Evaluation of the sector health and childcare under the EEA/Norway Grants

EEA/Norway Grants

Country Report Romania

October 2011

COWI

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Country report - Romania

1. Introduction

1.1 The Romanian health system in brief

In the last 20 years, the Romanian health care system has undergone, and is still undergoing, a transformation. Regardless of the political approach of the party in power, the lack of strategies with clearly defined objectives has contributed to slow or delayed reforms in the health sector. Since 2000, the basic laws regulating the health system have been modified and adjusted several times.

Primary care

Improvement in primary care was seen by the Romanian authorities as a key point of the reform of the health system. The reforms were intended to strengthen the access to and the quality of primary health care, improve patient responsiveness through competition among GPs, and reduce reliance on specialists and hospital care by giving GPs a "gatekeeper" function. The gate-keeping role of GPs was strengthened by introducing direct payments at hospitals without referral. Primary health care services are provided by approximately 11,000 family doctors. In addition to preventive and curative care, family doctors also provide antenatal and postnatal care and some health promotion and health education activities. They also provide health certificates for marriages, for incapacity to work and for deaths. The patients in Romania are allowed to choose their primary care doctor. In the last two years, family doctors have been given more responsibility, including monitoring of type 2 diabetes patients or assessing the health status of the population. Those responsibilities have been accompanied by an increased budget for primary care.

One of the main concerns related to primary health care is the distribution of services: there are stark differences between rural and urban areas.

Secondary care

Specialized health care is delivered by a network of hospital inpatient and outpatient departments, centres for diagnosis and treatment, and office-based specialists. The health reform has meant that patients now have a free choice in selecting a specialist.

The specialized physicians who work in ambulatory care generally divide their time between the public and private sectors. Many of them are employees of a hospital and work extra hours in private settings. Most hospitals are publicly owned and administered by the state, except for a few small private hospitals.

According to the Health Reform Law (95/2006), hospitals are organized on the basis of geographical criteria into: (1) local hospitals: general hospitals providing services for the area in which they are located (town, village); (2) district hospitals: located in the district's largest town, with a complex structure, providing almost all medical and surgical specialties and an emergency care unit that ensures services for the problems that cannot be solved at local level within the district; and (3) regional/university hospitals: assuring services for the most severe cases that cannot be solved at district or local level.

Tertiary care is provided in specialized hospitals, institutes and clinical centres such as the Institute for Maternal and Child Care, the Institute of Oncology, etc.

Romania has a relatively high inpatient admission rate, reflecting not only the underutilization of primary and ambulatory care services, but also the fragmentation of services and insufficient development of different levels of care. The high admission rates at hospitals support the hypothesis that patients are admitted directly to the hospital without proper care at the outpatient clinic. The average length of stay, excluding the chronic care hospital, is above most western European countries. The number of acute care beds in Romania decreased dramatically between 1990 and 2010.

Even though there has been an increasing trend in the number of physicians in Romania since 1990, the total number is still very low (1.9/1,000 population) compared with the EU average. Since 2007, the migration of young physicians has been an important concern for authorities and has emphasized the need to elaborate a strategy of human resources in the health care system.

Financing

With a 2010 health care budget of 3.6 per cent of the GDP, Romania comes last in the European Union in terms of health care financing. Annual healthcare spending is expected to rise gradually in 2011-14, as Romania recovers from the economic crisis, to about 5.8 per cent, but this will still be well below average EU levels of 8.5 per cent of the GDP. Moreover, regional differences in health care spending are significant, with spending per head about twice as high in the capital, Bucharest, as in the north-east of the country.

As in most countries, Romania has a mix of compulsory and voluntary elements of finance, but the dominant contribution mechanism since 1998 has been social insurance. Health funds derive primarily from the population, the most part through third-party payment mechanisms (social health insurance contributions and taxation), but also by out-of-pocket payments (co-payments and direct payments). Minimal expenditures on maintenance, repairs and non-medical materials are supported by local budgets. Private providers have no access to these funds. The Ministry of Public Health has elaborated measures aiming for the reallocation of budgets within the health care system along with specific measures to increase the utilization of primary, ambulatory and home care services, and development of special home care programmes for the elderly and patients from isolated areas in order to prevent their admittance to hospitals. The low expenditure on health care has had a negative impact on the maintenance of the health system, investment in new equipment and access to services, especially for low-income groups.

Ongoing or possible reforms in the future

Individual and population-based public health services and their further integration into the practice of primary health care are the focus of the current reforms. Currently, further reform plans are being discussed: to restructure and reorganize hospital services; to foster greater decentralization of the health care system by giving more responsibility to the management of hospitals to local authorities; to diversify and use new hospital service financing methods based on performance and quality of services provided to the patients; to develop new management models for ensuring the continuity of care with therapeutic efficacy and economic efficiency.

To sort out the problems in primary health the following solutions are proposed: development of primary care multidisciplinary teams; improvement of resource allocation at primary care level, simultaneously with raising the efficiency of their use and integration of health services; significant increase of the resources dedicated to primary health care development in areas like human resources, physical infrastructure, information and communication systems and medical equipment. The Centre for the Study of Family Medicine (CSNMF) and the National Association of Family Doctors are very active in stimulating the development of general practice and primary care.

Other priorities for improving the situation of the health system in Romania are: adopting standards for medical products, medical technologies, professional training, establishing information networks; introducing and using the medicine concepts based on evidences and assessment of the medical technologies; promotion of the cooperation between the EU Member States in order to ensure the quality in the health systems, equipment, blood, tissues and organs, laboratories etc.; drafting standards for the safety measures of patients.

1.2 National health strategy

The core objective of the health care system formulated in the national health strategy is to improve the health condition of the population and achieve a modern and efficient health system, compatible with the health systems of the European Union. The strategy is based on the following values: the right of the population to health protection; the guarantee of the quality and safety of the medical act; the increase of the role of preventive services; ensuring the accessibility to health services; the right to a free choice and equal opportunities; valuation of the professional competences and encouraging their development and decisional transparency.

The biannual collaborative agreement for 2010–2011 between Romania and the WHO/Europe identifies the following priorities for action: 1. Strengthening individual and population-based public health services for protecting health (including immunisation; tuberculosis (TB); HIV/AIDS; food safety); 2. Strengthening the resources of the health system with focus on pharmaceuticals and blood products and safety; 3. Improving maternal, child and adolescent health services; 4. Strengthening the health system with focus on financing and stewardship; 5. Reducing and preventing non-communicable conditions, mental disorders, violence and injuries.

The medium-term priorities of the national health strategy that Romania undertakes to fulfil are: 1. Actual provision of the equal access of the citizens to basic health care; .2. Increase in life quality by improving the quality and safety of the medical act; (3) Aligning to the safety, health and demographic indicators of the EU countries, simultaneously with the decrease of the pathology specific to the developing countries.

Health of children and government policy

Romania has continued to make progress in the reduction of the under-five mortality, although the rates are twice as high as the EU average. The most common causes of death among infants continue to be perinatal, respiratory infections and congenital malformations, and among children aged 1-4 are accidents, with a high 40 per cent occurring at home, pointing to poor parenting skills. There are more such deaths in rural areas. The malnutrition and anaemia levels among infants and children indicate poor feeding practices and low levels of breastfeeding. Romania has the largest number of children living with HIV in Europe.

There are still many children living with HIV/AIDS who are unable to attend normal schools, because either the teachers or parents of the other children oppose their integration into the school system. Other groups who are prone to social exclusion and health inequalities are children with mental and physical disabilities, children who are currently inside the social protection system and Roma children. Romania is confronted with a new situation, namely the mental health problems of children whose families are working abroad. Work in this area is in progress, and the Ministry of Public Health has developed a document which defines the mental health of children and adolescents as a health policy priority.

Improving the *quality and use of services for reproductive, maternal, newborn, child and adolescent health care* is a priority in the national health strategy. Among the subprogrammes are: prevention of malnutrition of infants; obesity prevention among children; screening for early diagnosis of several deficiencies; oral health. Other programmes of national interest have been developed in this respect, such as: "*Development of alternative services for children with disabilities/handicaps/AIDS*"; "*Development of the specialized service network for children who are victims of abuse, neglect and exploitation*" programmes.

Health of the Roma and government policy

The Roma population, one of largest minority ethnic groups in Romania, is estimated to be between 1.8 and 2.5 million. Life expectancy and infant mortality rates are, respectively, ten years shorter and 40 per cent higher among the Roma than among the general population. Homelessness and vulnerability to forced evictions, overcrowded living conditions and a lack of access to safe water and adequate sanitation are problems disproportionately affecting the Roma, rendering them vulnerable to communicable diseases, including hepatitis A and tuberculosis. Other factors leading to inequalities between the Roma and the rest of the population are low levels of education; poor nutrition; poor communication between health professionals and Roma health system users; lack of access to information on health issues; and a lack of identity cards and documentation, which precludes access to health insurance. Estimations from several studies and reports indicate that the percentage of Roma with cover from the health insurance fund is far below the national average of 75 per cent. Stigma and discrimination inhibit the access to health care in addition to giving rise to poverty and social exclusion. The Romanian government has adopted some important measures to tackle stigma and discrimination against the Roma and to promote their health. The *Law on Preventing and Punishing All Forms of Discrimination* (2000) prohibits discrimination, including in relation to the right to health, medical assistance and social security. The government has also adopted the *National Strategy for Improving the Condition of the Roma.* A Roma advisor has been appointed at the Ministry of Public Health, and Roma advisors have been appointed in some local councils. A significant and successful initiative is the development of Roma community health mediators in a joint initiative of the Ministry of Health, Romani Criss and other organizations: Roma persons who have been trained to mediate between the Roma population and medical staff, like GPs and hospital staff. In spite of the evidence that they effectively contribute to better access to health care and to a better mutual understanding between the Roma and health professionals, their employment (by municipalities) is insecure due to financial constraints.

Among the strategic objectives set in relation to health of the *National Anti-Poverty and Social Inclusion Plan* are universal coverage with basic health services and increasing access to health care for deprived population groups, especially for populations living in rural areas, the unemployed and the poor Roma

population. A remaining challenge is the further development of the national social work system and its links with the health system. However, despite the existence of these frameworks and programmes, Roma continue to face particular obstacles to their right to health and access to health services.

1.3 National set-up for implementation of EEA/Norway Grants

The priorities of the calls for *Health and Childcare Programme* in Romania have been decided in cooperation between the EEA grants and the Ministry of Health. The focus areas were: 1. Supporting children at risk; 2. Rehabilitating buildings and modernizing equipment and managerial systems; 3. Implementing preventive measures to promote a healthy lifestyle; 4. Preventing and improving the treatment of communicable diseases (HIV/AIDS and TB).

Under this call for proposals, eligible applicants were public or private sector bodies and non-governmental organizations (NGOs) constituted as legal entities in Romania and operating in the public interest (e.g. national, regional and local authorities, education/research institutions, environmental bodies, voluntary and community organizations and public-private partnerships).

According to most of the interlocutors interviewed for this evaluation, the call for EEA/Norway Grants was not sufficiently visible in Romania, which may be one factor explaining the relatively few applications (25) for the *Health and Childcare Programme.* Another factor may have been the 10 per cent co-funding requirement that may have been too heavy. This cannot be stated with certainty, however, because no NGOs have been interviewed for this evaluation which considered to apply but finally did not. The number of selected projects to be financed was 17, and all of them were individual projects. The open calls for individual projects, selection and contracting, followed these stages: 1. Applications were submitted in a sealed, intact envelope/box as a letter/package by registered or express mail, by courier or in person to the Ministry of Economy and Finance (Authority for Coordination of Structural Instruments); Applications sent by any other means (e.g. by fax or by e-mail) or delivered at other addresses were rejected. If the applications complied with formal requirements, they were sent to the Ministry of Health; 2. The Ministry of Health made the first evaluation of the quality of the applications to EEA grants, based on the high relevance for national and regional health and childcare needs; 3. Applications recommended by the Ministry of Health for funding were sent to EEA grants/ FMO (Financial Mechanism Office) which made the final decision and recommendations. The FMO made an on-site visit to discuss with the applicants. After final approval, the FMO sent a grant offer letter to the National Focal Point (NFP), which put forward a letter to the applicant, followed by an acceptance letter to the FMO; 4. The project grant agreement was compiled and signed by the FMO and the NFP.

Setting up the administration for the NFP took some time – including the necessary legislation. The NFP entered into an implementation contract with the project promoter through the Central Finance and Contracts Unit (CFCU), as auxiliary institutions. The task managers of the CFCU received and checked interim reports according to a pre-defined structure which follows the structure of the project implementation plan and sent it to the NFP to be verified. If the reports were approved, the request for payment was passed on to the FMO. These interim reports cover periods of between 3 and 12 months.

The NFP participated in monitoring visits with CFCU and observed macro issues like fulfillment of indicators. The project promoters got an advance payment of 10 per cent of the grant and must pre-finance the remaining part of the project expenditures and apply for reimbursement. There were three requests for extension of the deadline for finalizing the project, but only one was granted. There were some minor deviations in achieving the objectives of proposed plan, but with some changes, the indicators have been achieved. The National Agency for Regulating and Monitoring of Public Procurement has the role of monitoring, analysis, evaluation and supervision (control) of the awarding process of public procurement contracts and fits in the procedures. The NFP, CFCU and a representative from the line ministries (including the Ministry of Health) form the Monitoring Committee that meets 2-3 times per year.

By the end of the project, a project completion report must be submitted to the NFP to assess whether targets have been met.

2. Relevance

The overall objectives of the EEA/Norway Grants are twofold, i.e. to contribute to the reduction of economic and social disparities in the European Economic Area and to strengthen bilateral relations between the donor and beneficiary countries.

In the sector health and childcare, the focus areas of the EEA/Norway Grants to Romania in the programming period 2004-2009 were[1]:

1. Supporting children at risk
2. Rehabilitating buildings, modernisation of equipment and managerial systems
3. Implementing preventive measures to promote a healthy lifestyle
4. Preventing and improving treatment of communicable diseases (HIV/AIDS and TB).

The focus areas/priorities for the next programming period have not been precisely defined. There is no list of policies or strategies to be addressed, but projects are selected, among others, on the basis of acknowledged programmes or strategies. According to the Ministry of Health, there are competing priorities: Romania now needs funds for clinical/curative care and for surveillance, but also for prevention. Since the projects funded by EEA/Norway Grants mainly address prevention, they are complementary to Romanian policies. EEA projects have made it necessary to pay more attention to prevention and not only to treatment and surveillance. However, funding of clinical activities would be very welcome, both for equipment and for staff, since there is a brain drain going on.

[1] Memorandum of Understanding of 25 October 2007

Some prevention projects are more suitable than others to address concrete needs. For example, support to screening programmes is a higher priority than support to a project that provides balls for children to play with.

Still according to the Ministry of Health, setting priorities also is a matter of multiple pressures. Within the government there are many actors with a voice and also the media puts pressure in the direction of one or the other priority. The Ministry of Health would appreciate if EEA/Norway Grants would add its voice and advocate its priorities.

Overall, the Ministry of Health considers that EEA/Norway Grants and the three projects studied for this evaluation have the same vision: the projects will reduce economic disparities. The EEA/Norway grants reduce the need for the Romanian state to fund these areas.

TableA9-1 Relevance of EEA/Norway Grants support to Romania

	Focal point and intermediate bodies	Project promoters
EEA/Norway Grants - social cohesion	The overall aim of the EEA/Norway Grants is to contribute to the reduction of economic and social disparities in the European Economic Area and to strengthen the bilateral relations between the EEA/EFTA states and the beneficiary countries.	All three projects were successful in addressing this objective. However, only one out of the three project promoters has knowledge on the priorities of the EEA/Norway Grants, the other two do not know.
EEA/Norway Grants - bilateral relations		N.A.
EEA/Norway Grants - focus areas in the sector health and childcare	Compared to the needs in the country there were relatively few applications for the sector health and childcare, but that does not say anything about relevance, it is related to low notoriety of EEA/Norway Grants. The Ministry of Health believes that EEA/Norway Grants are more inclined to fund prevention projects than projects for curative activities that also need funding.	All three projects address the focus areas of the sector.
National/EU health strategies	All the approved projects relate to one or more EU and national strategies	Project promoters all refer to the various national strategies.

Sources: In-depth project reviews and interviews.

2.1. Objectives of the EEA/Norway Grants

The project promoters themselves are hardly aware of the EEA/Norway Grants priorities, but nevertheless they all contribute to the objective of social cohesion and address focus areas in the sector health and childcare.

Table A9-2 How successful was the project in addressing the objectives of the EEA/Norway Grants?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Was the project successful in addressing the objective of social cohesion – the reduction of health inequalities?	The project was successful in addressing this objective, because it creates positive interactions between children/adolescents and emphasises values and future life chances for all.	The project was successful in addressing this objective because it enhances health. Also it improves the quality of life of disfavoured individuals/groups and thus contributes to equity.	The project was successful in addressing this objective because it contributes to health and promotes certain values among young people (responsible behaviour).
Was the project successful in addressing the objective of strengthened bilateral relations?	The project is not a partnership project. Therefore the contribution to achieving this objective is limited.	The project is not a partnership project. Therefore the contribution to achieving this objective is limited.	The project is not a partnership project. Therefore the contribution to achieving this objective is limited.
Was the project successful in addressing the focus areas in the sector health and childcare?	The project did address one focus area of the health and childcare sector, namely 3. Implementing preventive measures to promote a healthy lifestyle.	The project did address one focus area of the health and childcare sector, namely 1. Supporting children at risk.	The project did address two focus areas of the health and childcare sector, namely 3. Implementing preventive measures to promote a healthy lifestyle, and 4. Preventing and improving treatment of communicable diseases (HIV/AIDS and TB) .
Evaluator assessment*	3: The project contributed to the achievement of the objectives of the EEA/Norway Grants.	3: The project contributed to the achievement of the objectives of the EEA/Norway Grants.	3: The project contributed to the achievement of the objectives of the EEA/Norway Grants.

*Explanation of the score: The score 4 is given if the project contributes to achieving both of the overall objectives of the EEA/Norway Grants (social cohesion and strengthened bilateral relations) and the focus areas in the sector health and childcare. The score 3 is given if the project contributes to achieving two of the objectives (either social cohesion, strengthened bilateral relations or specific focus areas in the sector health and childcare). The score 2 is given if the project contributes to achieving one of the objectives (either social cohesion, strengthened bilateral relations or specific focus areas in the sector health and childcare). The score 1 is given if the project does not contribute to any of these objectives.

Source: In-depth project review.

2.2. National and EU health strategies

All three projects selected for in-depth review fully addressed the objectives of both EU and national strategies or policies.

Table A9-3 How successful was the project in addressing the objectives of national and EU health strategies?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Was the project successful in addressing the objectives of national health strategies?	Yes. The project helps to implement the National Health Education Programme in Schools. Also, Law 123/2008 was adopted, through which the importance of healthy food for the young generation is acknowledged: “Healthy food in the pre-university school". This law stipulates that no fast-food should be consumed or distributed/sold in schools. Furthermore, it stipulates that teachers require training on this subject.	Yes. The project is successful in addressing national priorities: the National Health Strategy (friendly services) and a draft strategy of the Ministry of Education. Furthermore, Law 272/2004 concerning the protection and the promotion of children's rights stipulates that (….) the Central Public Administration, the Authorities of the Local Public Administration and (…..) are obliged to adopt all necessary measures for developing actions and programmes for the health protection and the prevention of disease, assistance and education of the parents.	Yes. The project aims at implementing the national HIV prevention programme. The Ministry of Public Health has a strategic plan 2008-2010 and another one in draft version for the period 2011-2013, with a specific objective related to reducing the impact on public health of major communicable diseases, including HIV/AIDS and a specific objective on shifting the focus towards preventive services and increased education among the population to motivate the adoption of healthier lifestyles.

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Was the project successful in addressing the objectives of EU health strategies?	Yes. The project does not aim at implementing EU legislation. However, the project supports the EU PHP objectives: information and knowledge for the development of public health; and promotes health and prevents disease through addressing health determinants across all policies and activities, namely through the education system. In 2007, the EU White Paper on Strategy for Europe on Nutrition underlined that overweight and obesity are one of the greatest health challenges of the 21th century. Effective and sustainable programmes and partnerships must be the cornerstone of Europe's response to tackling nutrition, overweight and obesity and their related health problems.	Yes. The project does not aim at implementing EU legislation. However, the project supports the EU HP in the field of Mental Health. In addition, the 2008 European Pact for Mental Health and Well-being calls for action in five priority areas, including Mental Health in Youth and Education. Programmes to promote parenting skills are specifically mentioned.	Yes. The project does not aim at implementing EU legislation. However, the project supports the EU PHP (c) promotes health and prevents disease through addressing health determinants. Also, the EU White Paper "Together for Health: A Strategic Approach for the EU 2008-2013" underlines that a coordinated approach to combat HIV/AIDS in the EU and neighbouring countries is required.
Evaluator assessment*	4: The project contributed significantly to the achievement of objectives of national or EU health strategies.	4: The project contributed significantly to the achievement of objectives of national or EU health strategies.	4: The project contributed significantly to the achievement of objectives of national or EU health strategies.

*Explanation of the score: The score 4 is given if the project contributes directly to achieving objectives of national or EU health strategies. The score 3 is given if the project contributes indirectly to achieving the objectives of national or EU health strategies. The score 2 is given if the project contributes to achieving objectives of other national or EU strategies. The score 1 is given if the project does not contribute to any of these objectives.

Source: In-depth project review.

3. Impact/effectiveness

Impact and effectiveness in general are adequate, although a single project (Ro0063) has an implementation approach that raises concerns about its effectiveness. The impact of prevention projects cannot be assessed in the framework of these projects. Apart from supervising and controlling the formal requirements, the NFP and authorities do not have much attention on the implementation of the projects once they have been approved.

The visibility of the EEA/Norway Grants and its projects is not high. Through an electronic newsletter or short TV announcements this could be strengthened, according to the Ministry of Health.

Table A9-4 Impact/effectiveness of EEA/Norway Grants support to Romania

	Focal point and intermediate bodies	Project promoters
Project deliverables	All projects deliver as expected. "Weaker" projects have not been funded.	All projects delivered as expected.
Dissemination and visibility of EEA/Norway Grants	The visibility of the EEA/Norway Grants could be stronger; e.g. previous Phare requirements.	All projects dutifully display the origin of the funding on its communication materials.
Impacts	No comments on the impacts, since the authorities have strong focus on "following the rules" and less focus on the impacts of the projects.	An assessment of the impacts is not always possible due to the nature of the impact (behaviour change).

Sources: In-depth project reviews and interviews.

3.1 Project deliverables

Two of the three projects selected for in-depth review have met all their pre-defined targets and all project deliverables are in use.

Table A9-5 Have the project activities resulted in the planned project deliverables and have they been used?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
What was the purpose of the project?	The purpose of the project is to implement a broad educational campaign for teaching and advertising healthy food and lifestyle, with the overall objective of improving the health of children in Bucharest.	The purpose of the project is to develop an operational network of parenting services in urban and rural areas delivering specialized assistance for parents and their children and enhancing the human resources capacity in this field, with the overall objective to contribute to the improvement of the quality of mental health care service provision for children in Romania.	The purpose of the project is to implement an HIV/AIDS awareness campaign targeted at young people in ten districts in Romania, with the overall objective of encouraging responsible and non-discriminative behaviour in relation to HIV/AIDS.
What are the pre-defined targets (indicators)?	Effective information about healthy nutrition and physical activity for the children in Bucharest: 200,000 children aged 5-18 addressed by the information campaign, 1,000 participating teachers and the General Directorate of Social Assistance of the Bucharest Municipality (GDSABM) staff. 500,000 hits on the website of the project.	Five parenting services centres established and operational. Five mobile teams covering rural areas in the targeted counties. One virtual resource and consultation centre available for professionals, parents and other community members.	23,760 students who participate in in-school interpersonal communication sessions developed by peer educators and educational staff. 2,520 trainees (1,680 peer educators and 840 educational personnel) who develop in-school interpersonal communication activities on HIV/AIDS prevention. 50,600 adolescents and young people who receive

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
			messages on HIV/AIDS through interpersonal communication activities developed out-of-school. General population: 60 press appearances (press insertions and press articles); 20 radio airings; 20 TV shows. Professionals + People Living With AIDS (PLWA): 100 PLWA trained on legislation on discrimination, rights and responsibilities; 88 journalists who attend sensitisation workshops on HIV/AIDS, stigma and discrimination; 440 medical personnel who attend training on HIV/AIDS, stigma and discrimination.
Have pre-defined targets (indicators) been met?	Most, but not all of them, no website is in the air. The effectiveness of part of the health education is doubtful.	Yes	Yes
Have project deliverables been used?	Yes - all deliverables are in use, except for the website.	Yes - all deliverables are in use.	Yes - all deliverables are in use.

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Evaluator assessment*	3: Project activities have partly resulted in the planned deliverables and all deliverables have been used by the users.	4: Project activities have resulted in the planned deliverables and all deliverables have been used by the users.	4: Project activities have resulted in the planned deliverables and all deliverables have been used by the users.

*Explanation of the score: The score 4 is given if the project activities have resulted in the planned deliverables (pre-defined targets have been met) and all project deliverables have been used by the users. The score 3 is given if the project activities have resulted in the planned deliverables (pre-defined targets have been met) and most project deliverables have been used by the users. The score 2 is given if the project activities have resulted in the planned deliverables (pre-defined targets have been met) but project deliverables have only been used to a limited extent by the users. The score 1 is given if project activities did not result in the planned deliverables (pre-defined targets have not been met).

Source: In-depth project review.

3.2 Dissemination and visibility of the EEA/Norway Grants

In general, dissemination of information is the key objective of the projects and they all have a strong focus on that. The media is used as much as possible. All projects display logo and further information of the EEA/Norway Grants on information/education material and on websites.

Table A9-6 How effective was the dissemination efforts and has the EEA/Norway Grants' support become visible?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Have the dissemination efforts been effective?	Yes, visibility is a core issue for the project; the website www.123letsgo.ro is not operational, however.	Yes, thanks to the focus on dissemination there are more beneficiaries than was planned.	Yes, visibility is a core issue for the project.
Has the EEA/Norway Grants' support become visible?	Yes, a large part of the information material (booklets) carries the logo of EEA grants.	Yes, there is a dedicated website http://www.consiliere-parinti.ro/centrul-de_consiliere-pentru-parinti that shows the EEA/Norway Grant support.	Yes, the website of the project www.y4y.ro refers to the EEA grant.
Evaluator assessment*	3 - The project carried out dissemination mainly at local level (there have been some TV spots at national level) and the EEA/Norway Grants have become visible.	4 - The project carried out dissemination mainly at local and regional level (and through the website somewhat at national level) and the EEA/Norway Grants have become visible.	4 - The project carried out dissemination at local, regional (and through the website somewhat at national level) and the EEA/Norway Grants have become visible.

*Explanation of the score: The score 4 is given if the dissemination efforts were effective at both local and national levels and the EEA/Norway Grants support is visible. The score 3 is given if the dissemination efforts were effective at either local or national level and the EEA/Norway Grants support is visible. The score 2 is given if the dissemination efforts were not effective or the EEA/Norway Grants support is not visible. The score 1 is given if the dissemination efforts were not effective and the EEA/Norway Grants support is not visible.

Source: In-depth project review.

3.3. Impacts

All three projects selected for this evaluation aim at behavioural change: two of them from a perspective of prevention (Ro0063, Ro0062) and one of them from a perspective of treatment (Ro0046). Measuring impact in terms of behaviour change is a costly and complex exercise. In the context of project Ro0046, the behaviour change of parents can be assessed during counselling sessions, but the time span of the project does not really allow for a relevant assessment. The project did measure parent satisfaction, which is an acceptable proxy indicator for behaviour change. The impact of Ro0062 is assessed by population-based surveys on sexual behaviour that are regularly held in the country, not depending on this project. However, repeated measurements over several years are necessary for reliable impact assessment. The impact of Ro0063, education for healthy eating, cannot be assessed at all in the context of this project. So, evidence of (lack of) impact in these projects is weak or absent.

Table A9-7 What have been the planned and unplanned impacts?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Has the project achieved the planned impacts (on institutional capacity and the targeted areas/groups)?	The deliverables have been produced, but there is no evidence of impact. Measuring impact in the sense of healthier eating habits of children is very difficult to demonstrate and in the context of this project virtually impossible. Impact in the sense of schoolteachers being able to convey health messages could be measured, but was not foreseen in this project.	Yes. The five parenting centres have been developed at community level in rural and urban areas. The innovation of this project consists of the fact that Strategies for Children (SCF) has implemented this type of centre for the first time in Romania. The promoter has drawn up a study for measuring the beneficiaries' satisfaction through focus-groups discussions and questionnaires. The study showed that the effects of the Triple P Programme increased the level of competency in parenting and satisfaction with this role.	Yes. The percentage of youth that use condoms during the first sexual intercourse, respectively, every intercourse for three months has increased, according to surveys. The project promoter is aware that it is doubtful if this can be attributed to the project. Also the percentage of young people accessing information on the topic has increased.
Has the project achieved unplanned impacts (on institutional capacity and the targeted areas/groups)?	No unplanned impacts reported, although the interest expressed by school teachers and parents can be considered as unplanned impacts.	Yes, a higher number than planned of parents who benefit from counselling, and of professionals who wanted to attend the workshops and training courses. The number of partnership agreements signed (194).	No unplanned impacts reported, although some unplanned activities may strengthen the impact of the project.
Evaluator assessment*	2: The project outputs have led to some of the planned impacts only, and unplanned impacts have not improved this view.	3: The project outputs have led to many of the planned impacts, and unplanned impacts have not changed this view significantly.	3: The project has achieved the planned impacts, and any unplanned impacts have not changed this view.

*Explanation of the score: The assessment is based on information from the project promoter. No quantitative data has been available. The score 4 is given if the project has achieved the planned impacts, and unplanned impacts only enhance the overall positive impacts of the project. The score 3 is given if the project has achieved the planned impacts, and any unplanned impacts have not changed this view. The score 2 is given if project has achieved the planned impacts, but unplanned impacts have reduced the overall positive impacts of the project. The score 1 is given if the project has not achieved the planned impacts.

Source: In-depth project review.

4. Efficiency

All projects have suffered from organizational/financial problems and indicate that the time between receiving the grant agreement, signing the contract and receiving the first advance invariably is long. In addition, the (low) amount of the first advance is for some NGOs is an obstacle, because they have few funds for pre-financing.

Promoters and the NFP acknowledged that the NFP has had to learn the processes, since this was the first cycle of project funding. A number of the delays that occurred may not happen again in the future. Furthermore, it is obvious that the NFP does not have technical expertise, and when a discussion needs to take place, for example on the change of indicators, this should rather be done with the Ministry of Health than with the NFP. Promoters do not know when they can negotiate or not with the NFP – in other words, how much discretion the NFP has to make its own decisions and what is dictated by the rules. Most projects had to learn the formal procurement process.

Table A9-8 Efficiency of EEA/Norway Grants support to Romania

	Focal point and intermediate bodies	Project promoters
Problems and constraints	All projects show some implementation problems related to financial matters.	
Collaboration between stakeholders	It would be helpful to have a representative of the NGOs in the Monitoring Committee, as well as representatives from other authorities like the Ministry of Education or from the local community. The committee should study and discuss the whole process and not just the individual projects. Two meetings per year are not enough, because this means delays for the projects. A monthly meeting would be more efficient. The role of the Monitoring Committee should not only be surveying the selected projects, but also assisting them to achieve better results. In this sense, learning from other countries' experience would help the experts from the Monitoring Committee to get the best practices and to apply them in Romania by improving the implementation of project activities.	One project is a partnership of six organizations with different management systems or approaches and they needed to adjust to each other. For example, there are different (or no) quality standards. The organizations knew each other already and could solve this, but it took time and a conscious effort.
Donor efficiency	Responsiveness is limited, because the FMO forwards requests for project	Second and later PIRs can be sent when previous PIRs have been

	Focal point and intermediate bodies	Project promoters
	amendments to the Project Amendment Group, and this sometimes creates delays. There should be more possibilities to get project extension.	approved, which may take six months. The PIR approval process should be much quicker. Also, currently payment depends on the PIRs, but they could be de-linked. Starting implementation before contract is risky, because the contract may have clauses on (ineligible expenses) or national procurement that was not respected. The contracts specify more conditions than the legal requirements. E.g., the promoter is considered a contracting authority according to the contract, but not according to the legislation.
Beneficiary country efficiency		NFP organized a seminar for all promoters. The deliverable of this meeting was a list of documents on reporting plus a list of documents on the implementation plan. NFP organized a second seminar on public procurement, which was characterized by (unsuccessful) negotiation between NGO promoters and NFP.

Sources: In-depth project reviews and interviews.

Virtually all activities and outputs were delivered on time. Due to several issues related to the (timely) availability of the funds granted and to the procurement process, all projects had to reschedule their activities quite significantly. A number of these issues are related to the donor's funding conditions and several are related to the beneficiary country's efficiency: the NFP needed time to be set up and had to learn how to handle the procedures itself.

Table A9-9 How efficient was the project implementation set-up?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Were anticipated activities and outputs delivered on time and according to specifications?	Yes, but due to delays in the start of project activities, some activities had to be rescheduled.	Yes, in spite of a budget reduction and delays, all activities could be carried out and outputs were achieved according to planning.	Yes. There was a delay in the implementation of activities and a request to the FMO was made to have a budget-neutral extension of the project. This was not granted, however. In order to achieve the agreed indicators, a number of activities, especially outreach by People Living With AIDS were then developed in an additional 10 counties, so that 20 are now covered, with concentrated intervention in 10 counties.
What are the main problems or constrains that project promoters have faced?	One procurement process failed and as a result, the procurement of some equipment had to be cancelled; the project implementation period	Due to delays in signing the contract (four months after the grant agreement) and receiving the advance (another three months), the actual project	Advancing cash for project activities was a problem for the promoter, who did not have the cash. This created a delay in the start of the activities.

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
	became very short and an extension had to be requested, which was granted.	implementation is just one year. For that reason a part of the budget could not be spent. In the beginning the promoters did not know how the public procurement system worked, but they learned and at the end, it worked well.	
To what extent are these problems related to donor efficiency?	Approval was asked and granted for extending the deadline for finishing from November 2010 to April 2011. There is no direct contact with FMO, however, all communication is through the NFP.	Less flexible; the extension of the project with three months was not approved.	The 10% minimum co-financing requirement is heavy. There were many negotiations on the amount of co-financing. There were no known specific criteria. In July 2009 the grant agreement was received and on 23 December 2009, the contract was signed. The advance was received in March 2010, which leaves just one year for implementation. For health education this is an extremely short period. Every year, new generations of young people need to access information and build life skills. This process needs to be continuous. The promoter recommends supporting strategic programmes on a five-year basis, as this is the only way to change behaviours and create a healthy society. A grant of two years covers gaps in funding, but the best way to reduce the social disparities is to approve a set of strategic interventions on health (maybe like the NGO grants model). The FMO did not agree to a budget neutral extension of the project, in spite of advocacy by UNICEF, UNFPA, the National Committee to Fight AIDS, and others. The FMO was flexible and responsive in terms of changing the financial procedures in order to help the promoters, and the "extension" was the only request which was not approved. The criteria for

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
			"approving extension" were too restrictive and did not consider the technical implementation arguments at all.
To what extent are these problems related to beneficiary state efficiency?	Signing the contract took eight months due to a delay in the ministry. The promoter could not open a bank account in that period due to a lack of clarity between the NFP and the municipality. This was finally solved by the municipality.	The reimbursement takes too long; from November they did not receive any funds and they are functioning with their own money (EUR 600,000), which is very difficult.	The promoter had difficulties finding the required funds for pre-payment, but they managed, because real expenses were lower than foreseen. Setting up the procedures between the FMO and NFP was the main reason for the delay. The reporting itself is no problem. The CFCU started to verify all bills, but later allowed hiring auditors – the fastest reimbursement was two months and one week. A guideline or training on the financial modalities before the application process would have helped. NFP provided a training session on public procurement, but not on other issues.
Evaluator assessment*	4: No significant extension, and activities and outputs have been delivered according to specifications.	4: No significant extension, and activities and outputs have been delivered according to specifications.	4: No significant extension, and activities and outputs have been delivered according to specifications.

*Explanation of the score: The score 4 is given if anticipated activities and outputs have been delivered according to specifications without any significant extension of the project period (< 6 months). The score 3 is given if anticipated activities and outputs have been delivered according to specifications, but the project period has been extended by 6-12 months. The score 2 is given if anticipated activities and outputs have been delivered according to specifications, but the project period has been extended by more than 12 months. The score 1 is given if anticipated activities and outputs have not been delivered according to specifications.
Source: In-depth project review.

5. Sustainability

The selection process is such that only projects with a firm and stable set-up have been funded. Project activities could continue if funding were available.

Some of the deliverables will continue to exist (websites, trained staff, education material), but their use or dissemination will be strongly reduced without continued supervision or encouragement. Without renewed funding this will happen much less. Promoters have been asked to provide a declaration that the deliverables will be sustainable for 5-10 years. This is a questionable requirement according to the evaluator.

Project impacts (behavioural change especially) cannot expect to last, since a much longer implementation period is required for any lasting impact.

Table A9-10 Sustainability of EEA/Norway Grants support to Romania

	Focal point and intermediate bodies	Project promoters
Project set-up	The Ministry of Health observes a tension between the need for quality projects developed by large and established NGOs and the need to give opportunities to smaller or starting NGOs that can be an innovative force, but which carry risks of lower quality.	All three projects consider continuing the activities with more or less the same set-up. There are some lessons learned as to how to best set up and manage the project, but the overall approach will be the same.
Project deliverables		All three projects have set up infrastructure, trained experts or volunteers and developed education materials. These will continue to be active or available for some time.
Project impacts	Due to, among others, a difficult procurement process, many projects started the actual implementation rather late, and the implementation is a very short period, which leaves little room for absorption of activities and development of sustainability. Some projects generate lasting effects, like a (draft) strategy and a report for key stakeholders.	The impact of all three projects is at the level of awareness, knowledge and behaviour of individuals or families. Since messages and interaction need to be repeated for a long period of time before they sustain in people's behaviour, the impacts of the project cannot be considered sustainable. Exception can be made for the parents who have been successfully counselled with lasting results under project Ro0046. Their number or percentage cannot be asserted.

Sources: In-depth project reviews and interviews.

Project set-up

The project set-up of all three projects is firm and will easily last for a longer period of time (several years) or at least can be set up again in a short time in case a follow-up project is considered.

For projects Ro0046 and Ro0062, the main carrier of the project is an NGO with a core of experienced staff that is running various projects. These NGOs will try to continue the activities and will look for further funding. They will be able to establish project management easily if follow-up funding materialises.

Project Ro0063 is somewhat different in that it was developed and implemented by a local authority – the municipality of Bucharest. As yet it is unclear whether the municipality will consider the continuation of the project a priority - fitting in its role of local authority - or whether it was a one-off initiative. The project staff was quickly assigned to other activities after the end of the project.

Deliverables

All three projects have developed information/training materials and trained staff/volunteers. These deliverables will remain available for some time. However, there is little concrete perspective to the further dissemination of the information and training material once the project has ended. None of the projects makes the material available on the website (the website of Ro0063 does not exist). Ro0046 and Ro0062 do have staff (working on other projects) who could continue to disseminate the material (on demand or on their own initiative), but for R00063 the project promoter does not expect that this will happen.

All three projects expect that those who have been trained to inform or counsel others will continue to do so. Ro0046 will offer its courses to professionals for a fee and expects that there will be a demand for that. R00063 expects (some) school teachers to continue to provide education on healthy food to pupils; R00062 expects that its volunteers will continue to counsel young people on safe sex, at 50 per cent of their previous level activity.

Impact

The impact of all three projects is at the level of awareness, knowledge and behaviour of individuals or families (parents). Since health messages and interaction between trainers/educators/counsellors and the people who are targeted need to be repeated for a long period of time before they sustain in people's behaviour, the impacts of the project cannot be considered sustainable. This is even more so in these three projects because new generations are permanently targeted (children, young people and parents), and the messages and interaction need to be repeated again and again.

R00046 and R00062 are social marketing projects. Social marketing research has abundantly provided evidence that health education needs to be permanent or at least intermittent. Also, its effects are stronger if the messages are accompanied by other measures like taxation on unhealthy consumables (tobacco, alcohol), promotional measures (legislation or regulations on selling healthy food in schools) or financial measures (free contraceptives for young people).

Ro0046 also has a social marketing component, but is essentially a project that targets individual parents. It has developed an infrastructure in five districts as an example. One of the aims is to show the need for these infrastructures in all districts of the country, to show how such an infrastructure can be set up and run and what contribution it actually delivers. Indeed, this is a long-lasting impact, because for years to come there is a model that can be copied – if funding is available. Furthermore, the project has helped to establish 5 June as the annual day of anti-violence against children. Such a symbolic day also has a long-lasting impact. Finally, the project promoter has become a partner to the Ministry of Education in developing the National Strategy for Parental Education. This is a long-term impact in the sense of establishing itself as motor and promoter of relevant strategies and policies in the country.

Table A9-11 Are project set-up and outcomes sustainable?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Does the project set-up sustain beyond the EEA/Norway Grant co-funding period?	No, the project management will not continue the activities. If a new application to EEA/Norway Grants for continuation is approved, the directorate will determine the new project management.	Yes, the promoter will apply for further funding to several donors including EEA/Norway Grants.	Yes, the activities will be continued with support from the Structural Funds. Continuation will not be done with all the same partners. Y4Y will do the application, it will not be the consortium which applies.
Do project deliverables sustain beyond the EEA/Norway Grants co-funding period?	A number of schools and their teachers may continue to provide health education messages for weeks or months.	Yes, in the form of the draft of National Strategy for Parental Education of the Ministry of Education.	Yes, counselling will continue on a volunteer basis, at an estimated 50% level of the current activities; this will happen only for a period of weeks or months.
Do project impacts sustain beyond the EEA/Norway Grants co-funding period?	No, the implementation period is too short. To change the eating behaviour of children a long-term approach is needed	Yes: 1. A model has been developed; 2. A national day of anti-violence against children has been established; 3. The promoter is a strategic partner to the Ministry of Education.	No, the implementation period is too short, since a continued information campaign and counselling for young people is necessary in order to maintain behaviour change and to inform new generations about sexual behaviour change.
Evaluator assessment*	1	2 :The project set-up is partially sustainable and some of the deliverables and impacts sustain, but most of them will last for a period shorter than five years.	1: Although the project set-up partially sustains, the deliverables are assessed to sustain for a period shorter than 1-2 years.

*Explanation of the score: The score 4 is given if the project results fully sustain beyond the EEA/Norway Grants co-funding period, i.e. the project set-up sustain (if relevant), the project deliverables sustain for a period of at least 10 years, and sustainability of project impacts is likely. The score 3 is given if the project results partly sustain beyond the EEA/Norway Grants co-funding period, i.e. the project set-up partly sustains (if relevant) and the project deliverables sustain beyond the co-funding period, but for a period of 5-9 years sustainability of project impacts are not likely. The score 2 is given if the project results sustain only to a limited degree beyond the EEA/Norway Grants co-funding period, i.e. the project set-up partly sustains (if relevant), the project deliverables sustain beyond the co-funding period but for a period of < 5 years or sustainability of project impacts are not likely. The score 1 is given if the project results do not sustain beyond the EEA/Norway Grants co-funding period, i.e. the project set-up does not sustain (if relevant), the project deliverables do not sustain beyond the co-funding and sustainability of project impacts are not likely.

Source: In-depth project review.

6. Cross-cutting issues

The projects do not explicitly or implicitly contribute to environmental sustainable development, nor do they do any harm. The projects ultimately address children or young people (in one case through their parents) and therefore, by contributing to the development of healthy and conscious young people, the projects implicitly contribute to social and economic development. All three projects take into account gender aspects, in terms of specific needs and approaches. They also try to reduce gender stereotypes, although one project (Ro0063) actually inadvertently reinforces stereotypes by using stereotype colours for education material.

The contribution in the field of good governance is not very strong, in any case not directly oriented towards good governance goals. Two out of three projects, however, implicitly contribute to good governance by helping young people to develop into persons with an explicit sense of responsibility for themselves and for others. This responsibility in the first instance passes via healthy eating/cooking and responsible sexual behaviour, but is easily extended towards feeling responsibility for other people's health and well-being. Also, the third project, Ro0046, contributes to good governance because counselling to parents helps to strengthen their general sense of responsibility.

Table A9-12 Does the project contribute to sustainability, gender equality and good governance?

Project	Affect lifestyles	Prevent or treat diseases	Prevent or treat diseases
Sustainable development (environmental, economic, social)	No environmental sustainability role. The project aims at positive social aspects, preventing obesity and associated diseases as a cause of social exclusion. Indirectly, the project aims at better economic sustainability of the society as well as of individuals.	No environmental sustainability role. The project aims at positive social aspects, the growing up of healthy individuals and families. Indirectly, the project aims at better economic sustainability of society as well as of individuals.	No environmental sustainability role. The project aims at positive social aspects, growing up of healthy adolescents who have internalized values and responsible behaviour. Indirectly, the project aims at better economic sustainability of the society and of individuals.
Gender equality	By providing training courses in cooking to young people, male and female, the project addresses the traditional division of roles. Also, the project encourages girls and women to take a leading role in the family, breaking with stereotype roles.	The project intends to reduce male/female stereotypes.	The project addresses both male and female youngsters and thereby contributes to gender equality. Gender balance is kept in all project components, steering committee members, in hiring project staff and in involving target groups, especially the People Living with HIV/AIDS

			(PLWA).
Good governance	The project raises awareness of the effects of eating habits on health and thereby contributes to citizen responsibility.	The project creates the positive context that helps to build an essential civic attitude necessary in any social development process, participating as a volunteer in the community life.	The project creates the positive context that helps to build an essential civic attitude necessary in any social development process, participating as a volunteer in the community life.

Source: In-depth project review.

7. Conclusions

Objectives and relevance: the projects that have been funded help to implement national strategies or policies and are in line with EU policies. Consequently, they have relevant objectives and are in synergy with national and international funding.

A particular aspect of two out of three projects is that they fund prevention activities, aiming at the change of lifestyle/behaviour of target groups. As argued above (paragraph on impact), to bring about lasting behavioural change requires many years of investing in health education in many different ways, often supported by parallel activities like facilitating access to healthy food, or to providers of health care for contraceptives. While these synergies do indeed exist, because the projects are embedded in the national strategy or policy, the period of one project of 2-3 years is too short to have a lasting impact. For project Ro0063 (healthy eating) it is very unlikely that the health education will be continued on a significant scale. For project Ro0062 (HIV prevention) there is more ground for optimism about the continuation of part of the activities, but even so, sustainability is limited. Also for the third project (Ro0046, parent education) it is questionable whether the activities will be continued: the infrastructure has been set up, but functioning costs are not assured.

As a consequence, **one area for improvement** is to either fund projects for a longer period of time or to allow promoters to introduce a proposal for continuation of the project, in such a manner that there is no significant interruption of the activities between projects.

The issue of the duration of the projects is even more pressing, because the actual implementation period of the three projects was little more than one year. This was caused by start-up problems of the Focal Point and its collaboration with other authorities. After the letter of agreement, it took many months to have a contract signed and before the actual activities were started. Promoters consider it a risk to start activities without a contract, as they cannot be sure that they respect all the conditions that will be contained in the contract. **A key lesson learned** is that the beneficiary state needs more time for preparation before the first grant agreements are decided upon and the promoters expect a contract – or greater flexibility is required in terms of contract extension. The latter, greater flexibility on contract extensions, is considered as an **area for improvement.**

All three projects asked for an extension and two of them were refused, with the promoters not knowing why. Promoters do not always know on what basis (the amount of) advances are calculated. An **area of improvement** is better feed-back to the promoters. The procurement process was an obstacle that created delay in all the projects. Training on this was provided by the NFP but came late. **A key lesson learned** is that the NFP could provide training immediately when grant agreements were sent by the FMO. Such training should not only be on public procurement, but on all relevant elements of project management as well as the relationship with NFP and the FMO.

Returning to the issue of impact of the projects, the following suggestion by the Focal Point has been considered, but finally not adopted by the consultant: To establish a provision in the contract with the beneficiary of the grants, according to which they have to provide a report to the NFP on the project impact, within for example 24 months of the finalisation of the project. According to the consultant this does not add to improvement of impact and creates a (financial) burden, disproportional to its purpose.

The Focal Point also suggests that the project promoter develop a list of issues and/or indicators which should be reported on when analyzing the project impact (e.g. stability of staff trained within project – if applicable, maintenance of equipment procured within the project, number of partnerships operational, etc). According to the consultant, this implies criteria for sustainability, and these are already in use.

A **further area of improvement** would be that an agency or organization could help (future) promoters to understand the requirements and to develop quality proposals, in the form of a help desk. The current NFP cannot do that because it would create a conflict of interest if the NFP is to assess projects later.