosis and treatment of drug-resistant TB cases

Objective 2. To strengthen community involvement and foster partnerships for effective TB control

Interventions under this Objective aim at promoting multisectoral and multidisciplinary response to TB

epidemic, with special emphasis on involving non-state actors and communities. This will be achieved through continuing support to strengthening TB community centers, small grants for NGOs, addressing special needs of high risk groups (prisoners and PLWH), involving church and conducting public awareness and communication activities.

Activities:

- 2.1. Active TB case finding and screening in prisons
- 2.2. Strengthening TB Community Centers
- 2.3. Small grants program for NGOs
- 2.4. Supporting involvement of groups at high risk of TB: PLWH
- 2.5. Involvement of church in reducing TB stigma and discrimination
- 2.6. Increasing TB awareness through peer educators' program
- 2.7. Public communication and social mobilization campaigns

Objective 3. To ensure successful TB case management through patient support and strengthening health system capacities

Under this Objective, the project supports a program for intensive patient support and follow up as a fundamental component for ensuring adherence and completion of TB treatment, including complex and lengthy treatment of MDR-TB cases. This program provides a comprehensive set of measures including incentives and enablers, psychosocial support and information / communication activities. In order to enable the health system for effective TB case management, a number of capacity building interventions are foreseen, in particular strengthening TB M&E system.

Activities:

- 3.1. Patient support for drug-sensitive TB patients
- 3.2. Patient support program for drug-resistant TB patients
- 3.3. Strengthening capacities of TB service staff
- 3.4. Strengthening capacities of PHC providers for TB care
- 3.5. Operational research on priority issues of TB control

The total amount of funds requested for Period 2 is EUR 9,643,231; it includes the TGF-mandated adjustment (10% reduction) vis-à-vis the initial TRP approved budget:

Grant No.	PR	Year 1 (2013)	Year 2 (2014)	Year 3 (2015)	TOTAL, EUR
MOL-T-PCIMU	PR-1 (PI CIMU HSRP)	2,659,450	2,687,701	0	5,347,151
MOL-809-G05-T	PR-2 (PAS Center)	1,442,070	1,508,350	1,345,660	4,296,080
TOTAL		4,101,520	4,196,051	1,345,660	9,643,231

The program workplan and budget reflect re-allocation between Principal Recipients, which is required to uphold the priority needs of treatment of MDR-TB patients (reallocation for procurement of 2nd line anti-TB drugs).

* * *

1.3.2 Proposed Changes in Programmatic, Budgetary and Implementation Arrangements

1. Are you proposing any changes in the Implementation Arrangements of the grant/program? Yes
(delete as applicable)

If yes, please indicate the nature of the change.

Reallocation of funds between PRs	Changes in institutional arrangements	Budgetary changes
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes

Please describe and provide rationale and justification for each proposed change.

The budgetary changes represent 10% reduction from the total TRP clarified amount for years 2013-2015 (Rounds 8 and 9 TB grants) as currently mandated by the Global Fund for renewals of grants in lower-middle income countries.

In order to uphold high priority interventions (i.e. treatment of MDR-TB patients), re-allocation of funds between PRs is proposed (see details below in the documents and Financial Template file).

If you are adding new PR(s) to the grant/program, please provide name(s).

Not applicable

If you are discontinuing any PR(s) in the grant/program, please provide name(s).

Not applicable

2. Are you proposing any changes to the scope and/or scale of the performance framework of the grant/program? Yes

If yes, please describe and provide rationale and justification for the proposed change.

Using the updated estimates based on the most recent epidemiological data including drug resistance burden and the resulting calculation of DR-TB management needs, the PF for Period 2 was updated to enroll a higher number of MDR-TB patients in treatment (670 and 660 for years 2013 and 2014, respectively, instead of 530 annually). Accordingly, the indicators for treatment enrolment and patient support have been adjusted.

Do the proposed changes entail material reprogramming compared to the original proposal(s)? No

If yes, please indicate and explain whether the changes affect the entire program or a specific PR.

Not applicable

1.3.3 CCM Request for Renewal

CCM Requested Budget for Renewal				
		PR 1	PR 2	Total Program
a	Adjusted TRP clarified amount for the next Phase/ Implementation Period	4,820,560	4,822,763	9,643,323
b	Total budget requested (after cut-off date to the end of the next Phase/Implementation Period)	7,848,816	6,778,541	14,627,357
c	- Undisbursed amount at cut-off date	2,265,802	1,354,163	3,619,965
d	- Cash at cut-off date	329,136	1,390,547	1,719,683
e	= Incremental amount requested	5,253,878	4,033,831	9,287,709
f	% of adjusted TRP clarified amount (cannot exceed 100% of adjusted TRP clarified amount)	109.0%*	83.6%	96.3%

* Note: The reallocation between PRs (of EUR 526,591 from PAS Center to PI "CIMU HSRP") is in order to increase the number of MDR-TB patients enrolled in second line treatment

Has the CCM taken into account any Board-approved funding limitations? Yes

(Please refer to the CCM Invitation Letter for further details).

SECTION 2: CCM GOVERNANCE

2.1 CCM Governance Overview

Please refer to the CCM Requirements listed in the CCM Request Guidelines.

2.1.1 When was the last Round that the CCM/RCM/sub-CCM applied for funding?

Round 10, August 2010

Was the CCM/RCM/sub-CCM determined compliant with the CCM requirements at this time?

Yes

If the CCM/RCM/sub-CCM was not compliant when they last applied, please describe what remedial actions were taken by the CCM/RCM/sub-CCM?

Not applicable

**CCMs/RCMs/sub-CCMs should answer questions 2.1.2 and 2.1.3, 2.1.4, and 2.1.5 (not 2.1.6)
Non-CCM applicants should proceed directly to question 2.1.6.**

2.1.2 CCM Membership

a) When was the last time that changes were made in the CCM/RCM/sub-CCM membership of people living with HIV and people affected by tuberculosis and malaria? Please provide details for those changes, including the current membership of people living with and/or affected by the diseases.

CCM membership was subjected to modifications in 2010. Those modifications were approved through the Government decision # 375 of 06.05.2010. Nonetheless, those changes did not alter the membership of PLWHA and people affected by TB. The present CCM Membership includes two members of the League of PLWHA, which consists of 58 individuals and 11 corporate members. The CCM membership includes also NGOs representing or providing services to key (TB & HIV affected) populations. They are: the Union of NGOs working in harm reduction representing CSW, IDU, MSM (1 member); GenderDocM (1 member); and Soros Moldova Foundation (1 member).

b) When was the last time that changes were made in the representation of non-government constituencies (e.g. community based organizations, faith based organizations, private sector, private academic institutions, people living with and/or affected by the diseases, key affected populations) on the CCM/RCM/sub-CCM? Please describe how new members were selected by their own constituencies based on a documented, transparent process developed within each constituency.

This CCM membership is active since 22 May 2009, when it was approved through a CCM Decision. In 2010, the CCM membership/composition was complemented and approved through a Governmental decision nr 375. (See CCM Decision No. 1 from 22 May 2009 and the Government decision No. 375 from 6 May 2010: <http://www.ccm.md/index.php?page=decizii-2>: Annex 1).

The election of CCM members on behalf of non-government constituencies (e.g. community based organizations, faith based organizations, private sector, private academic institutions, people living with and/or affected by the diseases, key affected populations) is made in accordance with the Regulations of the Country Coordination Mechanism (See Annex 2 to the Government Decision No. 825 from 3 August 2005 <http://www.ccm.md/uploads/hotarari/Regulament CNC Moldova.pdf>: Annex 2) and CCM's Operational manual, approved by CCM in 2011 (See CCM Decision No. 3 from 27 June 2011 <http://www.ccm.md/index.php?page=documente-oficiale>: Annex 3).

Thus, in accordance with the CCM Regulations, the government agencies delegate their representatives for CCM membership, while non-governmental agencies openly and transparently elect their representatives to sit on CCM and represent their interests.

Following these stipulations and election procedure, in 2009 the non-government constituencies elected their representatives as CCM members (See the attached hereby Summary of extracts from the Minutes of Civil society associations related to the selection of their representatives for CCM: Annex 4) and since that time civil society is represented in proportion of 40% in the CCM.

In 2011 CCM membership was subject to change, with respect to the representation of international agencies, which used to support HIV & TB response projects in Moldova. At the CCM meeting on 9 June 2011, CCM members considered the initiative of two international agencies (WB and USAID) to leave CCM and welcomed the request of the EU Commission in Moldova to join CCM (Annex 5). The WB and USAID requirement to leave CCM was dictated by the fact that the both agencies have no more specific projects on AIDS or TB control in Moldova.

2.1.3. Program Oversight

Does your CCM have an oversight plan which has been approved by the CCM?

Yes

If no, explain the reasons.

Not applicable

If yes, describe the oversight activities which are detailed in the plan. How has the CCM been implementing this plan? How does the CCM engage program stakeholders in oversight, including the CCM members and non-members, in particular non-government constituencies and people living with and/or affected by the diseases.

The CCM Moldova organizes the program and grants oversight procedure in accordance with the Oversight Plan, developed and approved by the CCM members for a period of two years. The oversight procedure and plan were developed in 2010 and approved at the CCM meeting on 27 June 2011 (See <http://www.ccm.md/index.php?page=documente-oficiale> : Annex 6).

The oversight responsibility lies on CCM members. They should: a) know how the programs and grants are implemented; b) what are the implementation successes and challenges; and c) make recommendations on their improvement. The oversight is carried out through: a) the programmatic dashboards evaluation (submitted twice a year by the Principal Recipients /PRs – Center PAS and PCU), b) field visits of CCM members and non-members/interested institutions to various project sites; c) CCM meetings (2 per year) for the PRs d) meetings of the technical working groups with the oversight thematic and e) all the reports of the SR are made public on the CCM web site (www.ccm.md) and the PRs ones: www.ucimp.md and www.pas.md

Late in 2010, the new elements of oversight – national Committee of Experts (dashboards) and the site visits were approved and developed, as well as made part of the CCM operational manual. Thus, the CCM launched in 2010 a process of consultations with all its constituencies to denominate 10 members for a National Committee of Experts (NCE) (an independent body), whose mandate was to directly support CCM and ensure the programmatic oversight of national programs of TB&HIV Control and GFATM grants implementation. As a result, on June 9, 2011, CCM has approved the NCE's establishment, which includes: 1 representative of the State Chancellery of Moldova; 2 rep. of the Ministry of Health; 1 rep. of the Ministry of Finances; 1 rep. of the National Company for Health Insurance, 1 rep. of UNAIDS Moldova; 1 rep. of WHO Moldova, 2 rep. of the civil society (League of PLWHA and the AIDS Network); and 1 rep. of the CCM Secretariat (without voting right) (See CCM Decision No. 2 from 9 June 2011 <http://www.ccm.md/index.php?page=decizii-2>: Annex 5). Every member of the NCE signed the declaration of interests form to commit they are not in conflicts of interests with the assignment.

The NCE meets each half a year with representatives of Principal Recipients and sub-recipients to assess (on the bases of dashboards information) the results of program implementation, make specific recommendations, and present the findings and Commission's recommendations at the CCM session.

In the fall of 2011, NCE met to evaluate the programmatic progress of TB and HIV/AIDS response grants implemented by the PRs within the period January-June 2011. At the meeting of October 21, 2011, NCE members have assessed the successes registered by the PRs and grant sub-recipients within the reporting period, addressed the challenges faced by grant implementers, and elaborated a set of recommendations:

1. Ensure that key actors (National AIDS Program Coordinator and National TB Program Coordinator) are present at the meeting.
2. The TB indicators show a high degree of regressive character in dynamics. Some are due to objective reasoning some are due to malfunctioning of the system. Ensure that TB Program Coordinator

presents at the next meeting and Action Plan for improving service delivery rates and subsequently the indicators.

3. Dashboards should be translated into Romanian as the greatest part of the members of the Oversight Committee (NCE) does not speak English. Only the Programmatic part of the Dashboard will be translated. (See the Minutes of NCE meeting and the TB dashboards: [Annex 6](#)).

Later, the programmatic oversight findings and recommendations were discussed by CCM members and approved at the CCM meeting on November 11, 2011. (See CCM decision #6 and the Minutes of the CCM meeting from 11/11/11. <http://www.ccm.md/index.php?page=decizii-2>, <http://www.ccm.md/index.php?page=procese-verbale>: [Annex 6](#)).

The field visits of CCM members & non- members to projects are facilitated by the CCM Secretariat, based on CCM interests/choice. CCM members are given the opportunity to choose among several TB and HIV/AIDS project locations.

In the fall of 2011 CCM members chose to visit: a) one of the 10 Community Centers (CCs) set up by the PR-Center PAS to support TB patients and their families in 10 administrative districts of Moldova (the Orhei CC); and b) the ARV Treatment Department and the Laboratory of the Infectious Diseases Hospital "Toma Ciorba" (project supported by RP UCIMP/CPU). The field visits participants included state and non-state members of CCM, as well as people representing communities of people affected by TB & HIV infections. Following the field visit, a field visit report was developed by the CCM Secretariat and made public on the website of CCM Moldova. (See the Field visit report attached hereby: [Annex 6](#)).

In 2012, CCM plans to:

1. Hold at least two meetings (late April and October 2012) of the NCE to assess the TB and HIV/AIDS programs and grant implementation results, on the basis of programmatic dashboards to be submitted by April 1, 2012 and September 30, 2012.
2. Organize field visits to other TB project locations.
3. Discuss the oversight results at the CCM meeting (late April 2012 and November 2012).

2.1.4 Managing Conflicts of Interest and Constituency Engagement

How does your CCM manage conflict of interest among its members and/or grant implementers who sit on the CCM? What measures are in place to ensure the CCM's conflict of interest section from your CCM governance documents is applied? How is the management of conflict of interest documented by the CCM?

The conflict of interest among the CCM members and grant implementers (PRs) who sit on the CCM is regulated in accordance with the Polity on Conflict of Interest Management, approved by CCM Moldova and its Operational manual in force since June 27, 2011 ([Annex 7](#)).

The Polity of Conflict of Interest Management defines the terms of "conflict of interest", "interested person", and "interested organization", and stipulates that:

1. Interested persons (director, chairman, member, and employee) cannot use their position and/or information hold within the institution to achieve financial or any other kind of benefits for himself or the agency he/she represents, charity or non-profit organizations inclusively.
2. The interested institution cannot use (directly or through CCM) its position and/or the decision-making power to achieve financial or any other kind of benefits for itself, a third person, or other institution, charity or non-profit organizations inclusively.

The CCM procedure of conflict of interest management states that:

- a. Any member of the CCM who realizes at the CCM Meeting or prior to it that he/she is in conflict of interest, must openly declare his/her interest and not participate in specific debates or vote on them.
- b. In case members are in conflict of interest but do not realize/admit it, any CCM member is to inform the CCM/the public about the nature of conflict, or bring that to the attention of the CCM Secretariat. The Secretariat should inform the CCM about the conflict, without disclosing the informing source.

- c. Any person who is in conflict of interest should refrain from any action that could influence the decision making process.
- d. If, following a decision taken, any CCM member reports a conflict of interest, the CCM chairman or deputy-chairman should check/verify the conflict and act correspondingly.

In order to avoid a violation of the Conflict of Interest Policy, PRs sitting on CCM, are not to participate in deliberations and decision making on issues related to: selection of PRs; re-appointment of PRs; distribution and/or reallocation of funds, GF grants inclusively; initiation/completion of transactions/contracts/other arrangements that can benefit the PR; involvement of family members in service providing activities.

All CCM members and members of the National Committee of Experts (mandated to support CCM in the process of programs & grants oversight) have signed a Declaration of Conflict of Interest, thus certifying any lack of interest on their side.

2.1.5 In case of any proposed changes in Programmatic, Budgetary and Implementation arrangements (1.3.2), please describe the documented and transparent processes followed to ensure participation of all constituencies represented on the CCM/RCM/sub-CCM (including members and non-members) in the development and approval of these changes. Please describe the process that was used to ensure effective management of any potential conflict of interest that might have affected this process.

One of CCM functions is to evaluate and recommend to the Government of Moldova solutions regarding budget estimations and identification of financial resources needed for the implementation of TB&HIV national programs.

If specific changes need to be made in Programmatic, Budgetary and/or Implementation arrangements with respect to TB or HIV response, then the initiative is preliminarily discussed amongst stakeholders active in domain. The issue is brought to the deliberation agenda of Technical Working Groups (TWGs), which adopt concrete decisions and document them. The CCM Secretariat makes public the decisions of TWGs and facilitates the organization of CCM meetings, where final decisions on Programmatic, Budgetary and/or Implementation arrangements are made in consensus. CCM meetings decisions and minutes are placed on the website of CCM Moldova.

This pattern of coordination and decision-making model was used most recently (1st quarter of 2012) with respect to:

1. CCM Moldova decision not to apply to FGATM grants within the framework of the Transitional Funding Mechanism (TFM).

The CCM Moldova Secretariat ensured the translation and dissemination of all information shared by the GFATM on TFM. Following that, the Secretariat has facilitated two consultation meetings (one with main stakeholders represented in CCM and another one with NGOs (members and non-members) of the League of PLWHA) on TFM essence, eligibility criteria, and application timeframe. The recommendations of both meetings were documented and shared with the CCM members at its meeting of February 23, 2012 (Annex 8). The CCM meeting took into account the abovementioned recommendations, further deliberated the eligibility of Moldova for the TFM grant, and decided not to apply for it.

2. CCM decision to apply to GF renewals of TB & HIV grants.

Following the translation and dissemination of all FG information on TB and HIV grant renewals, the CCM Secretariat organized, on 25/01/12 (Annex 9), a joint meeting with all TWGs on TB on grant renewals for Phase 2 of implementation. It has to be stated that the all TB and mixt TB&HIV TWGs include members of all stakeholders (government, civil society, international agencies, and people affected by TB&HIV co-infections). Based on programmatic and budgetary information presented by the PRs on TB program/grant, members of the TWGs have assessed the relevance of all activities carried during the 1st stage/phase of grant implementation (Rounds 6, 8 and 9), agreed on the need to exclude in the second phase activities that do not add vivid value to the money, and recommended CCM to apply for the renewal of a consolidated GF grant for the national TB response. The formal/documented recommendations of TB TWGs meeting were considered and supported by the CCM, which adopted (at its meeting of February 23, 2012) the decision to apply for GFATM

consolidated grant renewal. The decisions and minutes of CCM and TWGs meetings are made public and placed on CCM website.

During the “TB Diagnosis” TWG meeting, held on February 17, 2012, the list of consumables and laboratory tests to be procured in the 2013-2014 years, has been approved (Annex 9).

At the same time, during the “Management of classical TB, MDR TB and co-infection TB / HIV” TWG meeting held on March 19, 2012, the list of drugs and number of MDR-TB patients to be enrolled in the DOTS-Plus treatment in the same period of time, has been approved too (Annex 9).

A second joint meeting with all the TWGs on TB, on grant renewals for Phase 2 of implementation, was held on April 12, 2012, during which the final version of activities has been approved, including the budget, the list of indicators, the M&E Plan, the list of pharmaceutical products, consumables, and tests to be procured in the 2013-2015 years (Annex 9).

Non-CCM applicants only

2.1.6 Please refer to the original proposal(s) and provide a brief update on the status of exceptional conditions for which you were last approved as a non-CCM applicant (maximum 1/2 page).

Not applicable

SECTION 3: COUNTRY CONTEXT

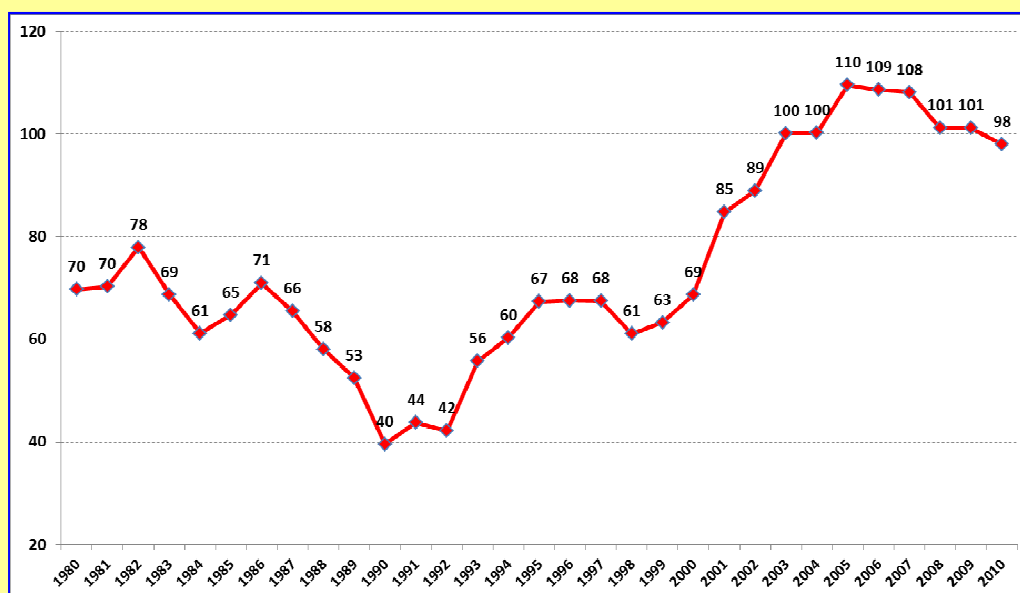
3.1 Epidemiological situation

Please describe any changes to the disease epidemiological situation that is likely to affect program implementation or strategies. (Please indicate sources of information)

The Republic of Moldova is a country in transition in Eastern Europe which gained independence after the breakdown of the Soviet Union in 1991. The total population is 4.1 million including the separated region of Transnistria (with about 0.52 million population). Tuberculosis re-emerged as an important public health problem after independence and its burden remains high in Moldova. The WHO case notification rate (new cases and relapses) in 2010 was just below 100 per 100,000 population and was the 2nd highest among the 53 countries of the WHO European Region.

Between 1990 and 2005, the number of notified TB cases (new cases and relapses) increased 2.6 times. Since 2005, there is a trend of decrease of the number of notified TB cases, which follows a trend common for the majority of Former Soviet Union countries (figure below).

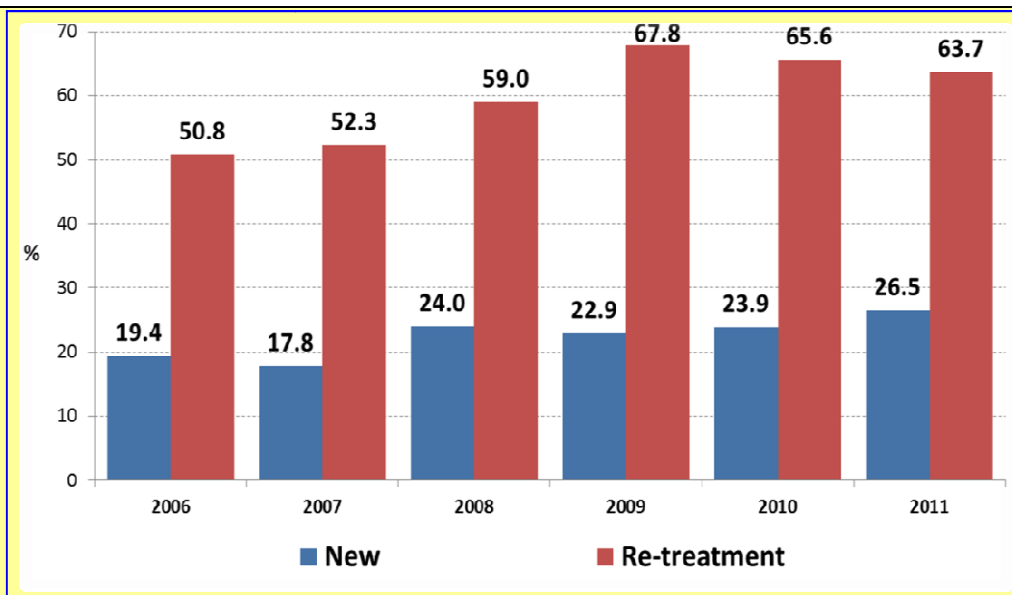
Figure. TB case notification rate (new cases and relapses) in the Republic of Moldova, 1980-2010 (source: NTP and WHO)



In 2011 (source: NTP preliminary data), there was documented an increase in TB notifications compared to the year before: a total of 4,826 new and recurrent TB cases were registered in the country (including Transnistria), which is equivalent to the rate of 103 per 100,000 population (the final 2011 notification data will be available by end-April 2012).

Resistance to anti-TB drugs represents an extremely acute and growing problem. The figure below presents MDR-TB prevalence in new and retreatment TB cases for the last 6 years starting 2006, when systematic routine drug resistance surveillance system was established. The MDR-TB levels are among the highest in the world, as reported by the most recent WHO report on drug resistance surveillance in the world (*Zgnol et al., WHO Bulletin, February 2012*). Among the overall number of culture-positive patients with DST results (both new and retreatment), almost 45% have MDR-TB.

Figure. MDR-TB prevalence rate in new and previously treated culture positive cases in the Republic of Moldova, 2006-2011, % (source: NTP/NRL)



The extremely high burden of drug resistance is the key challenge which influences program implementation from epidemiology point of view and necessitates adjustment to the program design and budget (i.e. in view of increasing number of MDR-TB patients diagnosed and requiring increased quantities and costs of 2nd line TB drugs to be procured). This application for Period 2 has been designed taking into account the epidemiological and resistance profile, which is reflected in relevant calculations (estimates) for the expected number of patients by category, in need of treatment and patient support measures.

3.2 Country Context

Please describe the relevant key changes in the national or program context (political environment, economic situation, social situation and legal context) and the effect of these on program implementation. Elaborate on the changes adversely influencing the program performance and any strategies put in place to mitigate the negative effect on the program. (Please indicate sources of information).

Although there have been changes in political situation in the country during the last three years, they have not influenced program implementation. For the period 2 (2013-2015), no further circumstances are expected in terms of political environment, economic situation, social situation or legal context that would require any substantial changes to the program design or implementation arrangements or undertake other measures to mitigate the negative effects on the program.

3.3 Health Systems Analysis

Please comment on the status of the HSS (Health System Strengthening) actions undertaken with the Global Fund and/or other domestic or partner support and how the identified health system constraints have been addressed.

Although the Global Funds in Moldova have not had special HSS components, a number of health system strengthening interventions have been implemented and they are also included in this Request for Renewal for SSF TB grants. These activities in the first place refer to strengthening involvement and participation of Primary Health Care (PHC) in TB control and strengthening cooperation between PHC and specialized TB services in TB case detection, referral, patient follow up and support under observation by PHC providers, as well as work at community level.

Priority PHC development has been the mainstay of the health system reform in Moldova since mid-1990s. The reform of primary health care was based on the introduction of Family Medicine institute, which was completed by 2001. Thus, PHC participation in TB control was greatly facilitated by the time DOTS strategy for TB control was introduced (between 2001 and 2004). PHC involvement was later further strengthened by a number of macro health system measures, which, inter alia, included changes in provider payment mechanisms within the mandatory health insurance system, e.g. introduction of performance bonuses for PHC providers for detected TB cases and completion of TB treatment.

At the same time, the emerging TB control issues, first of all high and increasing levels of drug resistance, pose

new and additional burden onto the health system in general and PHC in particular, since MDR-TB management is complex, lengthy and costly and requires increased cooperation between different care providers, stronger clinical skills of PHC staff (such as management of side effects of 2nd line TB drugs, etc.) and, importantly, changing the care delivery paradigm towards predominantly ambulatory care, introduction of patient centered and multidisciplinary approaches.

All these issues are paid significant attention by the Ministry of Health and the NTP and are being addressed through a number of measures at national, sub-national and institutional levels. Other partners (in special WHO and World Bank) are supporting the Government in further reform undertakings through a number of interventions aiming at improving main health system functions (governance, financing, care delivery and resource development) which directly or indirectly influence health system performance in regard to TB control. This application contains a number of capacity building activities for both specialized TB services and general health services, which are to be implemented under Objective 3 and are described below in this document as well as in the attached workplan.

Please answer the following question if you are submitting the CCM Request for a HSS grant/program. Otherwise proceed to the next HSS question.

In the context of the national health system strategic plan, goals and objectives, please elaborate on how the HSS grant/program has contributed to the progress towards MDGs 4, 5 and 6. Please also describe if the HSS grant/program has resulted in any demonstrable improvements in access (addressing geographic and gender inequalities), coverage and quality of services.

Not applicable

Please elaborate on any lessons learned and what health system gaps remain in scaling up the disease program.

As mentioned above, the key challenge for the Moldovan health system remains to adjust / improve the current TB care delivery model by strengthening links across all levels of care and different types of providers, first and foremost through further strengthening PHC role and performance in TB case finding and case management in conditions of high drug resistance burden. The main lessons learned during implementation of TGF support are about the need to place more emphasis on outpatient treatment, which requires introduction of multidisciplinary patient centered approaches which often extend beyond the traditional health system's boundaries and involve rigorous actions by other public services (such as social services) and non-state and community actors. In this regard, implementation experience during the first period of both SSF grants shows that the direction chosen and priorities are correct but require further streamlining and maintaining and expanding the efforts which, in the near future, will not be possible to manage by domestic resources and therefore necessitate additional TGF support.

The content of Period 2 application takes into account these lessons learned and focuses on bridging the health system gaps in regard to TB control. In particular, interventions assigned to Service Delivery Area 'Health system strengthening' (HSS) are included in the proposal under Activities 3.3 and 3.4 (grant MOL-809-G05-T, implemented by PR PAS Center) and aim at strengthening capacities of TB service and PHC service for effective TB control. Besides staff training, which will be reconfigured taking into account the emerging needs of placing emphasis on outpatient TB case management, including that of MDR-TB cases, and enabling health care providers for effective work at community level, the application also foresees upgrading of TB information, monitoring and evaluation system and program supervision, to be aligned with the revised international strategies for TB control (first of all concerning MDR-TB) and the resulting new WHO recommendations for TB information systems in the countries (Activities 3.3.3-3.3.7).

SECTION 4: PROGRAM OVERVIEW

4.1 Financial Gap Analysis, Counterpart Financing and Additionality

This section is not applicable for G20 UMICs that are no longer eligible for Renewals. Please continue to section 4.2 'Progress Towards Proposal Goals and Impact/Outcome'.

Please provide an update of the financial needs, actual and planned sources of funding, and financial gap of the disease/HSS program.

CCMs must use the 'Financial Gap Analysis and Counterpart Financing' table to provide financial information pertaining to the national program that implements the national disease strategy. Detailed instructions on how to complete the Financial Gap Analysis and Counterpart Financing table are provided in the Financial template provided with the CCM Invitation package: [Renewals_Financial_Template_FinancialRequest_ResourcesAvailable](#).

4.1.1 Overview of Government Financing of the National Program

Please specify the levels of government (central, regional, local) that incur spending on the disease programs and the major agencies through which government funds are spent. Elaborate on the availability of earmarked budget line items to capture government disease spending and the extent to which these budget line items capture total government spending on the disease program.

According to the latest WHO estimates (source: *Health For All Database, WHO/EURO, update January 2012*), public expenditures on health in the Republic of Moldova in 2009 constituted 6.4% of GDP which is the highest level in the former USSR countries and is higher than the EU average (5.8%). The share of health spending in the total government expenditure (14.1%) is also the highest in the region (CIS average: 8.7%) and is comparable to European Union countries (EU average: 14.8%). At the same time, due to the low level of national income, in absolute terms public health expenditure remained as low as 183 PPP\$ per capita in 2009 (EU: 1,609 PPP\$ per capita).

The main system of health financing and coverage in Moldova is based on national compulsory health insurance, introduced in January 2004. The funding channeled through the national insurance scheme currently comprises 90% of the total public health spending and covers all health care institutions and interventions at central and local level. The central health budget, administered by the Ministry of Health, accounts for about 10% of public health spending and is used for funding of public health services (formerly sanitary-epidemiology services), several national programs and administration at central level. The contributions to health from local (rayon level) authorities, other than MOH central state bodies as well as that of private sources is not significant and therefore is not taken into account in financial gap and counterpart financing analysis. While the TB funding needs include Transnistria, the information on funding from Transnistrian authorities is not available and therefore was not included.

In regard to funding of TB control interventions, exact financial information is available for the central MOH budget (covering mostly procurement of BCG vaccines) and, through the National Health Insurance Company (NHIC), for the following categories: payment of TB in-patient institutions, TB reference laboratories, limited support to patients undergoing intensive phase of treatment in outpatient conditions, and performance bonuses to PHC providers (for case detection and successful treatment completion under PHC supervision). At the same time, disaggregation of funding by disease is not available (and not possible) for overall PHC payments and payments to specialized outpatient services (where specialized services including peripheral laboratories are located). For these two categories, estimates were made based on previous analysis of workload, performance and financial data from several institutions (NTP and PAS Center).

4.1.2 Estimation of Current and Anticipated Domestic and External Funding

Describe how contributions from various sources of funds were estimated, including reference to:

- Methodology for estimating current and anticipated funding;
- Composition of reported government spending (part or all of government spending; programmatic costs alone or includes apportioned health system costs; recurrent costs alone or includes capital costs);
- Whether amounts contributed by each source for the current and previous years pertain to budget, disbursement, expenditure or an estimate of spending;
- Whether amounts forecast from each source for the future years pertain to estimation or commitment.

The figures on government expenditure on TB include all government spending (NHIC and MOH and MoJ central budgets, contributions of other governmental bodies are minimal). They include all costs (both recurrent and capital costs) including human resources. As mentioned above, the share of funding for TB in the

total PHC and specialized outpatient care funding was defined through estimates based on analysis of expenditures and performance in several facilities (on average, at 3.2-3.6% of PHC spending and 6.0-6.5% of specialized ambulatory care spending is apportioned for TB-related costs).

Amounts contributed for the previous years pertain to expenditures, for the current year – to budget, and for the future years – to estimations based on the commitments for overall public financing for health sector and latest trends (since 2010 which was the only year when an annual decrease in health expenditure was documented, due to fiscal constraints resulting from the global financial crisis).

Besides WHO technical support and contribution of FIND and TB REACH projects (the latter's duration is one year – 2012), no other external funding for TB control is anticipated for the coming five years. The agreement with FIND does not contain financial commitments, therefore the figures included in the table are estimates. Estimates for WHO contributions are based on current allocations for TB in the Biennial Collaborative Agreements (BCA).

4.1.3 Financial Gap and Counterpart Financing Data Sources

Please answer the following questions below:

- a. Cite the sources used to complete the financial gap analysis and counterpart financing table;
- b. Provide an assessment of the completeness and reliability of financial data reported, include any assumptions and caveats associated with the figures;
- c. Provide details of how the country plans to improve data quality consistent with the guidelines for reporting of program financial data to technical partners; and
- d. If applicable, state if the CCM Request includes a budget for an expenditure tracking study and/or measures to strengthen financial data collection and reporting during the next Phase/Implementation Period.

The information used to complete the financial gap analysis and counterpart financing table was obtained from the Ministry of Health, National Health Insurance Company and the Medical Department of the Ministry of Justice – for domestic resources; WHO country office in Moldova, FIND/ EXPAND TB and TB REACH project – for external sources.

The financial data presented are considered to be largely complete and reliable; as mentioned above, the apportionment of PHC and specialized ambulatory health care services expenditures to TB was made on the basis of estimates and therefore this should be taken into account when assessing the overall reliability of data.

The CCM does not have specific plans to conduct a TB expenditure tracking study and/or measures to strengthen financial data collection and reporting during the next implementation period; at the same time, the Government overall and the Ministry of Health work continuously in this area, e.g. on introducing a national health accounts (NHA) system and conducting different analyses, supported by the World Bank project and WHO.

4.1.4 Compliance with Counterpart Financing Requirements

Describe whether the counterpart financing requirements have been met as listed below. If not, provide justification which includes actions planned during the next Phase/Implementation Period to move towards reaching compliance.

- a. Minimum threshold for counterpart financing
→ *Percentage in Line M of the 'Financial Gap Analysis and Counterpart Financing' table must be greater than or equal to the minimum threshold that applies to the applicant's income level.*
- b. Increasing government contribution to national disease program over the next Phase/Implementation Period
→ *Figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table must increase over time.*
- c. Increasing government contribution to the overall health sector over the next Phase/Implementation Period
→ *Figures in Line I of the 'Financial Gap Analysis and Counterpart Financing' table must increase over time.*

The counterpart financing requirements have been met:

1. As seen from Line M in the 'Financial Gap Analysis and Counterpart Financing' table, the government contribution share is 74.0% and is higher than a minimum threshold set for lower-middle income countries (20%)
2. There is an increasing government contribution to national disease program over the next implementation period (figures in Line B of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).

3. There is an increasing government contribution to the overall health sector over the next implementation period (figures in Line I of the 'Financial Gap Analysis and Counterpart Financing' table increase over time).

4.2 Progress towards Proposal Goals and Impact/Outcome

Please refer to the results reported by the PR(s) for impact/outcome indicators included in the Performance Framework and provide additional updates if recent information is available (e.g. survey reports, impact assessment studies, etc.)

Impact/Outcome Indicators	Baseline		2010		2011		2012	
	Date	Baseline	Target	Result	Target	Result	Target	Result
TB mortality rate - Estimated number of deaths due to TB (all forms) per year, per 100,000 population	2009	18.0	13.0	17.8	12.0	16.1	10.0	N/A
New smear-positive TB patients, notified to the national health authorities, per 100,000 population	2009	32.1	34.39	31.2	35.12	31.25	36.10	N/A
Treatment success rate of new smear positive TB cases - number and percentage of new smear-positive TB cases successfully treated [cured + treatment completed] among the total number of new smear-positive TB cases registered in a given year, %	2009 (for 2008 cohort)	57.2	73	57.28	77	52.32	81	N/A
Treatment success rate of MDR-TB patients: number and percentage of laboratory-confirmed MDR-TB patients, successfully treated [cured plus completed treatment] among those enrolled in the second-line anti-TB treatment during a specified period, %	2009 (2006 MDR-TB cohort)	67	66	52.4	68	48.7	70	N/A
MDR-TB prevalence among new cases, %	2009	22.07	17	24.33	16	26.35	15	N/A
MDR-TB prevalence among previously treated cases, %	2009	67.36	46	65.44	44	63.80	42	N/A

NOTE: The impact and outcome indicators above are common for both grants.

Please confirm if the method of data collection and data source is consistent with the M&E framework agreed at the time of signing the Grant/SSF Agreement(s).

The methods of data collection and data sources are consistent with the M&E framework agreed at the time of signing the Grant/SSF Agreements. The projects rely on the country M&E system which is consistent with the international guidance and is based on individualized TB reporting and national electronic TB database (*TB Information, Monitoring and Evaluation System, SIME-TB*).

Is there a recent report analyzing information regarding health impact and outcome available?

Yes

If yes, when was it conducted?

June 2011, October 2011

Please summarize the main findings and include a full copy of the report with the CCM Request.

A comprehensive National TB Program Review in Moldova, conducted by the WHO Regional Office for Europe,

took place in September 2009 (i.e. before the start of SSF grants' implementation). Since then, a number of external monitoring missions to the country took place which looked at different aspects of TB control. To this application, we are attaching the reports of the three most recent missions:

1. HSS and M/XDR Mission Report (KNCV, WHO, June 2011)
2. Global Drug Facility (GDF) Monitoring Mission Report (WHO/EURO, October 2011)
3. Green Light Committee Europe (GLC-EURO) Monitoring Mission Report (WHO/EURO, October 2011)

The reports provide analysis of different components of the National TB Program (such as programmatic management of DR-TB, drug management, and health system functions in relation to TB control), including, to various extent, health impact / outcome assessment. The above reports are included in Annexes 10, 11 and 12, respectively.

Do you consider the program is making progress towards the goals and objectives of the proposal? If not, provide justification and explain how you intend to address the issues.

Both grants have achieved or succeeded programmatic targets in terms of coverage / output indicators and their performances are ranked high by the Global Fund (see more in section 5 below). At the same time, there are several factors that impede progress in improving impact and outcome targets. First, as shown in many countries, settings and programs, the lifetime period of a Global Fund project is short to document reliable improvements in impact and outcomes in TB.

Second, high burden of drug resistance is the key factor preventing from achieving progress in treatment success, which, according to the current WHO guidance, is conventionally calculated for all cases in cohort (new or retreatment), without taking into account resistance profile. In Moldova, about 45% of all patients tested for DST have MDR-TB and contribute to lowering the treatment success rates.

Third, the targets for such indicators as MDR-TB prevalence were set at the time of preparation of the Round 8 application (early 2008), when the routine drug surveillance system was just established, and there were no experiences at that time in forecasting the resistance trends (not only in Moldova but, as the recent international experience shows, in other countries as well). As a result, the targets were set with a significant expected decline over the project years, which did not take place in reality.

Fourth, nowadays WHO and other international partners are radically revising the estimates and principles for setting the targets for TB control worldwide (e.g. to take into account DR-TB issue), which had already led to some notable changes like as abolishment of such indicator as case detection rate for smear positive cases, etc.; by the end of 2012, WHO is set to come up with the revised framework for TB recording and reporting system including new definitions for case classifications and treatment outcomes including disaggregation by resistance status, and likely with revised targets for TB impact and outcome indicators.

As a result of extensive consultations in country and with international partners, first and foremost WHO, the Performance Framework for Period 2 was reviewed and revised to account for the above mentioned issues, and has been agreed within the CCM technical working group comprised by all relevant national stakeholders and international agencies. See more details in section 6.1 below and attached Performance Framework and M&E Plan.

4.3 Program Effectiveness

4.3.1 Aid Effectiveness

Did you discuss within the CCM how to improve the aid effectiveness of implementation arrangements of Global Fund financing? **Yes**

If no, please explain why no discussion took place, and then proceed to Section 4.3.2.

Not applicable.

If yes, was the process inclusive of key stakeholders, including those involved in donor coordination activities in your country? Please indicate the key stakeholders who participated in the discussion.

Although there were no meetings of CCM dedicated specifically to the issue, different aspects related to external assistance implementation (of the Global Fund and beyond) and aid effectiveness have been paid significant attention by the CCM as well as within other establishments such as the Council for Coordination of External Assistance chaired by the Ministry of Health. The discussion and consultation processes are transparent and inclusive of all relevant national stakeholders and international partner agencies.

Regarding TB, the key national partners in the CCM and beyond are the State Chancellery, Ministry of Health and central level health institutions accountable to MOH (National Center for Health Management, National Center for Public Health), National Health Insurance Company, Ministry of Labor, Social Protection and Family, Ministry of Justice, Ministry of Education and a variety of non-state actors and professional associations (see CCM list). Among participating international partners, there are country representations of the United Nations family (WHO, UNDP, UNICEF, UNAIDS, IOM, the World Bank), European Commission, Swiss Development Cooperation, USAID sub-contractors (e.g. AFEW), and others.

Please comment on the main findings.

As elsewhere, there has been a growing recognition in Moldova of the need to improve the quality of external aid and development assistance, based on the principles of aid effectiveness enshrined in the Paris Declaration on Aid Effectiveness (2005), namely ownership, alignment, harmonization, orientation for results, and accountability.

The Global Fund support is currently the main and only in most instances source of external funding support in the field of TB control in the country. An important effort has been made by the MOH and NTP, with support of external partners such as WHO, to develop, and adopt through a Governmental decree, the National TB Control Program for Years 2011-2015 ([Annex 13](#) to this application form). This document represents a platform for a comprehensive approach for effective TB control, which is nationally owned and results oriented, and provides a framework for effective implementation of external aid in a coordinated and complementary way to the national effort to be undertaken, in other words, a nationally-owned program approach setting the priorities where aid effectiveness measures are expected to improve implementation and to increase the probability of sustainable, high quality results that achieve maximum impact.

In terms of ensuring transparency and accountability of TGF financing for TB, the grants' cycles have been aligned with country cycles, and TGF financing is reflected in country budgets and in national accounting books. An estimate of the mid-term program financial needs and analysis of the funding gap is presented as part of the National Program document, and the TGF support complements available domestic resources for disease response.

To align with national systems and procedures, TGF projects use existing systems and aim at further strengthening country capacity in implementation, M&E, procurement and supply management (PSM). To streamline reporting, grant reporting have been aligned with country planning and fiscal cycles. The grant data collection and reporting rely on existing national M&E system and the national information flow. Grants' indicators and targets are in line with the national M&E plan on TB (see section 6.1.1 below). An appropriate part of the grants (in terms of number of activities / tasks as well as the budget) are allocated to M&E. Through the Global Fund project, the in-country systems for the management of pharmaceuticals and other health products are being strengthened and the experience obtained is increasingly used in the national procurement and supply management systems.

The Global Fund-financed activities are coordinated with other donor-funded activities, although, as mentioned above, the inputs from other donors in TB control have decreased substantially over the last decade (for example, after the completion of the USAID funded TB project in 2007, there was no continuation or new projects under USAID financing). Nevertheless, there is effective coordination of project implementation with technical assistance provided by external partners such as WHO.

In order to ensure sustainability of interventions initiated with TGF support, and avoid potentially negative distort the health sector workforce, the Moldova TB projects do not pay salaries for health care staff; in some instances, such as TB Community Centers, limited motivation payments are used with the scope of demonstrating the effect of interventions and trigger further takeover by the national authorities.

Based on your discussion did you identify any major risks? If so, please describe them and how you plan to address and monitor each in the next Phase/Implementation Period.

No major risks in relation to aid effectiveness issue above have been identified that may affect program implementation or require additional measures to be applied during Period 2. At the same time, the CCM will continue to monitor the issue and undertake relevant measures as necessary.

4.3.2 Equity

Did you conduct an equity assessment, or was an equity assessment conducted by the national program or other stakeholders, in the current Phase/Implementation Period? **No**

If no, please explain why an assessment was not conducted.

There is no specific assessment focused on equity relevant to TB control in the country. At the same time, relevant issues pertaining to equity are continuously assessed in different ways and are presented, inter alia, in a number of reports by development assistance partners including WHO (e.g. NTP Review 2009 and three reports attached to this Request for Renewal – see Annexes 10, 11 and 12).

Promotion of equitable and rights-based approach to health is a core principle of health protection and care in the Republic of Moldova and is stipulated in the Constitutions and relevant laws and bylaws. The key dimensions of the health system reform in the country, i.e. priority development of primary health care and ensuring fair financing and financial risk protection, are fully compliant with the equity considerations. In particular, universal mandatory health insurance system, functioning in Moldova since 2004, ensures fundamental equity and solidarity principles regarding financial contributions in health care, where the healthy persons pay for the sick, the rich pay for the poor, the young people pay for the elderly, employed persons pay for those who do not work.

The National TB Program, supported by the Global Fund grants, is built and implemented within the same framework and aims at ensuring universal access to TB services for all people regardless of age, sex, socio-economic status, geographical location, or other factors commonly considered for in terms of discrimination or limited access. It is well known that TB disease has profound socio-economic grounds and affects first of all persons from poor population groups and other disadvantaged populations such as prisoners and PLWH. In this regard, TGF program, covering the entire country (importantly, including population from the separated region of Transnistria, which is largely excluded from international development assistance and is therefore considered as underserved population) and supporting essential interventions, is seen as fully relevant in terms of upholding equitable access. Besides these, the Period 2 application aims to uphold and streamline relevant interventions targeting high risk population groups such as prisoners and ex-prisoners with TB and PLWH, as well as community interventions targeting those at highest need, especially poor rural communities).

Patients having drug resistant forms of TB are especially vulnerable in terms of risk of death as well as in terms of likeliness of incurring catastrophic expenditures during complex and lengthy treatment if essential treatment and support services are not provided free of charge at the point of delivery. The Global Fund provides support to cover funding and programmatic gaps which are currently not possible to be bridged with domestic resources, such as supply of 2nd line anti-TB drugs and a set of intensive patient and follow up interventions to ensure adherence to treatment.

At the same time, following the emerging TGF guidance, the CCM will consider conducting a comprehensive equity assessment (in TB as well as HIV grants) in due course during Period 2 of the project implementation.

If yes, please comment on the process for developing the equity assessment.

Not applicable

Please comment on the main findings of the assessment and include additional data, if available, which supports your findings (e.g. disaggregated data by relevant population groups for key indicators, findings from qualitative research, grey literature, etc.).

Not applicable

Based on your discussion did you identify any major risks (e.g. gaps in data availability or data use to assess equity, inequities in service coverage and impact/outcomes, gaps or weaknesses in planning, programming or implementation, or structural barriers)?

No

If yes, please list and describe the following: (a) how you plan to address those risks in the next Phase/Implementation Period; (b) how progress will be monitored in the next Phase/Implementation Period; and (c) how the M&E system may need to be strengthened to provide data to monitor results.

Not applicable

4.3.3 Value for Money

Please comment on the three dimensions of value for money listed below, demonstrating how the program is maximizing the health impact that can be achieved with available resources.

Economy: is the program minimizing the cost of resources and inputs whilst maintaining quality of services?

Yes. One of the key interventions supported by the program is procurement of quality assured second-line anti-TB drugs at concessionary process through GLC/GDF mechanism. In this instance, it works for both minimizing the cost (compared to much higher prices that would have been obtained through local procurement) and maintaining quality by obtaining quality products from WHO-prequalified manufacturers.

Efficiency: is the program maximizing the output that can be achieved from available resources and achieving its results at the lowest possible cost?

Yes. An example can be the work of TB Community Centers, which, although receive additional funding from TGF, have the key role to mobilize and optimize the use of existing capacities and resources (financial, human and infrastructural) for effective TB actions through multidisciplinary community-based and patient-oriented approaches, which are known to improve the results at the lowest possible cost.

Effectiveness: was the program approach and activities well designed to achieve the objectives and correspond to what needs to be done given the disease and local context?

Yes. The implementation experience shows that the program approach is well designed to achieve the objectives and fits well in the disease and local context. At the same time, as mentioned above, there are a number of factors that influence the changes at impact and outcome level; the positive changes in this regard are expected after achieving the full performance of initiated interventions which requires time and may extend until the end or beyond the program cycle.

Have any major risks been identified related to value for money?

No

If yes, describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

Not applicable

4.4 Quality of Services Assessment

This section is not applicable for a cross-cutting HSS grant/programs. Please continue to section 4.5 'Partnerships' if you are submitting the CCM Request for a cross-cutting HSS grant/program.

Please comment on systems to manage quality (quality improvement/quality assurance) that ensure adherence to national guidelines and Standard Operating Procedures (SOPs).

There are a number of measures that are currently applied in country in order to assure quality of TB services. The main document currently regulating all procedures related to TB case detection and diagnosis, TB treatment, referral and functions of different levels of involved services, case and outcome classifications, recording and reporting, supervision and M&E and other special aspects such as TB/HIV, is the Ministry of Health's Order No. 180 from 08 May 2007. Currently this document is under revision by the MOH and NTP to incorporate the emerging international guidance and recommendations and will be approved before the end of 2012. In addition, there are complementary MOH orders regulating certain aspects of TB control, in

particular in terms of PHC roles and functions and responsibilities of public health services (formerly sanitary-epidemiology services).

These national TB guidelines contain requirements for quality of services, which are to be observed by all health institutions in the country. The implementation supervision function lies with the NTP Central Unit (Institute of Phtysiopneumology, IPP), which carries this function through regular supervision visits to all peripheral TB service units in the country (and general health services sites as required), issuing and updating specific guidance and methodological materials, refreshing training of staff (in cooperation with the State Medical University and Medical Colleges) and other relevant activities.

There is a proper quality control and assurance system in TB laboratories. Standard operating procedures (SOPs) are in place in all laboratories (NRL, regional reference laboratories and microscopy centers). The NRL bears the function of quality control for microscopy and culture of all laboratories in the country through regular supervision (part of NTP M&E system); external quality assurance (EQA) for DST is carried out by the Supranational Reference Laboratory (SRL) in Borstel, Germany.

Please comment on major quality of services risks which have or could have a negative effect on performance, if any. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

No major quality of services risks are expected during the next implementation period which may have substantial negative effect on performance. The Global Fund support have substantially contributed to strengthening quality control and quality assurance; for Period 2, further support is included for several priority interventions such as NTP supervision, upgrade of the recording and reporting system and targeted capacity building activities for TB service and PHC staff.

If the RSQA (Rapid Service Quality Assessment) assessment was not conducted in your country, please continue to section 4.5 'Partnerships'

Please refer to the latest available information on quality of services annexed to the CCM Invitation Letter and provide updated information (updated national guidelines/protocols), if available.

The CCM is aware of the new TGF-developed strategy to assess quality of services and integrate this assessment in the performance-based funding model, based on Rapid Services Quality Assessment (RSQA), to be applied during program implementation by the Local Fund Agent in conjunction with the On-Site Data Verification (OSDV). The CCM is also informed that RSQA will be rolled out in a phased manner and the country will participate in the exercise as agreed upon with TGF Secretariat.

4.5 Partnerships

Using the table below, please indicate the technical assistance (TA), if any, already received in the current Phase/Implementation Period or confirmed to be conducted in the next Phase/Implementation period by the PR(s) and /or SR(s).

TA source/TA category	Current Phase/Implementation Period	Next Phase/Implementation Period
Bilateral	<input type="checkbox"/>	<input type="checkbox"/>
Multilateral	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
CSO	<input type="checkbox"/>	<input type="checkbox"/>
Private Sector	<input type="checkbox"/>	<input type="checkbox"/>
Academic Inst.	<input type="checkbox"/>	<input type="checkbox"/>
Mixed/other (specify)	<input type="checkbox"/>	<input type="checkbox"/>

Describe any current gaps and/or needs in the capacity building that are not being met by the existing TA providers.

The NTP Moldova has substantial overall technical capacities and expertise in different aspects of TB control, e.g. strengthened through a number of technical assistance activities during earlier stages of TGF support implementation. WHO through its Regional Office in Copenhagen continues to provide technical assistance and monitoring and evaluation of program interventions, e.g. through GDF and GLC monitoring missions. For Period 2, an additional need in external TA was identified by the technical working group in upgrading the national TB recording and reporting system and database in line with new WHO recommendations and is therefore included in this application (Activity 3.3.3).

SECTION 5: CURRENT PHASE/IMPLEMENTATION PERIOD PERFORMANCE

5.1 Programmatic Achievements and Management Performance

5.1.1 Programmatic Achievements

Provide an overall assessment of the progress of the PR during the current Phase/Implementation Period based on the key programmatic indicators in the Performance Framework.

Grant MOL-T-PCIMU (PR-1: PI "CIMU HSRP")

The Public Institution "Coordination, Implementation and Monitoring Unit of the Health System Restructuring Project" (PI "CIMU HSRP") is an independent legal entity which is accountable to the Government of Moldova and reports on its operations to the Ministry of Finance, Ministry of Economy and Ministry of Health. The PI "CIMU HSRP" was established in 1999 for the implementation of the World Bank and Dutch Government grants and credits for health system restructuring projects. Its structure, functions and accountability were revised and endorsed by the Decree No. 391 of the Government of the Republic of Moldova, dated April 19, 2000.

The PI "CIMU HSRP" was the Principal Recipient (PR) for the Global Fund grants since 2003 (Rounds 1, 6, 8 and 9) for both TB and HIV/AIDS components.

The PI "CIMU HSRP" at the country-level is legally responsible for programmatic results and financial accountability for the Global Fund - financed TB and HIV/AIDS grants. As a Principal Recipient for the Global Fund grants, the PI "CIMU HSRP" has established systems, processes and practices in accordance with the Donor's requirements.

As a Principal Recipient for the Global Fund grants, the PI "CIMU HSRP" role is to ensure that effective arrangements are put in place for: (i) disbursement of funds to all implementing entities (e.g. Sub-Recipients); (ii) procurement and supply management; and (iii) monitoring and evaluation, including reporting on programmatic results and financial accountability to the Global Fund and the CCM. The PI "CIMU HSRP" functions, structure, mode of operations and other details are described in detail in the Project Operations Manual (last update executed in August, 2007).

During the implementation of the 1st period of the Consolidated TB Grant (MOL-T-PCIMU), the following progress of programmatic indicators has been registered:

The average performance of all indicators accounts to 91.83% (on December 31, 2011), which corresponds to the A2 rating. From them, the average performance of Training Indicators accounts to 111,21% (which corresponds to the A1 rating for this type of indicators), and the average performance of Top 10/Top 10 equivalent indicators (including Training) accounts to 88,73% (which corresponds to the B1 rating for the Top 10/Top 10 equivalent indicators).

Thus, during the implementation of the 1st period of the Consolidated TB Grant (MOL-T-PCIMU), there were overachieved (>100%) the targets, corresponding to the A1 performance rating, for the following indicators: **number of laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment (138.13% – due to the liberalization of including criteria for the DOTS-Plus treatment); number and percentage of new and retreatment TB patients receiving diagnostic DST for 2nd line MDR-TB drugs, among the people eligible for DST, as per the national policy during the specified period (125.9%); number of medical staff trained in DOTS activities (111.21%); number and percentage of TB patients who had an HIV test result recorded in the TB register among the total number of registered TB patients (103.56%); and number of tests performed for rapid identification of R/H resistance using PCR technique (101.48%).**

At the same time, there were targets achieved in proportion of 90-100%, corresponding to the A2 performance rating, for the following indicators: **number of people receiving DOTS treatment - (Absolute**

number of TB patients with instituted treatment (directly observed treatment, short course (DOTS) based) (97.38%); and interim treatment success rate of MDR-TB patients: number and percentage of MDR-TB patients who have negative culture at the end of 6 months of treatment (93.95%).

For 5 indicators, there were targets achieved in proportion of 60-89%, which correspond to the B1 performance rating: **number of new smear-positive TB patients reported to the national health authority (88.68%); number and percentage of new and retreatment TB patients receiving DST for the first-line TB drugs, using the automated MGIT technique, among the people eligible for DST, as per the national policy during the specified period (88.48%); number and percentage of laboratory-confirmed MDR-TB patients, successfully treated (cured plus completed treatment), among those enrolled in the second - line anti-TB treatment (71.61%):** the low success rate (48%), registered for the last analyzed cohort of the 2008 year, is determined by the (1) diagnosis of many cases with an advanced disease degree, with low therapeutic success rate, (2) failure or impossibility to finalize the treatment in the continuation phase (usually in ambulatory conditions) in a number of cases, (3) liberalization of the treatment including criteria, which has determined an increasing number of patients enrolled in the DOTS Plus scheme (including re-treatment cases); the situation described above is explained by (1) the low level of compliance of patients due to their psycho-behaviorist specificity; (2) lack of socio-material support of patients, leading to treatment abandonment; and (3) insufficiency of medical staff in both the PHC and the Phthisio - Pneumology systems, necessary to ensure the treatment success; **number and percentage of new smear-positive TB cases, registered under DOTS, who are successfully treated (67.95%):** the low annual success rate for the 2010 cohort (52.32%) is determined by the (1) high level of MDR TB among both new and retreatment cases; (2) diagnosis of the lot of cases with an advanced disease degree, with low therapeutic success rate; (3) failure to finalize the treatment in the continuation phase (usually in ambulatory conditions) in a big number of cases; and **percentage of prisoners screened for TB using MRP mobile equipment (65.51%):** the low actual result (62.33%) is due to the technical deficiencies of the mobile MRP equipment, encountered during the 2011 year. The PI "CIMU HSRP" has procured pressure stabilizers for all the three units of mobile MRP and intends to sign a post-warranty contract with the supplier-company of the given equipment to ensure its adequate functionality and rapid reparation of possible deficiencies.

For 1 indicator, there was a target achieved in proportion of 30-59%, corresponding to the B2 performance rating: **number of released prison inmates on TB treatment supported through the TB treatment follow-up program (40%),** while a deeper analysis of this indicator reveals a completely reversed situation. So, there is a decreasing tendency registered, during the previous years, in the number of notified TB cases in prisons (from 245 in 2008 to 132 in 2011). As a result, the number of released prison inmates with TB has also decreased (from 111 persons in 2008, to 112 persons (2009), 76 persons (2010), and 81 persons in 2011); together with the number of released prison inmates with TB on DOTS or DOTS Plus treatment (from 84 persons in 2008 to 79 persons (2009), 59 persons (2010), and 53 persons in 2011). In effect, if to consider the total number of 53 released prison inmates on TB treatment in 2011 (out of which, 3 persons were foreign citizens subsequently deported out of the Republic of Moldova), the % achievement of this indicator for the 2011 year shall account to 94.33% (50 of released prison inmates on TB treatment supported through the TB treatment follow-up program /53 of released prison inmates on TB treatment). In the end, the performance rating for this indicator is A2.

Since for the implementation of the 2nd period of the Consolidated TB Grant (MOL-T-PCIMU), the financing of activities (consolidated from Round 6 grant), directed to the drug-sensitive TB control activities support, such as procurement of consumables and reagents for microscopy investigations, procurement of 1st line TB drugs, organization of trainings for medical staff, holding activities of Communication, Information, and Education for the TB patients and the general public, is coming to an end, the indicators describing the progress of these activities shall be further excluded from the list of indicators of the PR (PI "CIMU HSRP"). There will be

emphasized the indicators directed to the MDR TB control activities, i.e. the ones to be further carried out by the PI "CIMU HSRP".

Since the MDR TB level among the new and retreatment TB cases is much higher than the estimations formulated in the Applications for the GF Round 6 and 8, following the re-programming of budget sources for the initially planned activities, additional EUR 526,591 shall be redirected for the procurement of 2nd line MDR-TB drugs, in order to increase the number of MDR TB patients included in the DOTS Plus treatment (from 1,060 to 1,330 persons in the 2013-2014 years).

Grant MOL-809-G05-T (PR-2: PAS Center)

The Center for Health Policies and Studies (PAS Center) was established in 1999 and is a Moldova-based, non-governmental, non-political, non-for-profit organization. Its mission is to build up a democratic society through contribution to the health and social sectors development, policy advocating, capacity building and support to reforms. PAS Center works in close collaboration with the Ministry of Health and other governmental bodies as well as with relevant international and national partners.

PAS Center had been acting as a Sub-Recipient for grant funds within the Round 6 TB GFATM, being responsible for organization of training activities for TB and PHC service providers on DOTS and DOTS-Plus, revision of curricula and guidelines, training in TB surveillance system and conducting public awareness campaigns. Currently PAS Center acts as the Principal Recipient for three Global Fund grants: HIV Round 8 grant, TB Round 8 grant and TB Round 9 grant (the latter two grants were consolidated under Single Stream Funding in 2010). Another important program implemented by the PAS Center is 'Preventing Hepatitis B and C in Moldova' project financed by the World Bank (2009-2012). The total amount of funds within the externally financed programs and project that were implemented or committed / in course of implementation by the PAS Center during the last 3 years amounts to EUR 27.5 million (about USD 35.7 million).

Regarding performance of the consolidated TB grant (MOL-809-G05-T), after some delays in implementation of planned activities at the initial stage of the grant, during the second half of 2011 the program demonstrated a significant improvement in its achievements and catch up in program implementation. The reported programmatic performance was rated "A1" with the average achievement rate for all indicators due for reporting being 110% and the average performance rate for Top Ten indicators (including trainings) being 107%. Out of 8 indicators due for reporting in the current period, the targets for seven indicators were overachieved (over 100%) and for only one indicator substantially achieved (87%).

The significant progress and cash up of the program is reflected in the results. As of 31 December 2011 ten DOT community centers were renovated, equipped and opened, and the work of informational and educational rooms in TB hospitals was launched. 1,636 TB patients and 254 MDR-TB patients received food packages during the reporting period.

Out of 8 indicators due for reporting 4 were related to trainings and during the reporting period 249 TB service staff were trained in DR -TB management; 550 medical personnel in TB control, community involvement and methods of work with different groups of population, and 1,706 volunteers, NGOs representatives, priests, peer educators, journalists and local stakeholders in different aspects of TB, including TB community aspects and TB/HIV.

The description of the indicator "Number of new TB patients provided with DOTS plus program who are receiving incentives and enabler for improved treatment compliance" was updated through the Implementation letter #1 dated 24 November 2011 as follows: "Number and percentage of new TB patients in ambulatory phases provided with DOT support by the community". The updated indicator is calculated on the basis of the proportion of TB patients in ambulatory phases provided with DOT support by community centers against the total number of TB patients in ambulatory phases reported to the health authority in the same

administrative area. The target for this indicator (activity performed by SR Carlux) was achieved by 87% due to the initial delay in renovation and opening of the ten DOT community centers in the country. However, it is expected that the program will catch up with this delay during the next period.

Please provide a description of the related actions the CCM/RCM/sub-CCM will take, in its oversight capacity, to address these identified performance issues?

CCM owns the oversight mechanisms described in point 2.1.3 of this template (Bylaws, Operational Manual, oversight Plan).

Please summarize the current challenges in M&E systems and capacity based on any recent assessment undertaken during the current Phase/Implementation Period, and provide an update on status of implementation of M&E systems strengthening recommendations supported through Global Fund grant/SSFs and other partners during the current Phase/Implementation Period. Please also comment on the expenditures on M&E (variances, if any) against approved funding under the Global Fund grant/SSF during the current Phase/Implementation Period.

The Government of Moldova, in collaboration with international partners, has developed and endorsed the concept of a comprehensive National Monitoring and Evaluation (M&E) system for health. This concept recognizes its advantages and importance over separate systems that monitor separate initiatives, programs and projects. A multi-stakeholder Technical Working Group on M&E has been established within the CCM, which acts as 'one national authority' coordinating national responses to HIV/AIDS/STI and TB epidemics.

Following the UN recommendations to implement 'The Three Ones' principle, the functions of the single M&E mechanism for the diseases concerned were delegated to the Monitoring and Evaluation Unit of the National Centre for Health Management (NCHM) of the Ministry of Health. This unit is in charge of M&E of the National Programs on Prevention and Control of HIV/AIDS/STI and TB. At present, a full design of the M&E system has been conceived with a set of indicators agreed upon by all major stakeholders according to the international recommendations of Stop TB Partnership, UNAIDS and UNGASS. At the moment, the National M&E Plans TB exists in his advanced draft. After finalization, the plan will be discussed again and submitted to the Ministry of Health / CCM for approval. The plan will include activities and strategies aimed at capacity development, advocacy and technical assistance.

The NCHM has been appointed and is responsible for the implementation of different activities related to the program monitoring and evaluation under Global Fund Round 6, 8 and 9 grants (TB and HIV/AIDS components). This function is carried out by the Monitoring and Evaluation Unit, established within the NCHM in 2004.

The M&E Unit of the NCHM is responsible for monitoring and evaluating the national health programs and other interventions and activities aimed to improve public health. The main functions of the M&E Unit are:

- Design and implementation of M&E systems for national health programs and other health development initiatives at the country level;
- Collecting, processing, analyzing and interpreting relevant information for the M&E systems;
- Conducting operational research in priority areas relevant to M&E of the national health programs;
- Development and publication of analytical reports based on the information from the health programs' M&E systems;
- Development, implementation and maintenance of the electronic informational monitoring systems within the national health programs and initiatives, information support to the activities of the NCHM and other health institutions engaged in data collection, processing and analysis;
- Provision of technical assistance and capacity building support to the Ministry of Health and health care institutions and specialists in data collection, processing and analysis, use of new information technologies and other topics relevant to health programs' M&E;
- Development and maintenance of the web page and online applications for M&E of the health programs and other initiatives.

The collection and management of data for the Global Fund grants is integrated within the overall activity of the M&E Unit. The Unit is in charge of elaboration and implementation of the M&E plans for the National Programmes on Prevention and Control of HIV/AIDS/STI and TB for 2011-2015. It functions as a sole monitoring and evaluation mechanism at the country level for these diseases.

The M&E Plans for the Global Fund projects derive from the National M&E Plans for the above National Programmes and will mainly collect and process data through established mechanisms. This will ensure coherency and comprehensiveness of M&E arrangements and their integration with the National M&E Plans, strengthen the in-country capacities and collaboration with partners, and contribute to ensuring the sustainability of the robust national health M&E system in the future.

The data received from the implementing organizations are stored at the M&E Unit of the NCHM and summarized and submitted to relevant bodies (including the Global Fund projects' Principal Recipients) on a quarterly basis. In order to improve the routine statistics for TB, especially regarding case notifications and treatment success indicators, a special software program was developed (SIME TB: computerized TB Monitoring and Evaluation System). The central database is located at the national level (NCHM M&E Unit). Using the synchronization procedure, the local (district) levels enter data and transfer them to the central database and vice versa. The laboratories are also part of this system and are involved in the data exchange.

During the implementation of the 1st period of the consolidated TB grants, there have been financial resources forecasted for the M&E system strengthening activities, such as: (i) extension and adjustments of the existing TB reporting software (SIME TB), including costs of maintenance for the system, salaries for IT personnel; (ii) extension and strengthening of the system infrastructure; (iii) trainings for involved personnel, including training for involved personnel in use of SIME TB and data collection tools fulfilment, and national and international trainings of involved in TB data analysis personnel of the M&E Unit of the NCHM; (iv) support to realisation of the operational researches in on priority problems of DR-TB; and (v) support for operational costs of the M&E Unit of the NCHM including salaries for personnel, costs of office consumables, cover of phone communications and fuel for visits in territories.

On December 31, 2011, the cut-off date, EUR 118,708.95 were disbursed by the PI "CIMU HSRP" for the support of M&E activities, which represents 67.5% of the financial resources initially forecasted (EUR 175,922.50). The difference of EUR 57,213.55 is given by the **commitments** (EUR 25,000) scheduled for operational studies (National DR Survey 2011 and Nosocomial transmission of the tuberculosis in TB hospitals in Moldova), delay in realization of audit of TB service (EUR 18,700) and savings (EUR 13,300) obtained during activities' implementation.

5.1.2 Grant/SSF Risk Management

Please comment on the major grant/SSF management risks and issues, if any, including those attached to the CCM Invitation Letter. Describe how you plan to address those risks and monitor progress in the next Phase/Implementation Period.

No major grant management risks and issues were included in the CCM Invitation Letter. The same mechanisms of grant management (programmatic, financial, M&E, and quality of the data reported to the Global Fund) used during implementation of the period I of the grant will be used by the PRs during period of 2013-2014 years.

5.1.3 Grant Performance Rating

Please answer the following questions if you are submitting the CCM Request for a Phase 2 or RCC Phase 2. If you are submitting the CCM Request for Periodic Review, proceed to section 5.2 'Financial Performance'.

Grant Performance Rating for the current Phase (Phase 1/RCC Phase 1)

A1
 A2
 B1
 B2
 C

Please provide a rational and justification for the rating.

Not applicable

5.2 Financial Performance

5.2.1 Financial situation at cut-off date

Cash at cut-off date

*Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package [Renewals_Financial_Template_FinancialRequest_Cash-at-cut-off-date](#) – the CCM must paste a **screenshot** of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!*

Grant MOL-T-PCIMU (PR-1: PI “CIMU HSRP”)

	PR	SRs	Total
a. Disbursed to PR to cut-off date	4,531,889	N/A	4531889.11
b. Less: Disbursed from PR to SRs	-142,473	142473	0
c. Less: Expenditure incurred to cut-off date	-4,173,373	-108,717	-4282089.73
d. Add: Interest received	79,336		79336.45
e. Add: Other income - please specify			0
f. Equals: Cash at cut-off date	295379.88	33755.95	329135.83

Grant MOL-809-G05-T (PR-2: PAS Center)

	PR	SRs	Total
a. Disbursed to PR to cut-off date	2,903,017	N/A	2903017
b. Less: Disbursed from PR to SRs	-1,180,441	1180441.296	0
c. Less: Expenditure incurred to cut-off date	-836,645	-982,129	-1818774.633
d. Add: Interest received	46,065		46064.75
e. Add: Other income - please specify	260,240		260239.9
f. Equals: Cash at cut-off date	1192235.064	198311.9534	1390547.017

Please include a **Liabilities summary at cut-off date** with the CCM Request (goods and services received/ordered but not yet paid for).

As of 31 December 31, PR-1 (PI “CIMU HSRP”) had liabilities of a total amount EUR 1,060,902.55 for the goods, services, consultancies received/ordered but not paid yet. For more information please see [Annex 14](#).

At the same date, PR-2 (PAS Center), had liabilities of a total amount of EUR 481,204 (see [Annex 15](#)).

Have all liabilities at cut-off date been taken into account in the post-cut-off date budget?

Yes

5.2.2 Analysis of expenditures versus budget

With reference to the latest available EFR at cut-off date, please summarize the main reasons for any under-spending or over-spending against budget.

Grant MOL-T-PCIMU (PR-1: PI "CIMU HSRP")

According to the latest Enhanced Financial Reporting as of December 31, 2011, the cumulative budget of the grant MOL-T-PCIMU was EUR 4,214,031.16 and expenditures incurred amounted EUR 4,315,845.68. The cumulative figures on budget and expenditure and explanation on variances are presented in the table below.

#	Category	Cumulative budget	Cumulative expenditure	Variance	Reason for Variance
1	Human Resources	281,620.50	298,993.08	-17,372.58	The difference is caused to hiring additional PR staff. Also, the taxes related to salaries paid were higher than budgeted figures.
2	Technical Assistance	22,480.00	8,364.80	14,115.20	(1)There is a committed TA related to TB Drug management (13,3K). (2) Also there is a small difference related to currency difference from SR PAS (the agreement signed with them is in USD).
3	Training	117,359.60	87,699.36	29,660.24	(1) Savings were obtained related to external training of SYME TB personnel and related to NTP personnel. (2) Also, activities of SR NGO Carlux started later and as a result expenditures for trainings will be made later.
4	Health Products and Health Equipment	410,817.23	469,507.70	-58,690.47	(1) There were payments for additional procurements for stabilizers for X-Ray mobile equipment and related spare parts not budgeted initially (18K). (2) The prices for some products were higher than initially budgeted (ex: X-ray films for digital equipment, nutritive media for culture investigations and DST, respirators FFP3 for medical staff, and for some small equipment for TB reference laboratories).
5	Medicines and Pharmaceutical Products	1,627,796.86	1,867,157.48	- 239,360.62	(1) There was an advance payment related to 1st line anti-TB. (2) The prices of the drugs are higher than initially budgeted.
6	Procurement and Supply Management Costs	142,867.78	284,150.87	-141,283.09	(1) Initially the costs related to PSM were under estimated. (2) Costs related to external quality control of medicines (first and second line anti-TB) were not budgeted at all.
7	Infrastructure and Other Equipment	1,062,370.00	964,463.49	97,906.51	(1) There are unspent commitments related to 2 contracts for renovation of Vorniceni TB hospital 51K; and savings obtained in the amount of about 18K. from the same contracts. (2) There is an unspent commitment (14K) related to the procurement of car for NCHM and maintenance of NTP cars (15,3K).
8	Communication s Materials	63,005.10	55,568.20	7,436.90	(1)Activities of SR NGO Carlux started later and as a result expenditures for communication materials will be made later. (2) Also there is a small difference related to currency difference from SR PAS (the agreement signed with them is in USD).
9	Monitoring and evaluation	168,763.00	71,584.47	97,178.53	(1) There are delays in the amount of 23,9 K, namely: 2 operational studies which are under realization by TB Institute. Final payments will be made in semester 1. 2012 according to signed contracts; (2) There is a delay (18,7K) in realization of the audit of TB services. Tender for contracting of consultant for elaboration of audit methodology was closed due to the absence of offers from qualified consultants. Retender was organized and contract signed in Q1 2012. (3) There are savings in the amount of around 50K, namely: from monitoring visits, contract tracing related to TB patients, printing of TB forms, TB annual reports and realization of MESS plan.
10	Living support to Clients/target Populations	33,982.50	16,956.17	17,026.33	There are un-spent commitments due to the fact that the SR Agreement with NGO Carlux for providing the support for follow-up program for just released ex-prisoners TB patients was signed later than scheduled, there is a delay in implementation. Also, the number of TB patients in prisons decreasing during the last years, as a result the number of released TB patients on treatment decreasing too. It is not excluded that savings will be obtained by the end of 2012. The situation will be

					clearer by the next reporting period (at 30 June 2012).
11	Planning and Administration	125,604.40	78,835.10	46,769.30	The payment related to GLC 2011 annual fee was not made. Payment is under negotiation between GF and GLC.
12	Overheads	76,678.08	73,039.22	3,638.86	No major variance
13	Other	80,686.11	39,525.74	41,160.37	The line represents interest accumulated on the project account which is the part of the Grant and is used for operational activities and deficient amounts related to other activities under the grant necessities.
	TOTAL	4,214,031.16	4,315,845.68	-101,814.52	

Grant MOL-809-G05-T (PR-2: PAS Center)

According to the latest Enhanced Financial Reporting as of December 31, 2011, the cumulative budget of the grant MOL-809-G05-T was EUR 3,066,327.60 and expenditures incurred amounted EUR 2,017,086.81. The cumulative figures on budget and expenditure and explanation on variances are presented in the table below.

#	Category	Cumulative budget	Cumulative expenditure	Variance	Reason for Variance
1	Human resources	580,723.57	400,791.03	179,932.54	EUR 84,129 from the variance are unused from the line 1.1.5. From this amount EUR 11,200 are committed to pay salaries for the multidisciplinary team at Community Center in Ribnita, EUR 6,175 are forecasted to request the permission of GF to organize one additional training for multidisciplinary teams of CC on ACSM and counseling abilities. The rest of the variance is due to undisbursed funds to SFM (budget line 1.2.1, 2.2.5, 3.2.4, 8.1.2). The disbursement will be performed in semester one of 2012.
2	Technical assistance	62,841.72	12,794.34	50,047.38	EUR 9,870 committed for experts and consultants who will monitor public awareness campaign in rural area in February-March 2012. EUR 6,236 are committed to payment of consultant (budget line 6.3.1, contract nr. 256 TB-CONS/2011). EUR 1,111 unused funds are committed to SRs. Part of variance comes from some errors in distribution of the approved budget of the Grant by category.
3	Training	314,055.54	225,539.31	88,516.23	The variance is mainly due to the undisbursed funds to SFM (budget line 1.2.2, 1.2.3, 2.2.1, 2.2.4, 3.2.1,). The disbursement was not performed, due to the late signing of the contract with this sub-recipient. No request for disbursement was received from June 2011. Other part of the variance is explained by delayed activities on budget line 4.3.1 and 4.3.5. As well, IFP, SFM and PAS Center obtained better prices for the training/conference costs and EUR 21,526 are savings.
4	Health products and health equipment	0	0	0	
5	Medicines and pharmaceutical products	0	0	0	

6	Procurement and supply management costs	131,131.45	103,569.00	27,562.45	The variance is mainly due to the undisbursed funds to SFM (budget line 2.2.5, 3.2.4, 8.1.1). The disbursement was not performed, due to the late signing of the contract with this sub-recipient. As well, the sub-recipient Carlux didn't request the entire disbursement for budget line 6.3.5 and 8.1.2. The mentholated disbursements will be performed in semester one of 2012.
7	Infrastructure and other equipment	829,408.00	363,943.83	465,464.17	The variance is due to the readdressed funds from budget line 5.1.1 to renovation of new MDR-TB building in Vorniceni and unspent funds for renovation of penitentiary hospital Pruncul (EUR 333,051). Another part of the variance comes from budget line 1.1.2 and 3.3.1, where PAS Center obtained better prices for renovation works and for which, the PR will address a request for re-allocation in due course.
8	Communication materials	258,712.00	113,269.83	145,442.17	Mainly the variance is due to delayed activities. It was more efficient to postpone the printing, in order to avoid the storage of a big amount of ICM. The undisbursed to SFM, as well contributed to the variance. The disbursement will be performed in semester one of 2012.
9	Monitoring and evaluation	109,688.33	24,897.96	84,790.37	The variance is due, mainly, to the budget line 1.1.8, where the consultant was not hired. Due to the late opening of community centers, the input could be evaluate only starting in 2012, after 7 months of community centers activity. As well, the M&E costs included in budget of SFM were not disbursed. The mentholated disbursements will be performed in semester one of 2012.
10	Living support to clients / target populations	636,649.94	619,150.28	17,499.66	The variance is due to the undisbursed funds to sub-recipient Carlux. The disbursement will be performed in semester one of 2012.
11	Planning and administration	143,117.05	153,131.23	-10,014.18	The variance is due to interest income on bank account used for the office loan of PAS Center (EUR 46,064.75), for the period of implementation of Grant (as per GFATM approval).
12	Overheads	0	0	0	
	TOTAL	3,066,327.60	2,017,086.81	1,049,240.79	

Please comment on whether the overall % expenditure versus budget variance at the cut-off date is in line with the average % achievement against all indicators in the performance framework. If not, please explain the reasons.

For grant MOL-T-PCIMU, the overall expenditures match the budget; the overall performance of all indicators at cut-off date (December 31, 2011) is 91.83%. The total grant rating at the cut-off date is A2. There is a direct correlation between overall financial performance % at the cut-off date and the average % achievement against all indicators in the performance framework.

For grant MOL-809-G05-T, the cumulative expenditure rate at cut-off date was 66% of the budget; however, the most of delayed activities from 2011 are implemented in the 1st semester of 2012. The PR's expenditures for the last 6 months before the cut-off date constituted 90% of the semi-annual budget. At the same time, the

programmatic performance of the project and the total grant rating at 31 December 2011 is A1, with the average achievement rate for all indicators being 110% (107% for Top Ten indicators).

SECTION 6: CCM REQUEST FOR RENEWAL

6.1 Programmatic Proposal

6.1.1 Program Objectives, SDAs, Indicators and Targets

Please provide a Performance Framework for the next Phase/Implementation Period and comment on whether indicators and targets are aligned with the national program strategy, plans and systems.

This application represents a Request for Renewal of two TB grants from the Global Fund in the Republic of Moldova and covers the following periods:

1. Grant MOL-T-PCIMU (Principal Recipient 1: Public Institution “Coordination, Implementation and Monitoring Unit of the Health System Restructuring Project” [PI CIMU HSRP]) PI): 01 January 2013 – 31 December 2014
2. Grant MOL-809-G05-T (Principal Recipient 2: Center for Health Policies and Studies [PAS Center]: 01 January 2013 – 31 December 2015.

Both programs have been previously consolidated into Single Stream of Financing (SSF) projects from TGF TB grants obtained in Rounds 8 and 9 (in case of PI CIMU HSRP, Round 6 grant as well). At the stage of consolidation, the start dates and cycles were aligned across the two SSF grants. As the projects are parts of one program application, implemented by two entities representing governmental sector and non-governmental sector, and complement each other, this section provides description of the content of the Request for Renewal for both consolidated grants (and, respectively, both Principal Recipients), with indication of implementation arrangements and other aspects by PR as required.

The proposal is built to support the key priorities of the National TB Control Program 2011-2015, namely MDR-TB management and adherence support through multisectoral and multidisciplinary patient-centered approaches. The Government of the Republic of Moldova faces continuing fiscal constraints, exacerbated by the consequences of the global financial crisis during the last three years that have resulted in the need to reduce the overall public expenditures and reorient them towards strictly defined priority interventions, e.g. in the health sector. Nevertheless, the Government has demonstrated commitment to TB control, including sustaining and expanding financing of TB interventions. An example is the takeover of funding of supply of first line anti-TB drugs and conventional laboratory techniques, previously provided by TGF (from Round 6 grant expiring in the end of 2012); the Government bears substantial costs of staff and facility expenses.

At the same time, domestic funding resources remain insufficient to cover all costs of costly DR-TB management interventions, and the mechanisms are not yet in place to channel public resources for important community-based actions for TB, which are best implemented by the non-state actors. Therefore, the need of external funding for TB control remains important in Moldova, and the current application aims at obtaining additional resources from the Global Fund and channelling them effectively towards priorities not covered by domestic funds.

OBJECTIVES, SERVICE DELIVERY AREAS AND INTERVENTIONS

The interventions included in the proposal for Period 2 are aligned with the priorities of the National TB Control Program and are continue to have focus on strengthening the programmatic management of drug resistant TB, supporting patients and communities and consolidating health service’s capacities for successful TB case management, with special focus on groups at high risk. The application is built to uphold the goal, scope and key directions of the ongoing TGF-financed TB program. At the same time, it complies with current TGF requirements (including mandatory budget reduction); for this purpose, the activities implemented

through both Principal Recipients during the previous phase of the consolidated grants, have been re-organized under three main **Objectives**:

1. To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis;
2. To strengthen community involvement and foster partnerships for effective TB control;
3. To ensure successful TB case management through patient support and strengthening health system capacities.

A brief description of activities under each Objective is presented below.

Objective 1. To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis

The project will continue to support programmatic management of MDR-TB as the main priority. The proposal aims at maintaining universal access to diagnosis and treatment of DR-TB cases in the country, with enrolment of a higher number of patients in second-line treatment as required. This coverage extends to both civilian and penitentiary sectors including Transnistria region.

Activity No.	Activity No. and title	Service Delivery Area
1.1	Strengthening national capacities for management of drug-resistant tuberculosis	MDR-TB
1.2	Drug resistance surveillance, diagnosis and treatment of drug-resistant TB cases	MDR-TB

Implementing entity: PR-1 (PI "CIMU HSRP")

Activity 1.1 includes support to the Green Light Committee operations according to the Global Fund requirements: annual payments of equivalent of USD 50,000 for technical assistance and monitoring visits in the country for revision of the implementation of the DOTS-Plus treatment of the MDR TB patients.

Under DR-TB surveillance and diagnosis component, the project will continue support to strengthening of the TB laboratory network by provision of consumables for rapid diagnostic tests for the reference laboratories. Culture and DST to 1st line drugs will be performed to all smear-positive patients (both new and previously treated cases) using rapid techniques (automated MGIT method for isolation and polymerase chain reaction (PCR) method for rapid identification of R/H resistance). Culture will be also performed for verification of diagnosis to smear-negative pulmonary patients. Procurement of necessary consumables and reagents for automated MGIT and HAIN equipment, DST and rapid identification tests for the reference laboratories is foreseen for the next implementation period. The estimation of the quantities was made on the basis of forecasts of expected patients' numbers and resistance trends (please refer to the Excel file in **Annex 16** for formulas used and calculation details, sheet "Estimations 27.01.12").

Support is requested for a number of measures to strengthen infection control in TB service facilities: procurement of equipment for controlling negative pressure mechanical ventilation according to recommendations of the WHO mission on infection control (UV meter, ventilation smoke tube kits, velocity meter, anemometer/rotating vane, etc.); procurement of the HEPA filters for bio-safety cabinets; and procurement of N95 / FFP-3 respirators for staff at high risk of infection at the in-patient DR-TB treatment sites and TB laboratories. Maintenance costs of BACTEC MGIT and HAIN LPA equipment will also be covered.

The project will continue to support transportation of sputum from peripheral microscopy laboratories to four reference laboratories (National Reference Laboratory in Chisinau and regional reference laboratories in Balti, Vorniceni and Bender) for further culturing and DST, within the routine drug resistance surveillance system. Quality surveillance is of primary importance as it provides for rapid diagnosis and, subsequently, timely

initiation of treatment of DR-TB cases.

The NRL will continue to participate in external quality assurance (EQA) by regular proficiency testing exercises with the Supranational Reference Laboratory (SRL) in Borstel, Germany, and shipments of strains to the SRL for verification and quality control of DST to 1st line and 2nd line TB drugs.

PI “CIMU HSRP” will support procurement of 2nd line TB drugs for treatment of MDR-TB patients. The initial amount of funds available for Period 2 was sufficient to procure 2nd line drugs for **1,060** patients; after reallocation of funds between the PRs, the number of patients to be enrolled in second –line treatment will increase to **1,330** patients during the first two years of Period 2 (2013 and 2014). The Government’s co-financing covers other substantial costs of staff, facility costs, clinical investigations for treatment monitoring, drugs for management of adverse reactions of 2nd line drugs, etc.

The number of MDR-TB patients to be enrolled in DOTS-Plus treatment was defined on the basis of forecasts of expected numbers of TB patients by category and resistance trends (presented in Excel file in **Annex 16**, sheet “Estimations 27.01.12”). The schedule of enrolment is the following: **Year 1 (2013) – 670 patients, Year 2 (2014) – 660, totally 1,330 MDR-TB patients** will be enrolled in treatment with TGF support during Period 2.

The standard second-line treatment regimen will be applied in accordance with the WHO recommendations and will include Capreomycin, Levofloxacin, Ethionamide, Cycloserine and Pyrazinamide. In addition to the drugs indicated above, other 2nd line TB drugs will be used in part of the cases as required by the resistance profile and extent of disease: PASER (in about 20% of cases), Moxifloxacin (20%), and Amoxicillin – Clavulanic Acid (20%). Ethambutol will be added to the treatment scheme above if no resistance to this drug is found.

In accordance with TGF requirements, the project foresees centralized procurement of these drugs through the GLC/GDF mechanism. The average cost of 2nd line drugs per patient’s full treatment course was estimated at EUR 2,900 (including delivery costs). PI “CIMU HSRP” will cover the costs of storage and distribution in the country and external quality assurance of drugs (by KABS Canada).

Objective 2. To strengthen community involvement and foster partnerships for effective TB control

Interventions under this Objective aim at promoting multisectoral and multidisciplinary response to TB epidemic, with special emphasis on involving non-state actors and communities. This will be achieved through continuing support to strengthening TB community centers, small grants for NGOs, addressing special needs of high risk groups (prisoners and PLWH), involving church and conducting public awareness and communication activities.

Activity No.	Activity No. and title	Service Delivery Area
2.1	Active TB case finding and screening in prisons	Improving TB diagnosis
2.2	Strengthening TB Community Centers	TB community care
2.3	Small grants program for NGOs	TB community care
2.4	Supporting involvement of groups at high risk of TB: PLWH	TB / HIV
2.5	Involvement of church in reducing TB stigma and discrimination	TB community care
2.6	Increasing TB awareness through peer educators' program	ACSM
2.7	Public communication and social mobilization campaigns	ACSM

**Implementing entities: PR-1 (PI “CIMU HSRP” – for Activity 2.1
PR-2 (PAS Center) – for Activities 2.2-2.7**

PI “CIMU HSRP” will continue to support implementation of active TB finding in the penitentiary system through screening of detainees using the mobile digital MRP equipment, including the coverage of costs for X-ray films, fuel for visits, and equipment maintenance contract. The screening will cover detainees upon entry in the system (in pre-trial isolators) and population of 9 prisons twice a year. The average turnover of prison

population is between 3,000 and 4,000 persons; the project targets at covering 95% of annual needs of this high risk group.

A number of interventions aim at supporting the functioning of 10 TB Community Centers as a key priority for the project. These Centers were established during the previous implementation period with the support of SSF grant from Rounds 8 and 9 (PR: PAS Center). The Community Centers provide comprehensive services to TB patients (including DOT, support, education and follow-up) through multidisciplinary teams. Support to a Working Group will continue in Period 2 to monitor and oversee the activities including development of a framework for takeover after the end of TGF support. Incentives will be provided to TB Community Centers' workers (five persons per Center - manager, social worker, two DOT supporters and driver) to ensure full functionality of the Centers during the project life. In addition, support will be provided to meeting operational costs of these 10 Centers (communication, vehicle fuel and maintenance, stationery, printing and other relevant costs). Training courses on TB community work will be held for multidisciplinary teams of Community Centers, with participation of representatives of local public authorities and other relevant local actors, to ensure exchange of experiences between the Centers (2 training courses per year during years 2013 and 2014). Each TB Community Center will be visited monthly by the NTP and PR staff to monitor the activities, collect feed-back from beneficiaries and local public authorities and advise on correcting actions when necessary.

The project will support annual meetings to strengthen TB partnerships at local level, which will bring together relevant stakeholders from local public administrations (LPAs), Ministry of Health, Ministry of Labor, Social Protection and Family (MLSPF), NGOs and other partners to evaluate the progress in TB collaboration at local level and discuss future actions to improve partnerships for community involvement and patient support.

The project supports a small grants' program for NGOs to stimulate civil society participation in TB control, DOT, monitoring and follow-up of TB patients at community level. For this purpose, competitive bidding will be organized every year in order to select projects to be implemented by NGOs at local level (8 grants per year). The program has specific emphasis on stimulating community volunteer activities as well as addressing the needs of high risk population groups. Training for NGOs implementing small grants will be organized at national level, covering priority issues of TB community interventions including support to DOT (1 training course per year after grants' award). Another special training will be held for volunteers from NGOs working in TB field in rayons that have newly established TB Community Centers, which will cover different aspects of community TB work including information and communication with patients and their families, importance of DOT, psychological support to improve adherence, etc. The project will support 4 training courses per year (at local level).

The proposal intends to continue supporting involvement of groups at high risk of TB, in special people living with HIV (PLWH). For this purpose, the project will organize a series of informational meetings and workshops for organizations – members of the National League of PLWH on different aspects of TB control and involvement and peer support of PLWH (four meetings per year will be held). A series of TB informational and educational materials, specifically targeted at persons living with HIV, and materials on HIV/AIDS for TB patients (leaflets, booklets, posters, etc.) will be reprinted in years 2013 and 2015. With the project support during the previous implementation period, peer support groups (including PLWH as well as former TB patients) were established in 10 rayons working with affected people and those at high risk, their families and communities. The project will support meetings at local level (once per quarter), to monitor and coordinate TB and TB/HIV advocacy work of peer support groups. Support will be extended to facilitate the work of NGOs whose members are PLWH and former TB patients, to work with population groups at high risk of TB, including PLWH, at community level. Through a small grants' program, it is planned to support 2 NGOs' projects per year during Period 2.

The project will also continue working with church to facilitate and stimulate its involvement in TB control, in particular with the scope of reducing TB stigma, discrimination and expulsion of affected people by the communities. The project has established working relations with the Moldovan Metropolitan to strengthen the church involvement in TB control. During Period 2, it will support organization of a series of training workshops for priests of different levels; 30 workshops will be held in Year 2 (2014) in different territories (including Transnistria) to encourage church participation with the focus on stigma reduction and stimulating adherence to treatment. A set of special information and education materials on TB will be printed, to be used by the church in its work in the communities (poster-calendar with TB symptoms, booklet with appeal of leading Orthodox clerics).

Within the peer educators' program, volunteers including those who were sick and successfully treated of TB, will be supported to carry out informational work on TB with general population and disadvantaged groups within public awareness campaigns in pilot rayons. It is planned to organize 6 training courses per year. Peer volunteers will conduct informational meetings with different groups of population during public awareness campaigns and disseminate IEC materials on TB (on average, each volunteer will carry out 2 sessions per week during 4 months of the campaign). The project will provide incentive payments for coordinators of each peer support group, who are responsible for developing the working plans, scheduling activities, communicating with the authorities, logistics and reporting related to volunteers' activities. Supervisors from the central level will visit the areas which implement public awareness campaigns on TB with peer educators' involvement. The project will support 2 visits per month during 4 months of the campaign, to monitor and evaluate volunteer activities and collect feedback from the target beneficiaries in the field.

For conducting public communication and social mobilization campaigns on TB, informational materials on TB for general public (leaflets, booklets, posters, calendars etc.) will be reprinted in years 2014 and 2015. The project will also support broadcasting of TV and radio spots, developed during Period 1, on local and national stations. A local part-time consultant will provide technical assistance to the NTP and relevant partners in designing public awareness campaigns, pretesting materials, obtaining relevant endorsements with authorities, facilitate and monitor implementation.

The project will ensure that journalists from print and electronic media are provided with timely and reliable information on TB and its control in the country and locally. For this purpose, two training courses for national and local mass media will be organized. In addition, continuing successful practices established during Period 1, the journalists will visit TB institutions at central and rayon level (including Transnistria) to meet with service providers, patients and their families and civil society partners in order to understand better the problems and prepare real stories for further publishing; it is planned to support 2 such visits per year during Period 2. Contests for the best publications and/or active coverage of TB related problems are organized as incentives for journalists. In Period 2, the project will support 3 annual contests for national and local media.

The project will also support advocacy workshops at local (rayon) level to increase commitment of public authorities, improve coordination between LPAs, health and social services, civil society and other relevant actors for TB control. During Period 2, it is planned to organize 10 workshops annually in years 2013 and 2014.

Objective 3. To ensure successful TB case management through patient support and strengthening health system capacities

Under this Objective, the project supports a program for intensive patient support and follow up as a fundamental component for ensuring adherence and completion of TB treatment, including complex and lengthy treatment of MDR-TB cases. This program provides a comprehensive set of measures including incentives and enablers, psychosocial support and information / communication activities. In order to enable the health system for effective TB case management, a number of capacity building interventions are foreseen, in particular strengthening TB M&E system.

Activity No.	Activity No. and title	Service Delivery Area
3.1	Patient support for drug-sensitive TB patients	Patient support
3.2	Patient support program for drug-resistant TB patients	Patient support
3.3	Strengthening capacities of TB service staff	Health system strengthening
3.4	Strengthening capacities of PHC providers for TB care	Health system strengthening
3.5	Operational research on priority issues of TB control	Operational research
Implementing entity: PR-2 (PAS Center)		

Providing patient support in different forms (incentives, enablers, psychological support and other forms) is instrumental to ensure adherence of TB patients to treatment and achieve successful treatment outcomes; it is especially important in regard to lengthy and complex treatment of MDR-TB cases. For this purpose, the Period 2 application includes a number of interventions aiming at strengthening patient support measures to improve adherence, in continuation of activities initiated at earlier stages of implementation of the Global Fund grants.

Technical assistance (by a local consultant) will be provided to supervise, monitor and evaluate a comprehensive patient support program which places particular emphasis on strengthening adherence to MDR-TB treatment. Adherence counselors' groups were established earlier with the project support in districts and cities, consisting of a psychologist, a social worker and a nurse, to perform different patient support activities for DR-TB patients during intensive and continuation phase of treatment in respective areas. Two training courses for the counselors (newly involved persons) will be organized in years 2013 and 2014. The adherence counselors will conduct patient education and counseling sessions in the information centers in in-patient facilities and TB Community Centers.

Part of TB patients will receive incentives and enablers (food and hygienic parcels) to increase treatment adherence. Based on current implementation experience, it is expected that about half of all drug-sensitive patients (for an average of 4 months) and about 85% of MDR-TB patients (for an average of 18 months) on treatment will need additional support with weekly parcels during treatment, in both civilian and penitentiary sectors including patients discharged from prisons who need to complete treatment in the civilian health service facilities.

Another 15% of patients (in both sensitive and MDR-TB treatment cohorts) will need to cover substantial distances to come to a TB facility / PHC provider for taking drugs during out-patient treatment, or a DOT supporters will need to visit them at home to dispense drugs under direct observation. Transportation expenses ('enablers') will be covered in these cases to ensure adherence and completion of treatment. The estimates of number of patients to receive incentives and enablers are presented in Excel file attached to this application ([Annex 17](#), see 'Calculations' sheet).

Informational and educational materials for TB patients will be printed and distributed among patients and family members, with special emphasis on the need to complete treatment and prevent drug resistance. In addition, a set of short documentaries on TB will provide the patients with reliable and convincing information about different aspects of TB. These documentaries will be shown in TB in-patient facilities as well as in TB Community Centers; they will be updated in 2014.

The project will support monitoring and evaluation visits of the National TB Program in the field. These visits aim at assessing the quality and impact of integrated TB treatment, care and support services at local (community) level, with special emphasis on patient support activities including follow up of ex-prisoners and other persons evaluated as having high risk of treatment interruption (default).

In order to strengthening capacities of health service staff (including both specialized TB service and PHC service) for effective TB case management including MDR-TB, the project will continue supporting several training and capacity building activities. In-depth training in managerial, clinical and laboratory aspects of MDR-TB management, including drug management and infection control issues, will be conducted for TB service staff from in-patient and out-patient treatment delivery sites, covering both civilian and penitentiary sectors including Transnistria (3 training courses per year).

Taking into account the revision of TB care delivery model which places more emphasis on out-patient treatment (including MDR-TB treatment) and community TB care, two local consultants will be engaged to update the TB control guidelines for PHC providers (during 2013). The revised TB control guidelines for PHC will be printed and distributed to all PHC providers (doctors and nurses) in the country (in 2014). Training program of PHC staff (doctors and nurses) will be continued to strengthen their involvement in TB control, with priority attention to TB case detection, strengthening referrals and cooperation with specialized TB service, TB case management in out-patient settings (including MDR-TB cases), community TB care and adherence support, defaulter tracing and contacts' investigation, in conditions of revised TB care delivery model (5 courses annually during 2013-2015). Additionally, workshops will be organized for PHC staff on methods of informational work on TB with different groups of population will be organized (linked to the World TB Day) covering all districts of the country, including Transnistria (at inter-rayon level, 10 workshops per year).

The project will also support 4 regional conferences per year which will bring together TB specialists, PHC staff and community activists and will discuss priority problems in strengthening TB case management at community level, collaboration between different levels of care and plan future actions.

The proposal foresees continuation of supporting regular program supervision as the key NTP intervention. Regular supervision visits to be conducted by the NTP Central Unit and Regional Bender Unit (for Transnistria) teams to specialized TB facilities and selected treatment delivery sites in general health service (PHC) in rayons.

In order to further strengthen the national TB information system (SIME-TB) and align it with the most recent strategies and international guidance, technical assistance (by an external consultant) will be contracted in 2013 for revision of the TB recording and reporting system and electronic TB database to incorporate new WHO classifications (to be endorsed by end-2012), new diagnostic methods (e.g. Xpert MTB/RIF) and other aspects including social determinants and community support. It will be supported by a working group and two national consultants who will be employed to assist the NTP to manage the change and oversee implementation. Relevant training will be further provided for staff of the NTP Central Unit and TB service institutions at national and peripheral level who are responsible for data management, based on revised recording and reporting forms and upgraded software (4 training courses in 2014 and 2 courses in 2015). For optimal performance and efficiency, the M&E system strengthening activities, previously implemented through PI HSRP, have been transferred for Period 2 to the second PR (PAS Center).

Limited support is sought for attendance of training courses and international meetings and conferences abroad for NTP, M&E and other staff in priority issues of TB control.

In order to develop evidence, inform decisions and improve health system response on priority issues in TB and MDR-TB control in the country, two operational research projects are included in the application for Period 2 under this Objective. The first study addresses out-patient / community based management of MDR-TB cases and will cover two rayons where such model will be implemented. The issues to be addressed include delays in diagnosis and treatment along the patient pathway; drug management including adverse reactions management in out-patient settings; innovative ways of patient support to strengthen adherence; monitoring conversion and resistance patterns and treatment outcomes in comparison with predominantly hospital-based

model and other territories.

The second operational research study will look in depth into the problem of nosocomial transmission and drug resistance patterns in hospital setting. It will cover two in-patient TB facilities and study the patterns of conversion, resistance amplification and interim treatment outcomes in function of patients' characteristics, history of previous treatment, drug regimens, infection control measures applied, etc. For this purpose, monitoring of growth and resistance to 1st line drugs and 2nd line drugs will be carried out in hospital and after discharge using modern methods for isolation of strains, identification and genotyping. Recommendations will be developed and actions will be planned based on the findings of both studies. The executing organization(s) will develop the detailed study protocols and budgets to PAS Center prior to contract awards.

INDICATORS AND TARGETS

Since the key activities during the implementation of the 2nd period of the consolidated TB Grants are directed to support MDR-TB management interventions and community actions for TB control, the list of indicators is formulated in accordance with them (for a more detailed information, please see [Annexes 18 and 19](#)).

The PF includes the following indicators.

Impact Indicator:

- **“TB mortality rate”** (Number of deaths attributable to TB (all forms) registered in a specified period per 100,000 populations). The indicator is included in the revised M&E Plan of the NTP 2011 – 2015 ([Annex 20](#)). The targets for indicator are in line with this document.

Outcome Indicators:

- **“Treatment success rate of MDR-TB patients”** (Number and percentage of laboratory-confirmed MDR-TB patients successfully treated [cured plus completed treatment] among those enrolled in second - line anti-TB treatment during a specified period). The indicator is included in the revised M&E Plan of the NTP 2011 -2015. The targets have been up-dated based on last available data (for 2008 cohort) and according to the revised M&E Plan NTP 2011-2015.
- **“MDR-TB prevalence among new cases”** (Number of new TB cases tested to DST to H&R drugs and diagnosed with MDR over the given year from the total number of new TB cases tested to DST to H&R drugs over the given year). The indicator is part of the revised M&E Plan of the NTP 2011 -2015. The targets for indicator have been up-dated according to the last routine surveillance data (2010) and preliminary DRS 2011 data and the revised M&E Plan NTP 2011-2015.
- **MDR-TB prevalence among re-treatment cases”** (Number of re-treatment TB cases tested to H&R drugs and diagnosed with MDR over the given year from the all re-treatment TB cases tested to H&R drugs over the given year). The indicator is part of the revised M&E Plan of the NTP 2011 -2015. The targets for indicator have been up-dated according to the last routine surveillance data (2010) and preliminary DRS 2011 data and the revised M&E Plan NTP 2011-2015.
- **“Default rate among new smear positive TB cases”** (number of new smear positive TB patients who interrupted treatment among those enrolled in treatment during a specified period). The indicator is included in the revised M&E Plan of the NTP 2011 -2015. The targets have been up-dated based on last available data and are in accordance with the M&E Plan.

As mentioned above, as a result of extensive consultations in country and with international partners, first and foremost WHO, the Performance Framework for Period 2 was reviewed and revised to account for the above mentioned issues, and has been agreed within the CCM technical working group comprised by all relevant national stakeholders and international agencies. See more details the attached Performance Framework and M&E Plan.

Output / coverage indicators are presented as per Program Objectives:

Objective 1. To ensure universal access to diagnosis and treatment of drug-resistant tuberculosis

- **“Number of laboratory-confirmed MDR-TB patients enrolled in second-line anti-TB treatment”**. The indicator is part of the revised M&E Plan of the NTP 2011-2015. The targets for indicator are in the line with those in the M&E Plan.
- **“Interim treatment success rate of MDR-TB patients”** (number and percentage of MDR-TB patients who have negative culture at the end of 6 months of treatment). The indicator is included in the revised M&E Plan of the NTP 2011 -2015. The targets for indicator have been up-dated based on the last available data and according to the M&E Plan.
- **“Number and percentage of laboratory-confirmed MDR-TB patients, successfully treated (cured plus completed treatment), among those enrolled in the second -line anti-TB treatment”**. The indicator is included in the revised M&E Plan of the NTP 2011 -2015. The targets for indicator have been up-dated based on last available data (for 2008 cohort) and according to the M&E Plan.
- **“Number and percentage of new and retreatment TB patients receiving DST for the first-line TB drugs, using the automated MGIT technique, among the people eligible for DST, as per the national policy during the specified period”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of tests performed for rapid identification of R/H resistance using MTBDRPlus (Hain) methodology”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number and percentage of new and retreatment TB patients receiving diagnostic DST for 2nd line MDR-TB drugs, among the people eligible for DST, as per the national policy during the specified period”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.

Objective 2. To strengthen community involvement and foster partnerships for effective TB control

- **“Percentage of prisoners screened for TB using MRP mobile equipment”** (Number of prisoners screened for TB using MRP mobile equipment from the total number of eligible for screening prisoners in the penitentiary system during the reported period). The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of volunteers, members of multidisciplinary teams, NGOs representatives and priests trained in TB community aspects”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number and percentage of new TB patients in ambulatory phases provided with DOT support by the community”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of people (TB/HIV patients and their families) reached by peer support groups”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of peer educators, journalists at national and district level and local stakeholders trained in TB and TB/HIV issues”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.

Objective 3. To ensure successful TB case management through patient support and strengthening health system capacities

- **“Number of TB service staff trained in DR-TB management”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of MDR-TB patients registered under DOTS program who are receiving incentives and enablers for improved treatment compliance”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of TB patients registered under DOTS program who are receiving incentives and enablers to improve their treatment adherence”**. The indicator is not part of the revised M&E Plan of the NTP 2011-2015 and reflects grant activities.
- **“Percentage of released prison inmates on TB treatment supported through the TB treatment follow-up program”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.
- **“Number of PHC staff trained in TB case management, community TB care issues and methods of informational work with different groups of population”**. The indicator is not part of the revised M&E Plan of the NTP 2011 -2015 and reflects grant activities.

Based on the identified gaps and challenges under section 5.1.1 “Programmatic Achievements” please summarize the key M&E systems strengthening activities, including any planned operations research or evaluations to be undertaken during the next Phase/Implementation Period. Does the CCM propose reallocation of resources to support the above stated M&E strengthening initiatives? If yes, comment on the budgetary and programmatic implications, if any, on the overall request.

As the activities carried out during the implementation of the 1st period of the Consolidated TB Grant (MOL-T-PCIMU), directed to the M&E system strengthening, mainly supported from the GF Round 6 sources, are to be finalized on December 31, 2012, during the 2nd period of the Consolidated TB Grant implementation, the M&E support activities are reflected in the budget and work-plan under Objective 3 (Activity 3.3) and include: support to NTP supervision visits to rayons; external technical assistance for revision of the TB recording and reporting system and electronic TB database to incorporate new WHO classifications (to be endorsed by end-2012), new diagnostic methods (e.g. Xpert MTB/RIF) and other aspects including social determinants and community support; support to a working group and services of two national consultants to assist the NTP to oversee implementation; and training for staff of the NTP Central Unit and TB service institutions at national and peripheral level who are responsible for data management, based on revised recording and reporting forms and upgraded software. As mentioned above in this section, in Period 2 PAS Center as PR will be responsible for M&E system strengthening activities, previously implemented through PI CIMU HSRP.

6.1.2 Pharmaceutical and Health Product Management (if applicable)

Please complete this section only if procurement of Pharmaceutical and Health Products is planned in the next Phase/Implementation Period. Otherwise, continue to section 6.2 “Financial Proposal”.

Based on the key risks and challenges in the PHPM area in the current Phase/Implementation Period as identified under section 5.1.2 “Grant/SSF Management”, please summarize the measures and/or mechanisms that have been put in place or are proposed in the PSM plan (or the Country Profile if this is already in place) for the next Phase/Implementation Period. Please include an assessment of the risk of treatment interruptions at the health facilities in the next Phase/Implementation Period and a list of the possible underlying causes related to PHPM activities that may have a negative impact on the continuous availability/access to key health products (such as stock outs, diversion and theft of health products).

Management of TB medicines and health product will be performed following the country profile and procurement plan. Planning, forecasting, quantification, procurement, distribution and use of medicines in the country are coordinated by the Drug Management Team of the NTP with participation of government staff, experts, and other stakeholders. Coordination can also take place through “Technical Working Group” (TWG) meetings. The WHO guidelines are considered for the selection and quantification of TB medicines. The PI

“CIMU HSRP”, unit in charge for procurement, has well-established procedures on how to proceed throughout the procurement process.

The TB program runs a good-quality data management system called SIME-TB, which is operated and used at all levels of care, from the national institutions and hospitals down to the community level health care facilities. In addition, there are regular validation visits by different entities (e.g. Principal Recipient, TB Institute; National Health Management Centre).

The system of recording and reporting on TB medicines and supplies (SIME-TB) allows monitoring consumption, stock-out and stock level at central and health unit levels.

Receipt, storage and inventory management TB medicines and health products procedures are guided by the standard operating procedures. NTP developed and implemented a good distribution practice of TB medicines. There were no notifications of stock/out of medicines during the last years.

The PI “CIMU HSRP” continues to provide support to the NTP, to ensure proper management of TB medicines.

6.2 Financial Proposal

6.2.1 Resources available to finance the grant/SSF after cut-off date

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package Renewals Financial Template FinancialRequest Resources-available – the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!

Please note that TRP Clarified Amount must take into account Global Fund Board mandated adjustments based on Income level as follows:

- **90% for LICs and LLMICs**
- **75% for ULMICs and UMICs**

Please refer to your invitation letter for your income level. Further guidance can also be found in the Financial template.

Grant MOL-T-PCIMU (PR-1: PI “CIMU HSRP”)

	Year 2013	Year 2014	Year 2015	Total
a. TRP clarified amount allocated to PR	2,562,187	2,505,329	288,662	5356178
b. Any Board mandated adjustments	-256,219	-250,533	-28,866	-535617.8
c. Adjustment +/- for (borrowing) and/or staggered commitments not yet committed				
d. Adjusted TRP clarified amount	2305968.3	2254796.1	259795.8	4820560.2
e. CCM reallocations +/- (implementation arrangements)	353,482	432,905	-259,796	526591.06
f. Adjusted reallocated amount	2659450.2	2687701.06	0	5347151.26
g. + Undisbursed amount at cut-off date				2,265,802
h. + Cash at cut-off date				329135.83
i. =Total Resources available (after cut-off date for the next Phase/Implementation Period)				7942089.14

Grant MOL-809-G05-T (PR-2: PAS Center)

	Year 2013	Year 2014	Year 2015	Total
a. TRP clarified amount allocated to PR	1,977,927	1,993,967	1,386,731	5358625
b. Any Board mandated adjustments	-197,793	-199,397	-138,673	-535862.5
c. Adjustment +/- for (borrowing) and/or staggered commitments not yet committed				
d. Adjusted TRP clarified amount	1780134.3	1794570.3	1248057.9	4822762.5
e. CCM reallocations +/- (implementation arrangements)	-338,064	-286,220	97,602	-526682.98
f. Adjusted reallocated amount	1442069.84	1508349.84	1345659.84	4296079.52
g. + Undisbursed amount at cut-off date				1,354,163
h. + Cash at cut-off date				1390547.017
i. =Total Resources available (after cut-off date for the next Phase/Implementation Period)				7040789.637

6.2.2 Summary funding request from cut-off date to end of next Phase/Implementation

Please note that the financial information required for this section is in the Financial template provided with the CCM Invitation package Renewals Financial Template FinancialRequest FundingRequest – the CCM must paste a screenshot of the information to this section in the CCM Request template (Word document) by selecting the relevant cells in Excel and using Paste option in Word to insert as a picture. Financial Request must be filled out in the Excel file only. Do not edit the table after pasting it here!

Total Budget required (after cut-off date for the next Phase/Implementation Period)

	Year 2012 after cut-off date	Year 2013	Year 2014	Year 2015	Total
Grant MOL-T-PCIMU (PR-1: PI HSRP)	2,501,665	2,659,450	2,687,701	0	7,848,816
Grant MOL-809-G05-T (PR-2: PAS Center)	2,482,461	1,442,070	1,508,350	1,345,660	6,778,541
TOTAL	4,984,126	4,101,520	4,196,051	1,345,660	14,627,357

6.2.3 CCM Budget Request for the next Phase/Implementation Period

Please explain how lessons learned from the current Phase/Implementation Period have been factored into this funding request (e.g. budget reallocations, under-spending leading to more realistic budget estimates, reflection of price changes).

Since the necessities of MDR TB patient treatment are higher, in the context of achieving a universal access to treatment, than the ones estimated in the initial phases of the project, a reallocation of financial sources between the PRs (in the sum of EUR 526,591) has been executed, in the scope of covering the increasing number of patients to be included in treatment from 1,060 to 1,330 persons, for a period of two years. At the same time, the increasing costs of 2nd line TB drugs (especially for the Capreomycin drug cost registered last year) have been taken into account when estimating the budget for the II Period. Thus, the prices per unit have been taken from the last pro-forma invoices from IDA, Holland, dated February, 2012. Also, the PSM costs linked to the 2nd line TB drugs management have been correlated to the last expenditures too, including the storage and KABS (Canada) external drug quality control costs.

A reassessment of unit costs has been also performed for the consumables and reagents for culture and DST examinations (for both the classic and rapid method), as well as for the HAIN and Probtect method investigations. The prices per unit have been taken from the last contracts of the 2011 year, as well as from

the invoices of BD and HAIN for the closed type equipment. The number of examinations has been calculated by the NTP Central Unit at IPP on the basis of the estimated number of patients to be diagnosed and estimated MDR TB rate among the new and re-treatment TB cases.

The cost estimations of the activities linked to the monitoring visits in territories, as well as the costs of SIME TB soft maintenance and staff involved in data-base analysis, have been performed on the basis of actual real costs.

Does the budget request reflect the average programmatic performance in the current Phase/Implementation Period? If not, please provide an explanation.

For grant MOL-T-PCIMU, the overall grant implementation rating at the cut-off date is A2, and for grant MOL-809-G05-T (PR-2: PAS Center) the overall rating was A1. Therefore, no additional reductions were made to the Period 2 budget except 90% Board mandated adjustments (i.e. 10% cut) from the TRP clarified amount allocated to PRs for the next implementation (updated ceilings on the maximum amount which can be requested by Lower Low-Middle Income Country).

6.3 Compliance with Focus of Proposal Requirement

This question is not applicable for Low Income Countries.

Describe whether the focus of proposal requirement has been met per the threshold based on the income classification for the country.

Based on the Global Fund eligibility criteria, the Republic of Moldova, as Lower Lower Middle Income Country (Lower LMIC) with a severe burden of Tuberculosis, must focus at least 50% of the renewals budget on special groups and/or interventions.

For SSF grant MOL-T-PCIMU administered by PR-1 (PI "CIMU HSRP") the majority of activities are aimed at supporting special groups or specific interventions, i.e. MDR-TB. As per the work-plan and budget PR-1 will cover "Support to TB screening in prisons" with a total value of EUR 63,900 for 2013-2014 and activities for control of MDR-TB with a total value of EUR 4,799,726 for 2013-2014. As a result, the total amount of sources budgeted for support of the special groups and/or interventions are EUR 4,863,626, which represents 91% from the requested amount of EUR 5,347,151 for years 2013-2014.

For SSF grant MOL-809-G05-T, administered by PAS Center as PR, over 80% of requested funding goes for interventions covering specific vulnerable groups (e.g. those of patient support). Therefore, overall the budget for both grant well exceeds the minimum share required by the Global Fund in this regard.

Supporting Information (to be submitted with the CCM Request)

Mandatory documents

1. **Minutes of the CCM meetings** related to discussion on the CCM Request (including important elements such as reprogramming and/or changes to implementation arrangements, counterpart financing and focus of proposal);
2. **Performance Framework** for the next Phase/Implementation Period consolidated for all grant/SSFs (Template provided);
3. **M&E Plan** for the next Phase/Implementation Period (*if available and not previously submitted*). A grant/SSF specific M&E Plan may be submitted if a National Plan is not available;
4. **Procurement and Supply Management (PSM) Plan** (guidelines provided) (or a Procurement Plan, in case of a Country Profile) for the next Phase/Implementation Period per grant/SSF, if applicable (Template provided);
5. **Financial template** including:
 - a) **Financial Gap Analysis and Counterpart Financing** (Template provided);
 - b) **CCM Summary Budget Request** for the next Phase/Implementation Period consolidated for all grant/SSFs (Template provided);
 - c) **Financial request** for the next Phase/Implementation Period per grant/SSFs (Template provided);
 - d) **CCM analysis of the request versus original** budget consolidated for all grant/SSFs (Template provided);

- e) **Reallocation of original budget amount between PRs**, if applicable (Template provided);
6. **Detailed budget and workplan** for the next Phase/Implementation Period per grant/SSF; and
 7. **List of liabilities at cut-off date** per grant/SSF.

Supporting documents

1. **National Program Review/Evaluation** report including assessment of programmatic Impact/Outcome¹; and/or
2. Revised **Program Implementation strategy** (if applicable/necessary) and/or
3. Any other documents considered essential to the Global Fund Secretariat review of the Request, such as a report or study on Equity, Value for Money or Aid Effectiveness, if available.

¹ The Review/Evaluation report will be mandatory from 2012 for Periodic Reviews only.

LIST OF ANNEXES

<i>Annex No.</i>	<i>Annex name</i>
1	Government Decision No. 375 from 06.05.2010
2	CCM regulations
3	CCM Operations Manual
4	CSOs' selection for CCM membership
5	CCM Decision from 09.06.2011
6	CCM Oversight documents
7	CCM Policy on Conflict of Interest
8	CCM Decision from 23.02.2012
9	Technical Working Group meetings documentation (January-April 2012)
10	HSS and M/XDR Mission Report (KNCV, WHO, June 2011)
11	Global Drug Facility (GDF) Monitoring Mission Report (WHO/EURO, October 2011)
12	Green Light Committee Europe (GLC-EURO) Monitoring Mission Report (WHO/EURO, October 2011)
13	National TB Control Program 2011-2015
14	Liabilities PI CIMU HSRP
15	Liabilities PAS Center
16	Workplan and Budget Period 2 (PR-1: PI CIMU HSRP)
17	Workplan and Budget Period 2 (PR-2: PAS Center)
18	Performance Framework Period 2
19	TGF Program Monitoring and Evaluation Plan
20	Monitoring and Evaluation Plan for the National TB Control Program 2011-2015
21	Procurement and Supply Management Plan
22	Financial template
23	Minutes of CCM meeting 25.04.2012

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