Grant Scorecard

Grant Number: ARM-809-G03-T

BOARD VERSION

Current grant currency (Phase 1 currency):	**EUR**
CCM Requested currency for Phase 2:	**EUR**
Secretariat recommended currency for Phase 2:	**EUR**

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Grant Scorecard

Grant Number: ARM-809-G03-T

EXECUTIVE SUMMARY

GENERAL GRANT INFORMATION

Applicant Type	Country Coordination Commition on HIV/AIDS, Tuberculoses and Malaria issues
Country	Armenia
Component	Tuberculosis
Round	8
Grant Title	Scaling up the management of drug-resistant tuberculosis in the Republic of Armenia
Grant Number	ARM-809-G03-T
Principal Recipient	Ministry of Health of the Republic of Armenia
Related Grants (all existing grants)	
Same proposal	
Same disease component	ARM-506-G02-T
Other diseases (Same PR)	ARM-202-G05-H-00,ARM-809-G04-S

Proposal Lifetime (years)	5	**Lifetime Budget**	€ 5,925,238
Phase 1 Budget (1-2 year)	€ 1,745,311	**Original Phase 2 Budget**	€ 3,761,934 *
Program Start Date	01.Sep.2009		
Disbursed up to cut-off date	€ 938,640	**Disbursed funds as a % of the Phase 1 budget**	54 %
Undisbursed up to cut-off date	€ 806,671	**Undisbursed funds as a % of the Phase 1 budget**	46 %
Program End Date	31.Aug.2011		

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

Secretariat Phase 2 Recommendation Overview

Phase 2 Rating	B1
Phase 2 Recommendation Category	ConditionalGo
Incremental Phase 2 Amount Recommended for Board Approval	€ 3,348,122

* The TRP-Adjusted Phase 2 Amount includes the mandatory 10% savings as required by (GF/B22/DP25) for Rounds 8, 9 and First Learning Wave of National Strategy Applications. As such, the PBF and efficiency savings include the 10% savings.

Secretariat Assessment of Overall Grant Performance

Programmatic Achievements

The first 18 months of grant implementation have been challenging due to the following factors: 1) changes in the management of the National TB Program (NTP) and the Global Fund Program Implementation Unit (PIU); 2) high staff turnover at the NTP and PIU and lengthy recruitment of missing staff; 3) delays in approving yearly grant budgets by the Ministry of Health and the Ministry of Finance; 4) weak procurement capacities at the Global Fund PIU or lack of sufficient staff involved in procurement; 5) lengthy state procurement procedures; 6) delays in signing sub-recipient (SR) agreements.

Throughout those 18 months, the Ministry of Health and the Program Implementation Unit have deployed extensive efforts to overcome the above challenges. Finally, over the last six months, the grant performance has significantly improved and the cumulative grant results on key coverage indicators are reaching the targets set.

At the end of the Quarter 6, the Program shows satisfactory results overall: of the six indicators measured, four have achieved and over-achieved their targets, including two Top 10 indicators. One indicator (percentage of patients on MDR-TB treatment who were tested for drug resistance testing) is achieved at 88 per cent due to some samples being received at the end of the reporting period and tested in early April. One indicator (number of patients tested for rapid identification of R/H resistance using PCR technique) is achieved at 7 per cent only due to 1) delays in purchasing the PCR equipment; 2) delays in providing training to the laboratory staff on the use of this technology; and 3) insufficient buffer stock for reagents to launch a full-fledged PCR testing process after the initial piloting period.

While the quantitative indicator rating is "A2", the following data quality issues are to be noted:

1) the indicator on number of MDR patients receiving food parcels slightly (by 13 patients) exceeds the total number of MDR-TB patients enrolled on treatment during that period, hence there is some reporting inconsistency. Furthermore, the activity on nutritional support also concerns PDR-TB patients; while it is sensible to apply the same programmatic approach to MDR-TB and PDR-TB patients in this regard, the indicator definition needs to reflect this; and

2) the results reported for the number of education and counseling sessions for MDR-TB patients on treatment include the number of home visits performed for MDR-TB patients and group sessions involving regular TB patients also. While notionally the individual home visits can be considered as education and counseling sessions, the PR has been advised, through on-going correspondence and Management letters, to streamline the indicator description, data collection and reporting mechanisms in the M&E plan and in the Performance Framework.

In light of the epidemiological context (low case detection rate for sputum-positive TB, poor treatment success outcomes both on drug-sensitive and drug resistant TB, high prevalence of DR-TB, high mortality rate), a number of management issues in all functional areas (although none of the areas is believed to have a classification of "Major management issues", the overall performance rating for this grant is "B1" and it adequately reflects program's performance. Programmatic achievements under this grant should be reviewed against a broader context of the National TB Program which underwent radical and positive developments in its governnance during the last 18 months (for more details, please see sections B1.2 and C1.4.).

Financial Performance

At the cut-off date for the Phase 2 review (end of Quarter 6), the cumulative funds absorption stands at 38.7 per cent mainly due to the challenges described above (late yearly budget approvals in 2010 and 2011, insufficient staffing of the PIU, and frequent staff turnover at the PIU). These delays result in shifting many activities to the last implementation quarters (Q7 and Q8) as well as during the no-cost extension period (September - December 2011).

The actual expenditure rate for the reporting period (Quarter 6) is zero per cent, because the PR was not able to make any payments during the first calendar quarter of the year due to the absence of the Government's approval of the yearly budget. The Global Fund grants implemented by the Ministry of Health of Armenia typically encounter those delays, since due to improper staffing of the Program Implementation Unit the Government approvals could not be secured much in advance.

Cumulatively, by mid-July 2011, the Global Fund has disbursed 80 per cent of the grant's budget. The last disbursement in Phase 1 for the total amount of EUR 457,896 is being processed at the time of the development of this Grant Score Card (8 July 2011). After this disbursement, an amount of EUR 348,775 will remain un-disbursed at the end of Phase 1, which is taken into consideration in deriving the Phase 2 incremental amount.

Grant Management

As indicated above, during the first year of program implementation, the PR has faced significant management challenges that have affected program's performance: 1) high staff turnover at the NTP and the Global Fund PIU; 2) delays in completing the selection of sub-recipients (SRs) and signing PR-SR agreements which have adversely affected implementation of activities in Phase 1; 3) difficulties to establish an efficient coordination between the PR, the NTP and other organizational units of the Ministry of Health, as well as with the National TB Dispensary - main institution for TB treatment; and 4) the Operations and Program Management Manual of the Global Fund Program Implementation Unit has been developed and endorsed with significant delay only in May 2011. Technical assistance provided by Grant Management Solutions (GMS) to the Global Fund PIU throughout 2009 could not resolve the systemic issues that the Ministry of Health was facing in implementing the grants as a state entity. Throughout the grant implementation it has become obvious that the state systems and structures in Armenia are not particularly well adapted to a performance-based funding model of program implementation (for example, if the Government approval of a yearly budget takes up to one quarter, the expenditure rate for this quarter will show "zero" results which in turn affects the overall performance rating of the grant). Yet, a change of PR to a non-governmental entity or multilateral body would not have allowed achieving the high level political commitment on behalf of the Ministry of Health and other government institutions with regard to the TB control efforts, as it has been done thanks to a certain level of patience, on behalf of the Global Fund Secretariat, towards on-going grant management issues at the Ministry of Health level.

During the last six months, the PR has demonstrated some improvements and progress in its program management processes and practices. In particular, most of recommendations made by the Global Fund Secretariat through the past reporting periods have been implemented. Similarly, Conditions Precedent and Special Conditions, as well as management actions have been addressed. The recruitment of missing PIU key staff has been completed. The agreements with SRs have been signed. The PIU is deploying its best efforts to improve the sub-recipient selection, management and monitoring system by developing a new procedural document for SR selection and capacity assessment and by adhering to its recently endorsed Operations and Program Management Manual while managing and monitoring its SRs.

Pharmaceutical and Health Products Management: during Phase 1 the PR procured only medicines for treatment of the side effects for patients on MDR-TB treatment. Second-line anti-TB medicines were ensured through the Round 5 TB grant Phase 2, and by by GOPA/KfW for the first-line anti-TB drugs. There were delays in procurement due to lengthy procedures and poor planning due to lack of reliable data; an estimated value of almost € 60,000 of 2nd line anti-TB medicines procured with R5 TB grant expired. The Procurement Law was amended according to which the procurement function of the PCT will be transferred to a new entity as of January 2012. The storage and distribution practice has improved with the consolidation of stocks not requiring refrigeration at the NTP CO premises. The management of anti-TB medicines and medicines for side-effects, including forecasting and the update is expected to be greatly improved by implementing the information management system during the lifespan of this grant.

Secretariat Assessment of External Factors and Governance specifically impacting on grant implementation

External Factors specifically impacting on grant implementation

The high level political commitment on behalf of the Ministry of Health and Prime Minister's office, secured throughout the grant implementation, might be challenged by the parliamentary elections in 2012 and presidential elections in 2013. These external events might affect the sustainability of the progress achieved in the implementation arrangements of the National TB Strategy. In a context where the system is still fragile, progress and achievements are largely attributable to the personality of the manager. Thus, a change in leadership can heavily affect the ability of the system to ensure continued progress.

Governance issues specifically impacting on grant implementation

The Country Coordinating Mechanism (CCM) of Armenia has been under-going reforms since early 2011, with external technical assistance provided by GIZ. These reforms aim at revising the CCM bylaws and framework documents, renewing the membership and increasing the focus on program oversight by the CCM HIV and TB working groups.

The revised draft CCM bylaws have been sent to the Prime Minister's office for final endorsement at the end of June 2011. After the approval of bylaws, the election process of new CCM members will begin. It is expected that the approval process by the Prime Minister's office will be prompt and that the CCM will fully resume its work with a new composition in September 2011.

As mentionned in the Programmatic Achievements section above, changes in the National TB Program's and the Global Fund Program Implementation Unit's management affected Program's performance during the first 18 months. Yet, those changes are considered to be positive developments that will set solid grounds for the Global Fund's contribution to a comprehensive implementation of the National TB Strategy in the years to come.

Secretariat Rationale for Recommendation Category

The Secretariat recommends a "Conditional Go" decision due to the fact that the audit report of the first programmatic year's financial statements (1 September 2009 - 31 December 2010) is not available at the time of the Phase 2 review. The Secretariat does not identify any other major issue that would require a Board condition.

Secretariat Rationale for Recommended Phase 2 Amount

While the Secretariat accepts a possibility of enhancing the incentive scheme for adherence purposes, the current suggestion of additional cash incentives to current MDR-TB patients is neither feasible nor justified from the programmatic and financial standpoint. The Secretariat encourages the country to look into the possibility of expanding its incentive scheme to cover regular patients in addition to DR-TB patients. The Global Fund has supported such costs in R5, which is finishing this year, and encourages to find some savings in R10 and during consolidation to cover incentives for regular TB patients. Meanwhile the Secretariat considers that a design of a comprehensive and patient-centered social support and adherence incentives scheme for both regular TB and DR-TB patients is necessary to improve the adherence to treatment and treatment outcomes. Before grant signing the PR should submit a well thought-through and patient-centered social support and adherence scheme, describing all modalities of its administration and thorough oversight. In addition, the Secretariat has adjusted the Phase 2 budget by removing costs of inflation included in the budget for Years 4 and 5 for pharmaceutical and health products and adjusted the EUR equivalent of the GLC fee using the more accurate USD/EUR exchange rate. There are some inconsistencies in unit costs of PIU HR and admin costs, which need to be clarified during Phase 2 negotiations. Related to that the PR needs to establish clear processes and methodology for cost sharing PIU operational costs between Global Fund grants. Given the proposed detailed budget and the total adjustments proposed the Secretariat is recommending a budget amount of €3,709,744 for 3 years, and the incremental amount of €3,348,122, representing 89% of the adjusted original Phase 2 budget.

Proposed Secretariat Board Conditions for "Conditional Go" Category		
Issue	**Condition**	**Deadline**
Audit report not available at the time of Phase 2 review.	Prior to signing of the Phase 2 Agreement, the Principal Recipient shall submit to the Global Fund the following documents, in the form and substance satisfactory to the Global Fund: a) an audit report for the period from 1 September 2009 to 31 December 2010;b) a plan to address any issues identified in the audit report for the audited period.	Prior to Grant signing

Proposed Secretariat Conditions		
Issue	**Condition**	**Deadline**
The PSM plan for Phase 2 requires further completion. (Including the issue that the planned number of DR TB patients to be enrolled on second-line treatment is higher than the currently approved GLC cohort.	The PR shall submit to the Global Fund Secretariat the revised Phase 2 PSM Plan including a more detailed description of forecasting methodology, unit costs, specifications of health products and recently revised procurement procedures.	Prior to Grant signing
System-related delays in yearly grant budget approvals by the Government.	The Principal Recipient shall ensure that yearly programmatic budgets are agreed with the Global Fund Secretariat no later than September of each programmatic year, and that the agreed-upon yearly program budgets are submitted for review and approval by the Government of the Republic of Armenia no later than November each year, following the signature of the SSF grant.	Prior to Grant signing
Recent amendments in state procurement regulations have not been described in detail, and there is lack of information how the new procurement modalities might affect the Global Fund grant implementation.	The Principal Recipient shall submit to the Global Fund Secretariat a detailed description of procurement arrangements for 2012, including the roles and responsibilities of the Global Fund Program Implementation Unit and coordination mechanisms with the entities involved in procurement, as well as Standard Operating Procedures for pharmaceutical and health product procurement.	Prior to Grant signing
System-related challenges in sub-recipient selection, contracting and performance-based funding including risk of interruption of services delivered by SRs.	The Principal Recipient shall submit to the Global Fund Secretariat a description of sub-recipient management and oversight procedures both on programmatic and financial aspects, for ensuring sub-recipient management in accordance with the Global Fund principles of performance-based funding and in accordance to programmatic needs, as well as mitigating measures to be put in place to ensure no interruptions in delivery of components executed by SRs (e.g. social support).	Prior to Grant signing
Weaknesses of the National TB Program.	In consultation with WHO and other stakeholders and donors active in the TB control area in Armenia, the PR should prioritise the implementation of recommendations from the recent WHO review (April-May 2011) and develop a costed action plan to implement the prioritized recommendations as well as other capacity development measures of the National TB Program in line with the relevant recommendations from the Global Fund Secretariat. The prioritized actions to address weaknesses of the National TB Program should be taken into consideration in preparing the workplan, budget and performance framework of the Single Stream Funding (SSF) grant (Phase 2 of Round 8 and Round 10 proposal).	Prior to Grant signing

Proposed Secretariat Management Actions		
Issue	**Management Actions**	**Deadline**
Patient adherence incentive scheme needs additional revision.	By 31 December 2011, the PR shall provide an operational framework for patients' incentives prepared in accordance with the Global Fund Budgeting Guidelines, describing detailed implementation plan, including procurement processes and controls over the distribution of benefits and allowances to the target group of patients. The controls should exist to manage the following: (a) identification of the program clients and beneficiaries; (b) fair and equitable distribution of benefits within the selected groups of patients; (c) ensuring the support reaches its intended beneficiaries; (d) control over storage and distribution. The plan should describe and justify, which type of incentives will be used by the Program based on the review of existing incentives scheme, and ensure adequate coverage of both regular TB and DR-TB patients with adherence incentives.	31 December 2011
Insufficient operation research activities.	Prior to Grant signing, The National TB Program, in consultation with stakeholders and donors involved in the TB control activities in the country, should develop a strategy and costed action plan for operational research activities, including but not limited to risk factors for MDR TB, gender differences in TB case notification, influence of key social and contextual factors on the TB epidemic (i.e. labor migration).	Prior to Grant signing
Insufficient targeted case finding strategies among specific population groups.	Prior to Grant signing, the National TB Program, in consultation with stakeholders and donors involved in the TB control activities in the country, should develop a strategy and costed action plan for active case finding among specific population groups (i.e. women, migrant workers, prisoners, People Living With HIV/AIDS).	Prior to Grant signing

The Monitoring and Evaluation plan does not include all indicators and does not cover the entire lifespan of the Phase 2 of the Round 8 TB grant.	By the end of 2011, the Monitoring and Evaluation plan needs to be revised to include indicators of the Single Stream Funding grant, as well as to include a costed action plan for addressing Monitoring and Evaluation-related aspects as per the recent WHO review of the National TB Program.	By the end of 2011
Weaknesses in the procurement management information systems.	Throughout the first year of the SSF grant implementation, the National TB Program should collect and verify data on number of patients receiving treatment, medicines dispensed and stock levels through monthly visits (or any other trustful form of verification) in all treatment sites in order to improve planning and forecasting and avoid stock shortage or excess.	Throughout the first year of the SSF grant implementation
Lack of evidence basis for social support activities.	By the end of the first year of grant implementation, the PR should evaluate the social support component of this grant and adjust the corresponding approaches/activities to increase treatment adherence of regular TB and DR-TB patients.	By the end of the first year of grant implementation
Weaknesses in TB-related Monitoring and Evaluation system.	By the end of the first year of the SSF grant implementation, the PR should create and use electronic data management system for TB surveillance (e-TB Manager or similar) in line with WHO recommendations and in accordance with an agreed-upon gradual roll-out plan. The PR should strengthen NTP's Monitoring and Evaluation capacities for data collection, analysis, reporting, and evaluation. These capacity strengthening measures may include revising Monitoring and Evaluation staffing composition of the NTP, availability of corresponding programmatic software linked to Service Delivery Points (via Internet), and access to other resources (technical assistance/consulting, etc.).	By the end of the first year of the SSF grant implementation
Patient adherence incentive scheme needs additional revision.	By 1 December 2011, the Principal Recipient should develop staff performance management, top-up and/or incentive schemes and a monitoring system for health staff of TB cabinets providing treatment to DR-TB patients and National TB Program (NTP) staff in accordance with the local labor law and with the Global Fund budgeting guidelines. Job descriptions, Terms of Reference and Level of Effort proven to be incremental to the duties and responsibilities of the personnel to be engaged under the Global Fund grant or description of activities, targets, and criteria for which the incentives are envisaged should be an integral part of this scheme. Eligibility criteria for incentives should be clearly defined. In addition, a declaration of conflict of interest and disclosure of information about other jobs (as well as connected people working for the Principal Recipient/sub-recipients) by the staff paid by the Global Fund grants should be also part of this system. The Principal Recipient and sub-recipients should exercise close monitoring and formal performance appraisal of staff. All the top-ups/incentives are to be endorsed by the CCM, as per the Global Fund budgeting guidelines.	1 December 2010

COUNTRY AND PORTFOLIO ANALYSIS

COUNTRY ANALYSIS

Contextual Information

Please describe the situation of the below issues with particular emphasize on key changes and the effect of these on grant implementation. Elaborate on mitigation strategies and material changes adversely affecting grant performance.

Political environment

As of end of January 2010, there have been major changes in the area of TB control in Armenia - the Minister of Health took on the management of the National TB Program, thus demonstrating an unprecedented political commitment. In the fall of 2010, anew deputy Minister of Health (former head of the World Bank PIU) has been appointed and charged with direct oversight of the Global Fund PIU, with a particular focus on the TB grants. New managers of the NTP and PIU were appointed in March 2011 (former staff of the World Bank PIU) thus ensuring that the Program is managed by qualified staff with proper experience in health programs management and implementation.

Since the Minister's of Health leadership of the National TB Program, the following key orders, policy measures, strategy documents and plans have been developed, approved, introduced and their implementation is being monitored: TB Infection Control Plan, National Strategy on TB/HIV Control (2010-2014), 2010-2015 Plan on TB Monitoring and Evaluation, TB Home-Based Treatment and Standard Procedures, National Programme of MDR-TB Management (Ministry of Health Orders N 509, 510, 512, 513, 514 of 01 April 2010), Establishment of Working Groups on Drug Management Evaluation (14 September 2010), Coordination of TB/HIV Control Activities (2 December 2010), status of the National Reference Laboratory, and other relevant provisions that were overdue for several years in the past.

In order to support the recent initiatives led by the Ministry of Health in the TB control area, the Global Fund Secretariat representatives met with the Prime Minister's office in late November 2010 to discuss outstanding issues that could be addressed by increased political support (change of TB health care financing mechanism, increase of state's contribution to the TB control program, need to improve the management of the National TB Dispensary, etc).

The positive changes described above are the result of years-long efforts of national and international partners and donor agencies to strengthen the political commitment and management of the National TB Program. Before the Ministry's of Health take-over of the National TB Program, there was a lack of sound management and coordination of efforts in the TB control area. Despite the fact that all the above changes were needed to improve the implementation environment for the TB control program, this managerial instability heavily affected grants' performance and their direct contribution to the National TB Program, throughout the Round 5 TB grant and the Phase 1 of the Round 8 TB grant.

The currently very strong political support from the higher level Ministry of Health officials to the country's efforts to manage TB might be challenged by the upcoming parliamentary elections in May 2012 and presidential elections in 2013, which might bring about changes in the Ministry of Health upper management.

Economic situation

A major economic factor related to the health care is the fact that the overall public resources allocated to the health care sector remain low and significantly below other developing countries in the Eastern Europe and Central Asia (EECA) region. While 43% of the health care expenditure were covered from the public sources in Armenia in 2009 (source: World Bank databank), the average for EECA developing countries in the same year was 66%. Similarly, out-of-pocket health expenditure remains much higher in Armenia (53 per cent) than in other developing countries in EECA region (28 per cent), according to 2009 data. However, since 2006, one can observe an increasing trend of the proportion of public resources and a decrease of out-of-pocket payments for health care in Armenia.

The economic crisis affected Armenia in 2008-2009 and resulted in decreased levels of the state funding for health. In particular, the state spending on TB in-patient and out-patient services in 2010 dropped by almost 9% as compared to 2009. Toward the end of 2010, however, the situation showed signs of improvement. According to the Mid-Term Expenditure Framework (2011 and onward) of the state funding of health care services, the allocation of funds to TB in-patient and out-patient services is expected to increase by 8-10% yearly. This increase will mainly cover salaries of staff and preventive activities.

The state funding for TB could be made more targeted and efficient by reforming the current in-patient TB health facilities. An overhaul of the TB health care facility planning and financing is expected to take place in 2011-2012, following the recommendations of the recent (April-May 2011) comprehensive review of the National TB Program conducted by WHO.

The Global Fund remains the major financier of the TB diagnostics and treatment in Armenia.

Social situation

Two major factors related to the social situation influence the ability of Armenian population to access health care services: 1) high proportion of out-of-pocket payments for health expenditures, and 2) increase of percentage of population under the national poverty line from 23.5% to 26.5% between 2008 and 2009 (World Bank Databank) as a consequence of the 2008 economic crisis. Combined together, these factors lower the ability of population to ensure financial resources for health care and indicate the need for the state to increase the public funding even in constraint budget settings.

Inadequate housing, poor nutrition, labor migration to host countries were health care services are not available, as well as overcrowding in prisons, expose the population to the TB infection and hinder proper TB control (especially due to labor migration). Adherence to the lengthy TB treatment is particularly challenging because patients prefer caring for their families and leave the treatment institutions or ambulatory treatment. Low wages do not contribute to the TB health care staff motivation to closely follow-up the TB patients.

Legal context

The health care-related legislation undergoes development and revisions in all spheres, including TB, drug regulation, licensing. Some of of those efforts are supported from the Round 8 Health System Strengthening grant (HSS), implemented by the Ministry of Health. In particular, the development of the National Health Strategy is planned to be conducted in the framework of the HSS grant.

In late 2008, the American University of Armenia undertook an extensive TB legislation review identifying areas in need of revision. This work is yet to be conducted, and the support of the relevant Parliament commissions has been secured.

In the meantime, WHO has initiated work on reforming the TB health care financing from the current bed-day financing (hampering ambulatory treatment and motivating hospital management to keep patients longer) to a pay-for-performance system allowing to reward the TB health care staff for each successfully treated patient. This work is yet to be completed by linking this pay-for-performance system with other alternative financing mechanisms and in-patient unit reforms. A pilot of the pay for performance scheme is included in the CCM Request for Continued Funding.

The Ministry of Health developed a draft law on banning the sale of the first line TB drugs, which was sent to Ministries of Finance and Justice for comments. Upon receipt of their feedback the final draft law will be then submitted to Government for approval. A concrete mechanism for monitoring the execution of this order and eventual sanctions of pharmacies that still sell those drugs is yet to be developed and implemented. Currently, a high level discussion led by the Prime Minister's office is taking place regarding the sale of antibiotics. It is expected that this discussion will regulate the antibiotics market in the country and benefit the TB control program.

As the Government of Armenia adopted a new Procurement Law in January 2011 and it made a decision to outsource procurement functions of Ministries to Project Implementation Units created by the World Bank in those Ministries (including MOH) starting from year 2012. The corresponding legal acts and decisions associated with public procurement procedures are yet to be translated into detailed standard operating procedures. At present, due to the lack of detailed information about the new modalities, it is not clear how these changes will affect the procurement procedures under the GF grants.

The Ministry of Health is currently trying to find alternatives to bypass the State Procurement Law for selecting/contracting Sub-Recipients and instead - creating SR selection and contract administration procedures to be approved by the Government of Armenia. This may also significantly improve grant implementation because delayed SR selections/contracting procedures (through tenders) and inability of the PR to make advance disbursements to the SRs have greatly affected the grant performance throughout the Phase 1.

The Republic of Armenia is planning to sign the Privileges and Immunities Agreement with the Global Fund, which will facilitate the VAT exemption (currently, VAT exemption for each contract needs to be saught separately and takes 2-3 weeks).

Epidemiological situation

Tuberculosis re-emerged as an important public health issue after Armenia gained its independence from the Former Soviet Union. As in other Former Soviet Union countries, Armenia faces a high burden of TB: Armenia is one of the 18 high priority countries for TB control in the WHO European Region and also among the 27 high MDR-TB burden countries in the world. TB notification rate in 2009 was 45.5 and TB death rate was 3.9 per 100,000 population.

Some improvements in the overall epidemiological situation have been observed since 2005: the number and rate of new TB cases have been continuously increasing since 2000, reaching its peak in 2005, after which it started to slowly decrease. The trend in the TB notification rate in Armenia was stabilizing from 2005 to 2009; dropping substantially from 2005 to 2006; declining much less from 2006 to 2007; and almost remaining constant from 2007 to 2009. According to the Global TB Control Report of 2010, TB mortality rate in Armenia is on the increase from 9.7 deaths per 100,000 population in 2005 to 12 deaths per 100,000 both in 2008 and 2009. This represents a sizeable gap from the targeted 7 per 100,000.

The percentage of patients with interrupted treatment is decreasing. However, the percentage of MDR TB cases among new and re-treated patients is still alarming: the Drug Resistance Survey in 2008 reported 10.4% and 45.1% of any R resistance among new and retreatment cases, respectively. In 2009, the National Reference Laboratory reported 16.7% and 38% MDR-TB rate among new and retreatment patients, respectively.

TB detection rate for new smear positive cases decreased from 57% in 2009 to 36% in 2010, and it remains one of the main challenges of the National TB Program. The causes of this reduction have not been duly explored. The absolute number of new smear positive cases decreased from 440 in 2009 to 339 in 2010. According to WHO, this indicator, however, does not allow to properly measure the diagnostic capacity in the country. In the Phase 2 request, this indicator is replaced by the case notification rate. The National TB Program, with the help of the Global Fund grant support, has introduced some measures to improve case detection: training of health care staff involved in TB detection, diagnosis and treatment, development and distribution of TB guidelines, regularization of sputum transportation from regions to the National Reference Laboratory, introduction of regular supervision of detection activities in the regions. The Red Cross Society of Armenia has been in charge of Information, Education and Communication (IEC) and social support activities among TB patients and their families. The National TB Program needs to intensify its efforts of active case finding among specific population groups (i.e. women, migrant workers, prisoners, People Living With HIV/AIDS).

Treatment success rate (cured and completed treatment) for new sputum smear positive (ss+) cases increased from 69% for 2006 cohort to 73% for 2008 cohort. In 2009, the treatment success rate was 72.5% for 2009 cohort. Although treatment success rate of new ss+ cases is slowly increasing, the percentage unfavorable treatment outcomes for regular TB remains higher than those of successful TB control programmes: death 7%, failure 9%, default 8%. Introduction of treatment adherence incentives and implementation of ambulatory treatment country-wide might help to achieve better treatment success.

The high burden of MDR-TB cases (estimated 480 in 2009 by WHO) can be addressed by a scale-up of MDR TB treatments planned in the Phase 2 of the Round 8 grant and in the Round 10 TB proposal. It is planned to conduct a study on risk factors for MDR TB in Armenia. Its results (to become available in the fall of 2011) will further inform targeted strategies for addressing prevention and early detection of MDR TB.

TB/HIV co-infection: although the percentage of TB patients with known HIV status is steadily increasing (from 16% in 2007 to 26% in 2009, it still remains rather low and does not allow to fully analyze the impact of the two diseases. The Round 10 TB proposal plans to address the issue of low testing rate with target of 100% TB patients tested by 2016.

Data on the influence of key social and contextual factors affecting the TB epidemic are lacking. This particularly refers to labor migration (mainly to Russia) for which one operational research study is planned. Yet, there are no resources allocated to implement specific activities targeting this population as could be recommended following the research. Further, gender differences in TB case notification and possible issues underlying it remains unexplored. It is recommended to allocate resources for these important operational research activities.

Please describe the funding trends for the disease under review and HSS

Funding from external donors tends to decrease (as illustrated by KfW funding and ICRC withdrawal). MSF is the main partner/donor to the NTP along with the Global Fund. USAID provides mainly technical assistance and aims to bring a resident external expert to assist the management of the NTP with the implementation of the program. WHO offers technical assistance within its mandate and Biannual Service Agreement, like the recent extensive NTP review.

The World Bank-supported Health system Modernization Project assists with the development of primary health care services in general, targeting Family Medicine development in urban and rural areas through training of family doctors and nurses and improvement of physical infrastructure. The training curriculum of family physicians and nurses includes modules on tuberculosis management, whereas infrastructure of rural ambulatories acting as DOTS spots for rural communities is also improved in the scope of the World Bank project. The Institutional Strengthening component of the project covers technical assistance in the areas of Drug Policy, Health system licensing and improvements of financing mechanisms of the health care system in general.

Please describe how the program is advancing the promotion of broad and inclusive partnerships

Coordination of activities in the TB sector improved since the establishment, in 2009, of a CCM TB working group composed of national and international stakeholders, including non-governmental organizations. Nevertheless, due to personnality issues, a broader coordination of partners has been challenging up until early 2010 when the Ministry of Health took a direct leadership of the National TB Program and appointed new NTP and Global Fund PIU managers. Strong cooperation has been achieved among the following partners/donors: WHO, USAID, the Global Fund, American University of Armenia, MSF, and, before withdrawal, with ICRC. This donors/partner mobilization into one voice has greatly stimulated the growing attention of the Ministry of Health to the issues in the TB field.

Since early 2011, the CCM has been undergoing reforms in order to renew its membership and strengthen its fulfillment of core functions, including program oversight. The new bylaws and framework documents have been developed with external technical assistance and have been submitted to the Prime Minister's office for formal endorsement. It is expected that the CCM will also be responsible for assessing the gaps between the needs of tuberculosis control program and the available resources and coordinate the process of applications to the Global Fund and other donors for additional resources.The leadership of the Minister of Health of the CCM as a strategic coordination and decision making body allows for a constructive integration of the TB program with the broader health system. This marks a considerable difference from the previous CCM leadership arrangements where the CCM Chair was from the non-governmental sector.

PORTFOLIO ANALYSIS *(PROVIDED INFORMATION DEPENDING ON DISEASE COMPONENT)*

Number of grants by disease and PR

	HIV/AIDS	Tuberculosis	Total
Civil Society/Private Sector: Non-Governmental Organization	2		2
Government: Ministry of Health	2	2	4
Total	4	2	6

Overview of Portfolio Financing

	HIV/AIDS	Tuberculosis	Total
Approved Maximum	$ 21,923,089	$ 14,253,083	$ 36,176,172
Total Funds Disbursed	$ 16,095,251	$ 7,880,708	$ 23,975,959

Committed funds by Round and disease

	HIV/AIDS	Tuberculosis	Total
Round 2	$ 20,858,466		$ 20,858,466
Round 5		$ 7,015,460	$ 7,015,460
Round 8	$ 1,742,868	$ 2,491,763	$ 4,234,631
Total	$ 22,601,333	$ 9,507,223	$ 32,108,556

Grants in detail

Component	Round	Grant No.	PR	Grant age (months)	Financial performance				Latest performance rating
					Total grant amount	Disbursed to date	Percent disbursed	Time elapsed	
HIV/AIDS	2	ARM-202-G01-H-00	World Vision International - Armenia Branch	96	$9,104,989	$9,104,989	100 %	100 %	B1
Tuberculosis	5	ARM-506-G02-T	Ministry of Health of the Republic of Armenia	58	$7,015,460	$6,637,810	95 %	80 %	B2
Tuberculosis	8	ARM-809-G03-T	Ministry of Health of the Republic of Armenia	23	$2,491,763	$1,242,898	50 %	79 %	B1
HIV/AIDS	8	ARM-809-G04-S	Ministry of Health of the Republic of Armenia	21	$1,742,868	$1,399,856	80 %	50 %	A1
HIV/AIDS	2	ARM-202-G05-H-00	Ministry of Health of the Republic of Armenia	96	$5,204,844	$2,154,904	41 %	50 %	B1
HIV/AIDS	2	ARM-202-G06-H-00	Mission East	96	$6,548,633	$3,435,503	52 %	33 %	B1

Legend	A1 (> 100)	A2 (90% - 100%)	B1 (60% - 89%)	B2 (30% - 59%)	C (< 30%)

Please provide a summary of the objectives of each of the grants in the portfolio and describe the linkages.

The Round 8 TB grant complements the earlier Round 5 TB grant in strengthening the National TB Program. While the Round 5 TB grant focused on a wider range of activities (trainings, infrastructure renovation, IEC activities, social support), its main focus was drug-sensitive TB. The Round 8 TB grant mainly focuses on laboratory diagnosis of DR TB and treatment of DR TB cases. Overlaps in activities and funding between both grants have been avoided through detailed yearly budget reviews and approvals. Both grants were not consolidated in the past due to the fact that the Round 5 TB grant ends in December 2011 and there was insufficient PIU finance staff capacity at a time when the consolidation would have been relevant.

The Round 8 HSS grant benefits the TB control efforts by such broad activities as national health strategy development, information system strengthening, procurement and supply of pharmaceuticals.

PROGRAM DESCRIPTION AND GOALS

Program Description Summary

TB re-emerged as an important public health problem in Armenia in the 1990s. Armenia adopted DOTS as a national strategy in 1995. Although coverage is considered to be 100 percent, the country lags far behind the target in terms of treatment outcomes. One of the most important reasons for this is the high burden of drug resistance. The program aims to improve the treatment success rate by expanding multidrug-resistant TB diagnosis and treatment services. The program focuses on decentralizing TB case detection and ambulatory treatment through the involvement of the primary health care sector. It targets homeless people, prisoners and ex-prisoners, refugees and people with immunodeficiency syndrome. The overall goal of the program is to reduce the burden of TB in Armenia through increasing access to and the quality of TB diagnostic and treatment services.

Program Goals and Impact Indicators

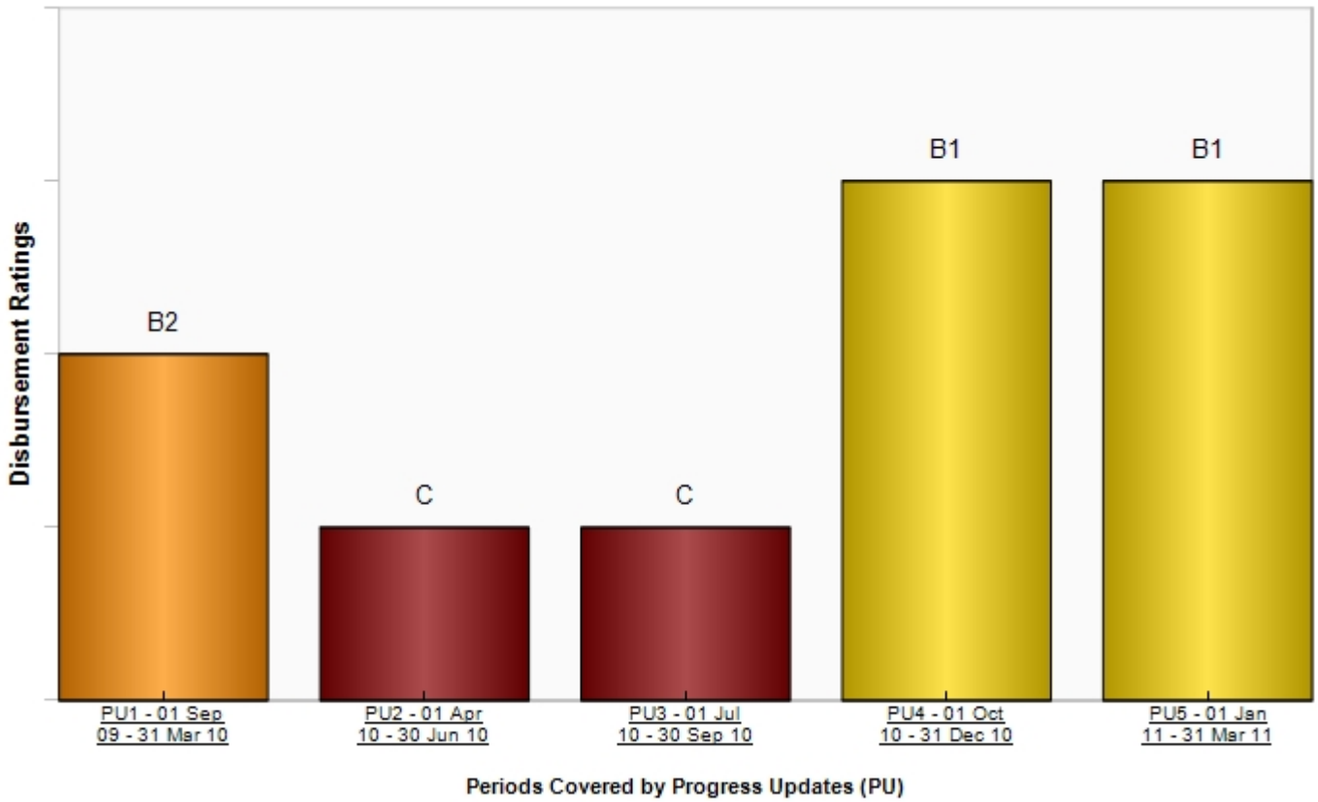
Goal Description	Indicator	Indicator Name
To reduce the burden of tuberculosis in Armenia by scaling up the management of drug-resistant tuberculosis	Impact Indicators	MDR-TB prevalence among new smear-positive cases, %
		TB mortality rate: estimated number of deaths due to TB (all cases) per yer par 100 000 population
	Outcome Indicators	Case detection rate for new smear-positive TB cases (number and percentage of new smear positive TB cases detected under DOTS to the estimated (by WHO) number of new smear-positive TB cases in a given year)
		Treatment success rate: new smear positive TB cases (number and percentage of new smear-positive TB cases successfully treated (cured+treatment completed) under DOTS to the total number of new smear-positive TB cases registered in a given year)
		Non-documented treatment result rate (default, transfer out, not evaluated) among new smear positive TB cases (number and percentage of new smear-positive TB cases who iterrupted treatment or were transferred out without being re-registered in another treatment unit or not evaluated for treatment outcome to the total number of new smear-positive TB cases registered in a given year)
		Treatment success rate of MDR-TB patients: number of patients who were cured or completed Category IV treatment (% of the total number of patients in the same registration cohort)
		Number and percentage of laboratory-confirmed MDR-TB patients still receiving treatment among those enrolled in second-line anti-TB treatment 12 months before
		MDR-TB prevalence among previously treated smear-positive cases, %

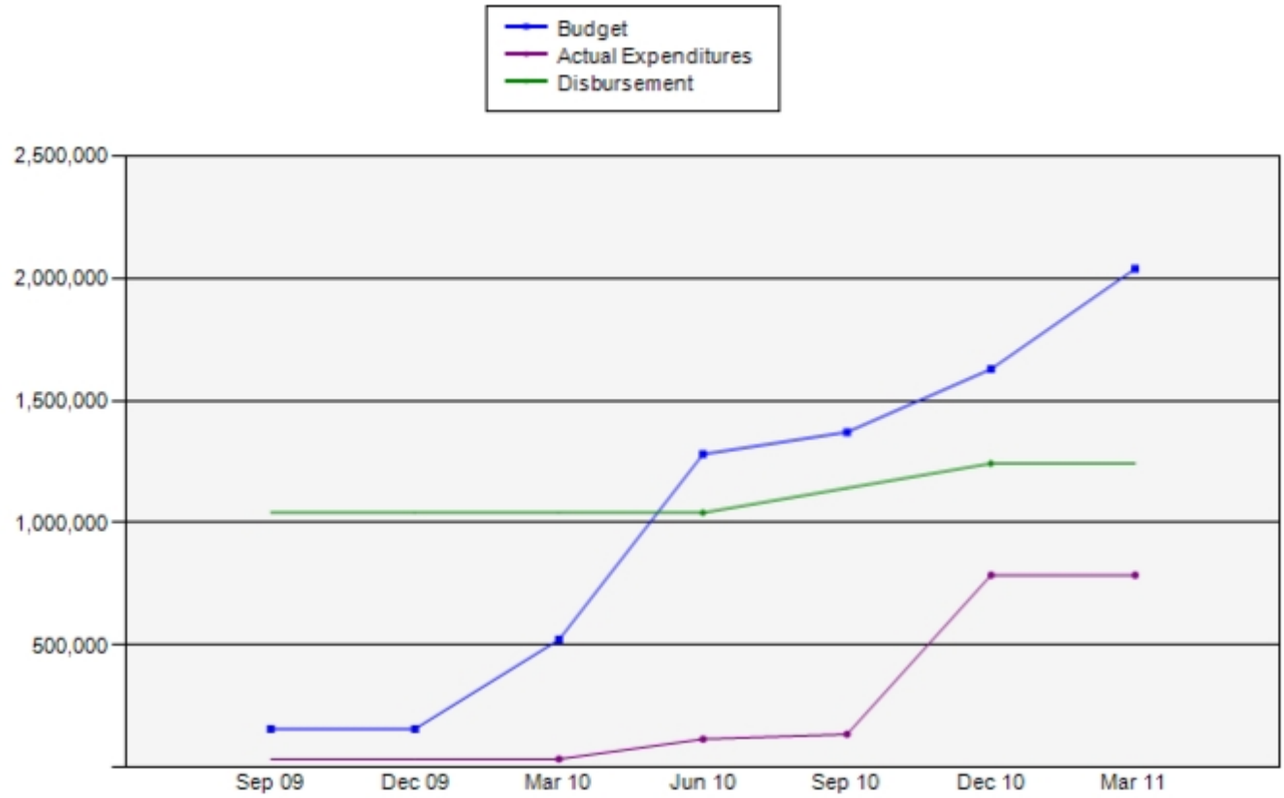
PHASE 1 PERFORMANCE

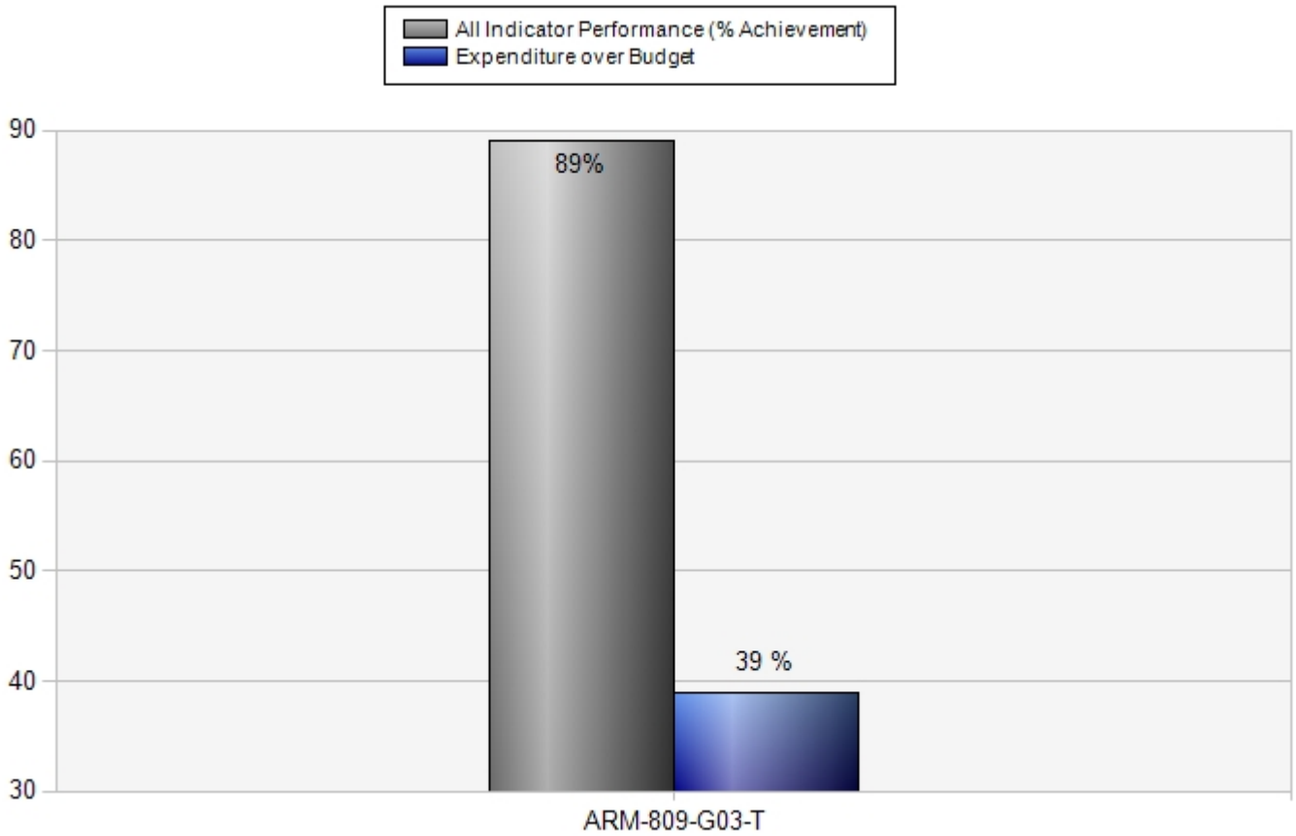
GRANT PERFORMANCE OVERVIEW

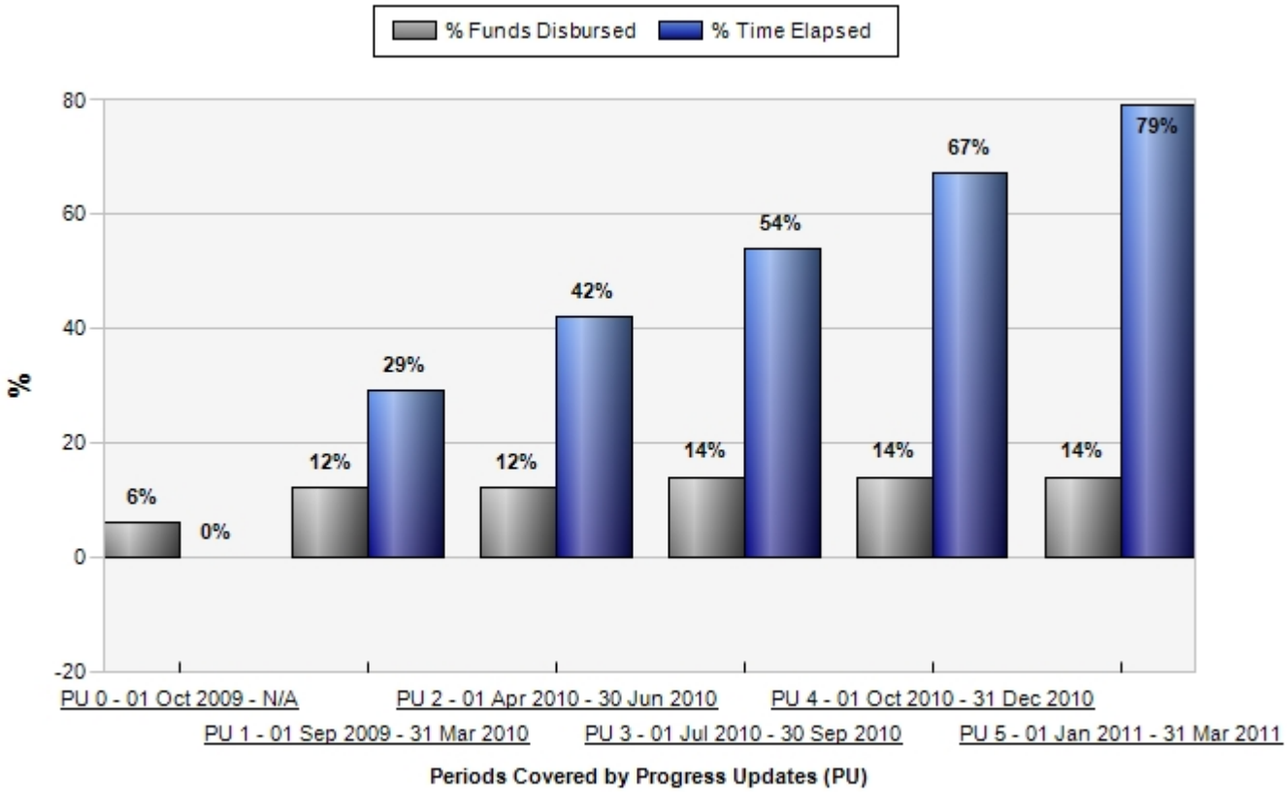
Latest PU	Latest TGF Rating	All Indicator Perf.	Top 10 Indicator Perf.	Time Elapsed	Disbursed to Date	Fulfilled CPs	Expenditure Rate	Latest Disbursement Date
01.Jan.2011 - 31.Mar.2011	B1	89%	111%	19 Months (79%)	$ 1,242,898	3/5	39 %	13.Dec.2010

Legend	A1 (> 100)	A2 (90% - 100%)	B1 (60% - 89%)	B2 (30% - 59%)	C (< 30%)




Budget
Actual Expenditures
Disbursement
2,500,000
2,000,000
1,500,000
1,000,000
500,000
Sep 09
Dec 09
Mar 10
Jun 10
Sep 10
Dec 10
Mar 11


All Indicator Performance (% Achievement)
Expenditure over Budget
90
80
70
60
50
40
30
89%
39 %
ARM-809-G03-T


% Funds Disbursed
% Time Elapsed
80
60
40
20
0
-20
%
6%
0%
12%
29%
12%
42%
14%
54%
14%
67%
14%
79%
PU 0 - 01 Oct 2009 - N/A
PU 1 - 01 Sep 2009 - 31 Mar 2010
PU 2 - 01 Apr 2010 - 30 Jun 2010
PU 3 - 01 Jul 2010 - 30 Sep 2010
PU 4 - 01 Oct 2010 - 31 Dec 2010
PU 5 - 01 Jan 2011 - 31 Mar 2011
Periods Covered by Progress Updates (PU)

FINANCIAL PHASE 1 PERFORMANCE

Are there any undisbursed funds or available cash from Phase 1? Yes

If yes, please explain the reasons for it (activities not performed, savings realized,...)

At the time of the Phase 2 review, the amount of EUR 348,775 has not been disbursed by the Global Fund Secretariat, mainly due to delays in program implementation as per challenges described in relevant sections of this Grant Score Card. It should be noted that large efficiency gains (300k) were achieved from infrastructure renovation works. This has also affected the volume of cash at hand at the PR level and the flow of disbursements from the Global Fund Secretariat.

A no-cost extension will be provided to the Grant for the period 1 September - 31 December 2011 in order to allow for the consolidation with the Round 10 TB proposal into a Single Stream Funding grant.

Was the Phase 1 expenditure in line with targets achieved in Phase 1? No

Please explain

Expenditures in Phase 1 have been made toward programmatic activities planned in the agreed workplan and budget. Yet, it should be noted that slow disbursement flow from the Global Fund and delays in funds absorption have only slightly affected the good programmatic performance in terms of achievement of indicators. This is due to the administrative challenges that the grant has faced and that have not allowed it to reach its full potential in terms of targeted support to the National TB Program. Also, it should be noted that thanks to a prudent use of funds by the Principal Recipient, considerable efficiency savings were achieved for the renovation of TB treatment facilities (EUR 300k).

A large portion of the total underspent during the first 18 months (932,183) is explained by efficiency savings identified during the development of the specs for renovations of MDR-TB in-patient department (300K), and the savings on staff salaries and side effect drugs covered by other external and GF funds (142K). Due to delays in procuring reagents/tests for PCR and training of staff in testing techniques (168K), because of the delayed procurement of PCR equipment the indicator on R/H testing of drug resistance has been achieved only by 7%. The rest of the underspent represent delays in implementation costs that have no direct impact on targets.

Secretariat Conclusions and Recommendations - Financial Aspects of Phase 1 Performance

The spending rate during the first 18 months of Phase I is 42% of the cumulative budget, and is mostly due to delays in approving annual budgets by the Ministry of Finance. The Secretariat is recommending a time-bound condition to address this issue and to ensure timely approval of the grant budgets. The forecast for M19-24 plans to catch-up many delayed payments and activities, and has been adjusted for realistic implementation rate.

47% of the variance is due to savings on renovation and efficiencies due to consolidation with R5. The PR is planning to use some of the savings for additional incentives to DR-TB cabinets' staff and patients to improve poor adherence in the program, and cover the increased cost of MDR-TB treatment. The Secretariat is recommending to retain the re-allocation of funds subject to fulfilling the conditions and management actions on implementation plans for the overall enhanced incentive scheme.

PROGRAMMATIC ACHIEVEMENTS AND MANAGEMENT PERFORMANCE

Top 10	Train.	#	Active Indicator Name	Target		Result		Percentage
				Period	Value	Period	Value	
	No	5.1	Number of culture investigations (manual proportion method) performed for confirmation of TB diagnosis	6	4,078	6	5,186	120 % *
	No	5.2	Number of TB patients covered by drug susceptibility testing (DST) to 1st line drugs for DR-TB diagnosis	6	1,014	6	963	95 %
	No	5.3	Number of patients tested for rapid identification of R/H resistance using PCR technique	6	710	6	47	7 %
	No	5.6	Percentage of patients on MDR-TB treatment who were tested on DSTto 2nd line anti-TB drugs according to a national guidelines	6	N: 96 D: 96 P: 100 %	6	N: 30 D: 34 P: 88.2 %	88 %
Top 10	No	5.7	Number of MDR-TB patients on treatment who received food parcels	6	170	6	173	102 %
Top 10	No	5.8	Number of education and counselling sessions for MDR-TB patients on treatment	6	40	6	186	120 % *

* Individual indicators should have a maximum score of 120%, when calculating the mean.

** The Results reported ealier than expected are rewarded with a 120% achievement.

Value for Reporting Period missing. The nearest preceding value is taken if available

Value of the first valid Target, for an Early Reporting scenario.

Performance Rating	All Indicator or Top Indicator Score
A1	>100
A2	90%-100%
B1	60% - 89%
B2	30% - 59%
C	< 30 %

Cannot Calculate Scenarios	
S1	Target and Result are in different value types
S2	Target and Result are entered as Text. % Achievement is missing.
S3	Target is zero
S4	Result is zero for indicator requiring reverse calculation.
S5	Numerator/Denominator/% value incomplete

AVG performance on TRAINING Indicators	0%
AVG performance on TOP TEN indicators (including TRAINING)	111%
TOP TEN indicators rating	A1
AVG performance ALL indicators	89%
ALL indicators rating	B1
Number of TOP TEN indicators with B2 or C Rating	0
Quantitative Indicator rating	A2

How does the grant contribute to the achievement of national targets? Please indicate the contribution of specific indicators.

The grant continues to contribute to the MDGs indicators for Objective 6 - Combat HIV/AIDS, malaria and other diseases. In particular the grant contributes to the achievement of main TB indicators, namely - deaths due to TB per 100,000 population, incidence and prevalence of TB per 100,000, case detection rate for all forms of TB and smear-positive TB treatment success rate.

TB mortality rate is one of the three main indicators used to assess the burden of disease caused by TB. The Stop TB Partnership has set a target of halving the 1990 TB mortality rate by 2015. By offering TB treatment (both first- and second-line), the grant contributes to reducing mortality from TB.

Treatment success rate is a very important indicator of the quality of TB care, and can be directly measured. The global target for 2015 included in the Global Plan to Stop TB 2011-2015 is 90%. TB Treatment success rate for new smear positive cases is gradually improving (equals to 69 % for 2007 cohort, 73.3% for 2008 cohort and 72.5% for 2009 cohort), however it is recognized that efforts need to be sustained to achieve the targeted 85%. The start of the MDR-TB treatment in the country will also contribute to its achievement.

In line with the WHO recent recommendations, less emphasis is now being placed on the case detection rate. The case detection rate has been replaced by the case notification rate in the Performance Framework for Phase 2, which can be directly measured and reported by all national TB programs. It is recognized, however, that the change of measurement from case detection to case notification does not alleviate the need to strengthen case-finding efforts.

Analysis of Indicator Performance to date (including reasons for important deviations between results and targets, if any)

At the end of the Quarter 6, the Program shows satisfactory results overall: of the six indicators measured, four have achieved and over-achieved their targets, including two Top 10 indicators. One indicator (percentage of patients on MDR-TB treatment who were tested for drug resistance testing) is achieved at 88 per cent due to some samples being received at the end of the reporting period and tested in early April. One indicator (number of patients tested for rapid identification of R/H resistance using PCR technique) is achieved at 7 per cent only due to 1) delays in purchasing the PCR equipment; 2) delays in providing training to the laboratory staff on the use of this technology; and 3) insufficient buffer stock for reagents to launch a full-fledged PCR testing process after the initial piloting period.

Despite the quantitative indicator rating being "A2", the following data quality issues are to be noted: 1) the number of MDR patients receiving food parcels slightly (by 13 units) exceeds the total number of MDR enrolled on treatment during that period, hence there is some reporting inconsistency; and 2) the results reported for the number of education and counseling sessions for MDR-TB patients on treatment include the number of home visits performed for MDR-TB patients and group sessions involving regular TB patients also. While notionally the individual home visits can be considered as education and counseling sessions, the PR has been advised, through on-going correspondence, to streamline the indicator description, data collection and reporting mechanisms in the M&E plan and in the Performance Framework.

Achievement against program impact goals

	Baseline			Year1		Year 2	
	Source	Date	Baseline	Target	Result	Target	Result
Case detection rate for new smear-positive TB cases (number and percentage of new smear positive TB cases detected under DOTS to the estimated (by WHO) number of new smear-positive TB cases in a given year)	WHO Global TB Report 2008	2006	59.3%	N: 772.00 D: 1143.00 P: 67.50%	N: 339.00 D: 934.00 P: 36.30%	N: 782.00 D: 1117.00 P: 70.00%	N: D: P: %
Treatment success rate: new smear positive TB cases (number and percentage of new smear-positive TB cases successfully treated (cured+treatment completed) under DOTS to the total number of new smear-positive TB cases registered in a given year)	R&R TB system, yearly management report	2006cohort	72.5%	N: 414.00 D: 487.00 P: 85.00%	N: 319.00 D: 440.00 P: 72.50%	N: 656.00 D: 772.00 P: 85.00%	N: D: P: %
Non-documented treatment result rate (default, transfer out, not evaluated) among new smear positive TB cases (number and percentage of new smear-positive TB cases who iterrupted treatment or were transferred out without being re-registered in another treatment unit or not evaluated for treatment outcome to the total number of new smear-positive TB cases registered in a given year)	R&R TB system, yearly management report	2006cohort	16%	N: 73.00 D: 487.00 P: 15.00%	N: 52.00 D: 440.00 P: 11.80%	N: 116.00 D: 772.00 P: 15.00%	N: D: P: %
Treatment success rate of MDR-TB patients: number of patients who were cured or completed Category IV treatment (% of the total number of patients in the same registration cohort)	TB treatment cards, NTP R +R system	2006	N/A	64% (27/42) (MSF 2006 cohort)	53.6% (30/56)	66% (38/58) (MSF 2007 cohort)	
Number and percentage of laboratory-confirmed MDR-TB patients still receiving treatment among those enrolled in second-line anti-TB treatment 12 months before	TB treatment cards, NTP R +R system	2008	N/A	70% (62/88) (MSF 2008 cohort)	32% (25/78)	72% (108//150) (MSF 2009 cohor	
MDR-TB prevalence among new smear-positive cases, %	Drug resistance survey	2006-2007	9.4%	N: D: P: 8.60%	N: D: P: 10.70%	N: D: P: 8.40%	N: D: P: %
MDR-TB prevalence among previously treated smear-positive cases, %	Drug Resistance Survey	2006-2007	42.9%	N: D: P: 38.00%	N: D: P: 22.90%	N: D: P: 36.00%	N: D: P: %
TB mortality rate: estimated number of deaths due to TB (all cases) per yer par 100 000 population		2003	11	7.00	12.00	5.00	

Is there a recent national survey or national study on impact and outcome available? No

If yes, when was it conducted?

Please provide a summary of the main findings

In cases of documented evidence of outcome and/or impact, please explain how the activities of the grant may have contributed

Grant Management Issues

ADDITIONAL Management issues

Monitoring and Evaluation Systems Management (incl data quality)

Data collection and reporting by the National TB Program needs improvement. The implementation of the e-TB manager countrywide as a comprehensive register of TB cases and a forecasting tool for laboratory consumables and treatments, is a full-fledged activity in the Phase 2 workplan and budget.

During the verification of the Progress Update/Disbursement Request, it was noted some data collection and reporting issues: 1) the number of patients to whom food packages were distributed (173) is slightly higher than the number of patients on treatment (160); and 2) individual home visits and group sessions to all TB patients are also reported under the indicator "Number of education and counseling sessions for MDR TB patients on treatment". In the last Management letter, the PR is requested to provide relevant explanations for addressing the issues identified with regard to further streamlining of the modalities of data collection and reporting for those indicators in the M&E plan and the Performance Framework.

Program Management

A major obstacle for a successful implementation of the National TB Strategy and management of the National TB Program has been the lack of visionary and sound managerial arrangements since the inception of a separate entity (National TB Program Central Office) for implementing the National TB Program. Up until February 2010, the National TB Program was managed by a person who was at the same time Director of the Health Care Services Department at the Ministry of Health and Manager of the Global Fund Program Implementation Unit. Moreover, there was no cooperation ensured with the National TB Dispensary that is led by the Chief TB doctor of the country. Both personalities were in opposition to each other and this heavily affected the coordination of TB services and sound management at all levels.

Since the Global Fund is the main financier of the National TB Program, a smooth flow of funding in support to programmatic activities is crucial. Yet, due to insufficient number and qualifications of the Global Fund PIU staff up until July - September 2010, the administrative, financial and procurement activities under the Global Fund grants were constantly facing delays and other issues resulting from insufficient planning and management.

Only since May 2010 when a new National TB Program manager was appointed and since July 2010 when a new Manager of the Global Fund Program Implementation Unit was selected by partners and donors in the country, sound mechanisms for mutual cooperation between the NTP and the GF PIU were established.

In November 2010, a new Deputy Minister of Health was appointed (former Director of the World Bank PIU) who started to transform the management practices at the Ministry of Health in line with international standards and performance requirements. In April 2011, a new GF PIU Manager was appointed from the World Bank PIU, followed by an appointment, in May 2011, of a new NTP Manager from the World Bank PIU also. These professionals bring with them a wealth of experience in health program management and it is expected that this set of individuals will manage to bring about positive changes.

The Global Fund program management by the Ministry of Health in its status of national entity goes hand-in-hand with various administrative bottlenecks that a state entity faces in developing countries: heavy bureaucratic procedures, lengthy approvals and iterations, cumbersome procurement procedures. The Global Fund grants have been affected by these challenges. Yet, considering the high level political support secured for the TB program on behalf of the upper management of the Ministry of Health and from the Prime Minister's office in the course of grant implementation, the "ownership" of the challenge and stimulation of better management practices have out-weighted the administrative burdens that can be addressed in future through adequate staffing and proper anticipatory planning.

One of the challenges related to the difficulties, for a state entity, to contract sub-recipients in the sense of implementation partners. According to the current state procedures, sub-recipients are considered as service providers who can only receive payment after the delivery of services. This lack of flexibility with regard to a donor-funded program implementation has resulted in delays with selecting and contracting sub-recipients as well as some weaknesses in the financial administration (i.e. the Armenian Red Cross Society had to advance funds from other sources to implement programmatic activities during the first quarter, after which it presented invoices for reimbursement by the Ministry of Health).

Financial Management & Systems

The main bottleneck for grant's implementation was the lengthy approval of the grant's yearly budgets by the Ministry of Finance (throughout the implementation period, this approval has taken about one quarter). Thus, as it can be seen from the funds absorption rate in Quarter 6 (January-March 2011), the absence of Ministry of Finance approval can result in zero funds disbursed during an entire quarter. Looking at grant's quarterly performance over time, spending of funds resumes in the second calendar quarter, continues increasing in the third quarter and reaches its peak in the fourth quarter.

Preparation of yearly budgets for the Ministry's of Finance approval takes considerable PIU staff time since the requirements in terms of budget details are different from the Global Fund. Therefore, the PIU performs double work to secure both approvals from the Global Fund and from the Ministry of Finance.

A recent review of sub-recipient expenditures illustrated some lack of oversight, on behalf of the PR, on the financial management at SR level, as well as insufficient scrutiny of financial documentation submitted by the SRs. The last Management letter strongly requests the PR to strengthen its fiduciary oversight of Sub-Recipients. It should be noted, however, that this oversight is expected to improve with the recent selection of additional finance and procurement specialists who have adequate background and experience in carrying out their work (at the difference of previously employed finance and procurement staff).

Pharmaceutical and Health Product Management

The Ministry of Health and the GF Program Implementation Team have faced a number of management challenges to resolve, including appropriate staffing at the PIU as well as delays in procurement of goods and services during the course of the Phase 1 period. Staffing problems have gradually been overcome in 2010 and in 2011 after two major reorganizations of the PIU, as described in the Program Management section above. A procurement review was conducted in October 2010 revealing significant shortcomings mainly in the procurement documentation handling and relative to the incompatibility of the State Procurement regulations with the Global Fund requirements for open and transparent procurement practices. According to the follow-up of procurement review in May-June 2011, some improvements are noticeable in terms of procurement planning and speed of conducting procurement. Also, a long outstanding Procurement Manual (Condition Precedent under the grant) in its final revision has been approved by the Minister of Health in April 2011.

The cumbersome Public Procurement Law has been revised and a somewhat less time consuming and less bureaucratic new law has come into force as of 1st of January 2011. According to the PIU Manager and Deputy Minister of Health it is likely that the procurement function of the PIU will be transferred to the World Bank PIU. As from the first of July 2011, all Works (infrastructural) will be transferred from the Ministry of Health to the World Bank PIU. This will be followed by a further transfer of procurement activity regarding procurement of goods and services from the 1st of January 2012. Unfortunately, no documentary evidence was available to verify this information except for the Government decree of February 2011 that states such possibility.

Considerable weaknesses in treatment planning are attributed to weak patient and medicines' management information system. Deficiencies in estimation of MDR TB cases to be treated by 2nd line anti-TB medicines and reporting on cases under treatment were persistent during the Phase 1. Currently the estimated number of MDR TB cases in the PSM Plan was not confirmed by the NTP and the National Reference Laboratory.

The law on public procurement which was recently amended will have an impact on the Global Fund procurements. However, since no documentation is yet available to define the new procurement roles and responsibilities, it is not possible to infer at this stage to what degree the revised law will influence the Global Fund procurements.

Other Management Issues (e.g. Quality of services etc).

N/A

Recommended Secretariat Phase 2 Rating

FINAL RECOMMENDED SECRETARIAT PHASE 2 RATING	B1

OTHER PHASE 1 PERFORMANCE ISSUES

Aid Effectiveness

Please elaborate on effectiveness issues identified in the Effectiveness Support Tool or other sources in the areas of a. ownership & accountability, b. alignment to country cycles and c. harmonization and coordination with other donor-funded activities.

Aid Effectiveness Tool: "The grant performs very well in terms of aid effectiveness. The grant's financing is reported on the country budget as approved by the Parliament, and its reporting cycle is aligned with the national fiscal cycle. Moreover, salaries are harmonized with interagency (donor-to-donor) salary frameworks".

The grant funds are recorded in the state budget. The grant financing is aligned with country systems and cycles. As the grant is implemented by the Ministry of Health, annual budget is reported and approved by the Ministry of Finance / Government; grant disbursements are recorded in the national accounting books and payments are made according to national budget execution procedures. Further, the PR is subject to the State Public Procurement Law. Also, management of pharmaceutical and health products purchased under this grant is done through the national system. Finally, M&E activities under this grant are implemented within the framework of the National M&E Plan for TB.

The Global Fund is the major donor supporting TB control in Armenia (since end of the German Government assistance). The Global Fund supported activities are part of the NTP and coordinated with other donors (mainly Medecins Sans Frontieres). Salaries under Global Fund supported grants are aligned with interagency salary framework.

Gender Equality

Is there evidence that women and/or sexual minorities are restricted from accessing care / receiving interventions? Yes

If yes, please explain

A correct answer to this question would be "No" - there is no evidence that women and/or sexual minorities are restricted from accessing care/receiving interventions, because there is no data available to validate this statement.

While there are no obvious and direct structural barriers that would limit access of women to health services (including TB diagnostic, treatment and support) there are some indirect factors related to overall position of women in society that influence help-seeking behavior, both in terms of access to health services and approaching them.

One observes that results reported under indicator "Ration female to male TB notification" are far below targets and remain unchanged since the beginning of Rd5 grant (2006). While the target for the last reporting period (ended 31 December 2010) was 1:1.6 the reported result was 1:2.9.

In terms of unchanged situation related to female/male TB notification ratio, the PR and NTP explained that this is due to the fact that men are more at risk at contracting TB since men migrate to neighboring countries (mostly Russia and Ukraine) with higher TB burden to work. However, it is observed that lower TB notification rate among women could also indicate low diagnostic in this particular group, as result of lower approaching health services due to poverty and stigmatization. This view can be supported by more detailed analysis of 2010 NTP report on newly detected sputum smear positive cases, which indicates the highest female to male ratio in the age group 25-55, where this ratio was 1 female to 6.9 male. In other age groups (below 25 and above 55) the ratio was 1 female to 2 males. This indicates that lowest proportion of notifications is among women of working and reproductive age.

Related to male/ female ratio in TB notifications it has to be acknowledged that there are no specific data related to gender aspects of TB in Armenia and that the set target may be unrealistic even with adequate help-seeking behavior of women and access to services, as this ratio is at the level of other European countries (source: Gender in tuberculosis research, WHO, 2005). At the same time, women are more vulnerable to poverty and poverty does influence addressing health services mainly due to large percentage of out-of-pocket payments in Armenia (source: Armenia Health System Performance Assessment, WHO, 2009).

The CCM Request for Continued Funding mentions that the grant aims to provide equitable and accessible health services to all citizens of Armenia, thus not excluding any particular population and aiming at reaching all those in need. Yet, besides this statement, gender issues are overall not addressed in the Phase 2 proposal as the CCM sees no structural barriers for women to access health care. More exploration of gender factors in TB epidemic in Armenia is required, however, no such analysis is available nor planned in the Phase 2 request.

PQR

Was the PQR data entry up-to-date for all relevant health products procured during Phase 1? Yes

if not, please explain

Please assess compliance with the Global Fund QA policy for pharmaceuticals

Section C2.3.1 - There was no need to update information in the PQR since no health products under this grant had to be reported in the PQR.

Regarding the QA policy, no non-compliance with the Global Fund QA policy has been identified.

PHASE 2 FINANCIAL REQUEST

FINANCIAL ASPECTS OF PHASE 2 REQUEST

Resources available to finance program after cut-off date

	Total	Year3	Year4	Year5
Original Phase 2 adjusted proposal Amount	€ 3,761,934	€ 998,675	€ 1,379,553	€ 1,383,706

Resources available to finance program after cut-off date	
Original Phase 2 adjusted Proposal Amount	€ 3,761,934
Undisbursed at cut-off date	€ 806,671
Cash at cut-off date	€ 350,446
Total Resources available (month 19-60)	€ 4,919,051

Phase 2 Budget and Recommended Amount

Recommendation	Year 3	Year 4	Year 5	Total Phase 2 Budget	% of original Phase 2 adjusted proposal Amount	Incremental Phase 2 Amount	Incremental Amount % of original Phase 2 adjusted proposal Amount
CCM Request	€ 1,263,391	€ 1,692,449	€ 1,767,319	€ 4,723,159	126 %	€ 4,372,713	116 %
Secretariat Recommendation	€ 1,022,089	€ 1,423,527	€ 1,442,782	€ 3,888,398	103 %	€ 3,348,122	89 %

Comment on CCM analysis of Phase 2 request versus original Phase 2 budget

There is a mistake in the calculation of the Original Phase 2 adjusted proposal amount: instead of EUR 4,179,927 available for Phase 2 as per the final TRP approval form, the CCM has indicated EUR 4,114,532 (EUR 65,395 less).

Secretariat Assessment of Financial Aspects of Phase 2 Request

The bulk or 65% of the budget is going towards the costs of treatment and diagnostics, and living support to patients. HR costs, including performance incentives to TB cabinets' staff represent €582,975 or 12% of the budget.

Given the proposed detailed budget and revisions proposed the Secretariat is in agreement of the recommended budget amount of €3,709,744 for Phase 2 period, which represents 89% of the original Phase 2 budget, and the incremental amount of €3,348,122, representing 89% of the adjusted original Phase 2 budget.

Based on the detailed review of Phase I performance and Phase 2 budget, the recommended amount is justified given the use of Phase I savings to cover the increase in the cost of MDR-TB drugs, and adequate programmatic performance not linked with financial underutilisation. The recommended incremental amount is 3% above the recommended maximum investment for a B1 rated grant.