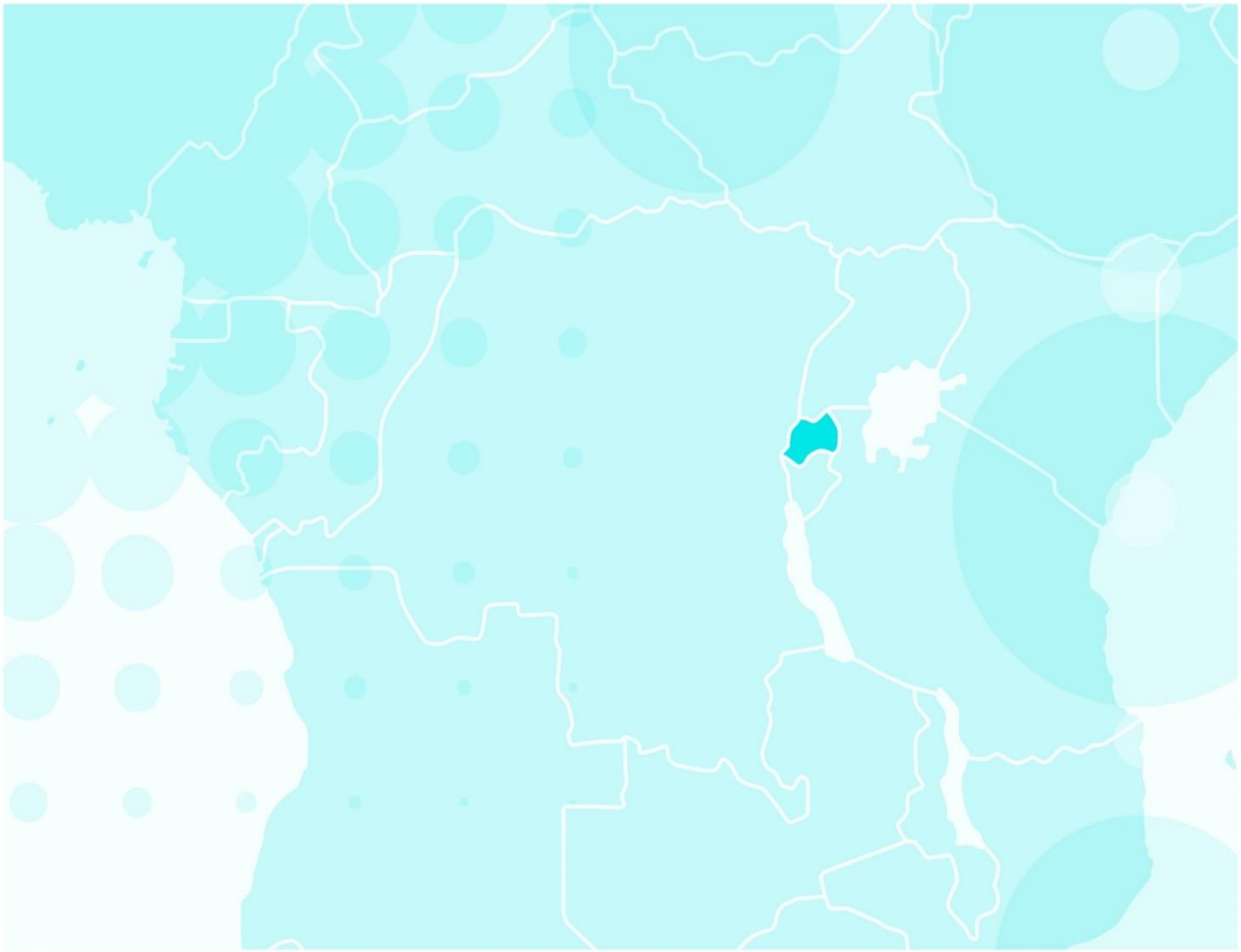

Audit Report

Global Fund Grants to the

Republic of Rwanda

GF-OIG-24-20
16 December 2024
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Rwanda has achieved significant programmatic results, supported by the Result Based Financing (RBF) model for Global Fund grants. Most National Strategic Plan (NSP) impact goals for HIV and malaria programs were achieved, with substantial reductions in morbidity and mortality for HIV and malaria, with a 56% reduction in new HIV infections, a 36% reduction in AIDS deaths as well as a 67% reduction in malaria cases between 2015 and 2022. There have also been achievements in the fight against tuberculosis (TB), with a reduction in missing cases for Drug-susceptible TB (DS-TB) and high levels of treatment success for DS and Drug-resistance TB (DR-TB). These successes were achieved in the context of Rwanda being a low-income country, with significant fiscal constraints.

The RBF model played a key role in these achievements. With RBF, Global Fund grants are fully integrated and aligned with domestic funding to support Rwanda's NSPs for the three diseases. Global Fund disbursements are based solely on programmatic results reported. The model is reliant on country-owned strategic plans and systems, increasing implementation efficiency and institutional sustainability, and allowing for a focus on country led solutions to achieve results.

The ability to use the RBF model is due to several critical success factors including strong governance, oversight and leadership from both the Ministry of Health (MoH) and wider Government of Rwanda, and strong systems and processes for financial, programmatic, and health financing data. Very high levels of programmatic data accuracy were also noted. This is important in the context of the RBF model, where accurate data informs Global Fund disbursements and ensures that the MoH can make timely data led management decisions. This high level of data accuracy was driven by a robust internal control environment at the MoH, with strong systems, tools, processes, and people to support data management.

Whilst there are opportunities to strengthen the RBF model, both in terms of the grants in Rwanda as well as beyond, the design and implementation of the Rwanda Result-based Funding (RBF) mechanism is **effective**.

There have been significant efforts made by the Government of Rwanda (GoR) and the Global Fund Secretariat to increase the Domestic Financing for Health (DFH). This is in the context of Rwanda being a low-income country and facing a decline in external funding. The Global Fund has supported National Health Financing (NHF) dialogues, online reporting of government expenditure and earmarked funding to update the NHF strategy. The GoR has provided strategic direction through its NHF Strategic Plan, along with establishing the community-based health insurance scheme (CBHI) to support universal health coverage. The GoR also developed very robust systems, tools and processes to support timely, complete and accurate health financing data. This led to Rwanda being able to timely report as well as meet and exceed grant cycle (GC) 5 and GC6 co-financing requirements. However, there are increased financial sustainability risks due to declining external funding and a need for more detailed operational sustainability planning, and there are opportunities for the Global Fund and GoR to strengthen their approach to sustainability in the unique context of Rwanda. Despite these challenges, the sustainability initiatives and co-financing supporting sustainable program achievements are **effective.**

1.2 Key Achievements and Good Practices

RBF model has incentivized strong country ownership and effective use of country systems, resulting in positive programmatic achievements.

The RBF model has supported strong programmatic results in combating HIV and malaria, as well as some positive results in reducing TB. Most NSP impact goals for HIV and malaria were achieved. There were reductions in new HIV infections and in AIDS related deaths as noted above, with Rwanda achieving the 95:95:95 UNAIDS targets. For malaria, estimated cases have significantly reduced and national targets to reduce mortality by half were met. There have been successes in reducing missing cases for DS-TB as well as high levels of treatment success for both DS and DR-TB. These achievements and the ability to use the RBF model are due to several critical success factors including strong governance and oversight from both the MoH and wider Government institutions, effective and robust country ownership and leadership, strong systems and processes for financial, programmatic and health financing data, and geographic access to services.

A robust control environment over programmatic data has led to good data quality to inform programmatic decisions.

Very high levels of data accuracy (above 95%) were noted for several sampled key HIV, TB and malaria indicators. This has ensured the MoH can make timely data led informed health management decisions and the RBF model can be effective. These positive results were achieved through a robust internal control environment established by the MoH. Data quality was being effectively managed at the health facility level through monthly data validation meetings. There are strong systems in place with DHIS2 rolled out at all health facilities. There was also good availability of standardized national data tools and well-designed MoH data management standard operating procedures. There were also high levels of trained staff dedicated to data management as well as effective supervision and oversight over data provided by the MoH.

Strong efforts to increase domestic health financing and meet co-financing requirements.

There have been significant efforts made by the Government and the Global Fund Secretariat to increase the amount of DFH. The Global Fund supported a 2023 NHF dialogue and helped improve the online reporting of government expenditure. Going forward, Strategic Initiative funding has been earmarked to support updating the NHF strategy. In addition, the Global Fund has made efforts to reduce rapid declines in funding across allocation cycles through approving upward qualitative adjustments in the allocation process. There has been a multi-pronged effort from the Government to strengthen DFH. They developed the NHF Strategic Plan, along with supporting the community-based health insurance scheme (CBHI).

In addition, there have been efforts to obtain additional loan financing from other development institutions. The GoR also developed very robust systems, tools and processes to support timely, complete and accurate health financing data. Health budgets and expenditures are published publicly and are routinely updated. This has been helped by a robust MoH Health finance department with clear accountability over health financing data. All these efforts have meant that Rwanda reported promptly on its co-financing requirements and has meet and exceeded both its GC5 and GC6 co-financing requirements.

1.3 Key Issues and Risks

The Global Fund should establish a framework on when, where and how the RBF model can be further applied.

There is limited Global Fund guidance on when, where and how the RBF model can and should be utilized. This impacts how the model is further enhanced in Rwanda as well as how it is applied in other Global Fund-supported programs. There is an over-due agreed management action from a previous OIG audit[1] to develop an operational policy note on results-based financing to establish a framework and guiding principles to help future design and implementation. However, this action has not yet been completed, impacting how the model can be further enhanced and leveraged both within Rwanda and beyond.

Enhancing indicator and target selection and Country Coordinating Mechanism (CCM) effectiveness under the RBF model could maximize performance.

There are opportunities to strengthen the indicator selection process. Currently, RBF indicators are sourced from the NSPs for the three diseases. However, if the NSP does not include specific indicators or targets, these cannot be included in the grant. This was noted for Key Population (KP) HIV interventions, DR-TB diagnosis and TB prevention where performance was relatively weaker. There are no Global Fund or country-level guidelines on how indicators and targets for results-based financing are established and finalized.

There is also an opportunity to tailor the role and focus of the Rwanda CCM to ensure it can focus on the specific risk areas under an RBF grant. There is a need to increase the role of the CCM in RBF indicator and target selection, programmatic results, data quality and assurance.

Moderate data variances for HIV viral load data highlight an opportunity to further strengthen data management for this area.

While the OIG generally observed very high levels of data accuracy, some moderate variances (between 7-15% over and under reporting) were identified for HIV viral load indicators. These specific issues with HIV viral load data were caused by fragmented systems, unavailability of standard tools and gaps in oversight in this area.

Declining external funding and need for more operational sustainability planning increases sustainability risks.

Despite significant progress, there are increasing financial sustainability risks due to declining external funding and insufficient sustainability planning. Comprehensive operational level sustainability planning has yet to be completed across the disease programs, although some work has been initiated on HIV sustainability planning. In this context, funding gaps and UQD for the three diseases have increased between GC5 and GC7. Due to gaps in the Global Fund Sustainability, Transition and Co-Financing (STC) Policy, low-income countries are not required to develop comprehensive sustainability plans. In addition, health sector strategic plans are yet to be completed and approved, and timelines to finalize sustainability plans have not been set. There were also opportunities to increase the focus of the CCM on sustainability planning and health financing.

[1] The Global Fund “Global Fund Grants in the Republic of India” (2023), accessed on 11 September, 2024 https://www.theglobalfund.org/media/13066/oig_gf-oig-23-011_report_en.pdf, 20

1.4 Objectives, Ratings and Scope

The audit's overall objective was to provide reasonable assurance to the Global Fund Board on the adequacy and effectiveness of Global Fund Grants to the Republic of Rwanda. Specifically, the audit assessed the adequacy and effectiveness of:

Objectives	Rating	Scope
Design and implementation of the RBF mechanism in Rwanda to sustain progress for the three diseases, including: (i) critical success factors for the RBF approach. (ii) grant oversight and assurance mechanisms. (iii) programmatic data quality.	**Effective**	**Audit period:** July 2021 to December 2023. **Grants and implementers:** The audit covered the Principal Recipient and sub-recipient of Global Fund supported programs. **Scope exclusion :** None.
Sustainability initiatives and co-financing to support sustainable program achievements.	**Effective**	

OIG auditors visited 13 health facilities and hospitals in 10 districts and four provinces. The selected sites include sites funded by other donors.

Details about the general audit rating classifications can be found in Annex A.

2. Background and Context

2.1 Rwanda Result Based Financing Model

Global Fund Grants in Rwanda operate under the RBF model. Piloted for the HIV program in 2014, it was subsequently extended to cover all grants in Rwanda since 2015.

Under this model, Global Fund Grants have been designed to be fully aligned and integrated with the NSPs for the three diseases. Performance framework indicators and targets are aligned to the NSP indicators and targets. A disbursement framework is established to calculate Global Fund disbursements based on the percentage achievement of performance targets. As a result, the country is exempted from the requirement to submit a detailed grant-specific budget, because the Global Fund relies on the NSP costed operational plans.

During grant implementation, the country submits annual reports from its three national programs on programmatic results achieved. These results are used to calculate the amount of funding to be disbursed to the national programs. This is done in lieu of the traditional Progress Update and Disbursement Request (PU/DR) submitted by other countries, which also includes financial expenditure data. To incentivize results and efficiency, exchange gains and other savings from the grants are reinvested by the country into further supporting the NSPs. There are no financial reprogramming requirements. The model also leverages national systems and oversight where possible. For programmatic data, there is a reliance on national data systems, national program reporting and MoH oversight on programmatic data. In addition, the model also leverages oversight by the Office of the Auditor General (OAG) to provide assurance not only on finance, but also on controls related to in-country data management.

2.2 Country Context

Country data[2]	
Population	14.4 million (2024 estimate)
GDP per capita	US$966.2 (2022)
Corruption Perception Index	49/180 (2023)
UNDP Human Development Index	161/193 (2022)
Government spending on health (% of GDP)	7.32% (2021)[3]

Located in the Great Lakes region of Central Africa, Rwanda is a landlocked country with an estimated population of 14.4 million in 2024, with approximately 82% of the population living in rural areas. Despite having one of the fastest growing economies in East Africa, with 8.2% growth in 2022, it is classified as a low-income country.[4] The political, social, and economic context of Rwanda

[2] World Bank Group, “Rwanda” accessed on: 05 July 2024, https://data.worldbank.org/country/rwanda; Human Development Reports, “Rwanda” UNDP, accessed on: 05 July 2024, https://hdr.undp.org/data-center/specific-country-data#/countries/RWA; Transparency International, “Corruption Perception Index” accessed on: 05 July 2024, https://www.transparency.org/en/cpi/2022/index/rwa; World Health Organization, “Global Health Expenditure Database” accessed on: 05 July 2024, https://apps.who.int/nha/database.
[3] World Health Organization, “Rwanda” accessed on: 05 July 2024, https://data.who.int/countries/646.
[4] World Bank, “The World Bank in Rwanda” accessed on: 05 July 2024, https://www.worldbank.org/en/country/rwanda/overview. accessed 05 July 2024

is profoundly affected by the civil war of the early 1990s and the 1994 genocide against the Tutsi[5].

The country is administratively divided into five provinces including one city, Kigali. The healthcare system comprises of 58,000 community health workers at the lowest level. There are several national referral and teaching hospitals, provincial and district hospitals as well as health centers and health posts[6].

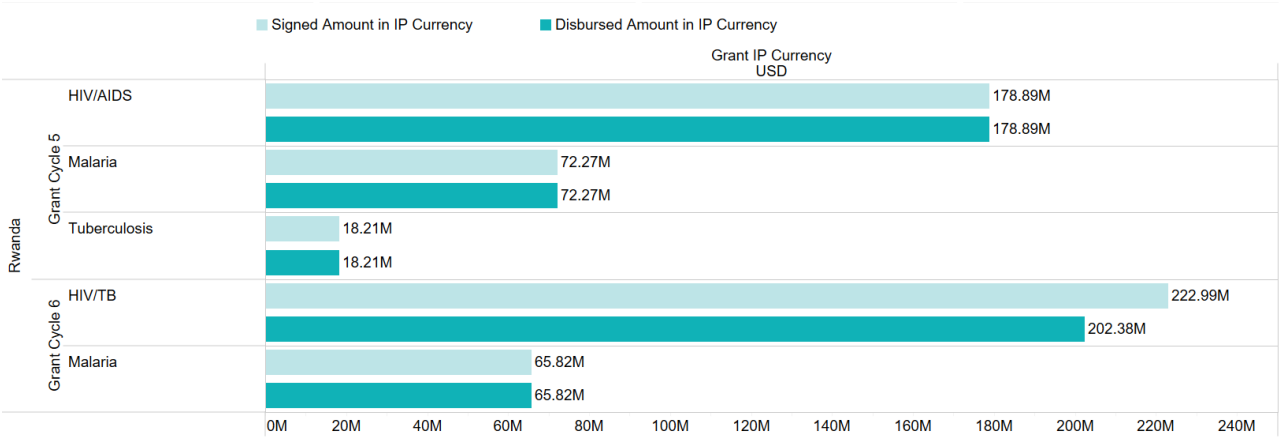
2.3 COVID-19 Situation[7]

When faced with COVID-19, a national steering committee of key Ministries involved in the response was constituted and chaired by the Prime Minister. The committee established a COVID-19 Joint Task Force on 9 March 2020 to coordinate the implementation of a preparedness and response plan, just in time for the first case. The declaration of the outbreak was followed by a series of preventive measures - such as the mandatory quarantine for all travelers coming into the country, compulsory wearing of face masks, hand washing and the practice of physical distancing.

The number of cases identified in the country since the start of the pandemic until July 2024 is of 132,489, out of which 131,007 people have recovered and 1,466 have died. The Global Fund has supported the efforts to mitigate the impact of COVID-19 on the fight against the three diseases with a total of US$92.83 million budgeted under GC6.

2.4 Global Fund Grants in Rwanda

Since 2003, the Global Fund has signed grants totaling over US$1.96 billion and disbursed US$1.78 billion to Rwanda.[8] Active grants amounted to US$289 million for the 2020-2022 funding allocation period (i.e., the 2021-2024 implementation period), of which US$268 million have been disbursed[9]. For this funding allocation period, the MoH is the single principal recipient for all grants.



[5] UN website page, accessed on 04 November 2024, https://www.un.org/en/preventgenocide/rwanda/index.shtml
[6] There are 5 national referral and teaching hospitals; 10 Level 2 teaching hospitals and referral hospitals; 3 provincial hospitals; 38 district and specialized hospitals; 8 Medicalized health centers; 505 health centers; 69 health posts second generation; and 1181 Health posts first generation.
[7] World Health Organization "COVID-19 in Rwanda: A country's response" accessed on: 05 July 2024, https://www.afro.who.int/news/covid-19-rwanda-countrys-response; Rwanda Biomedical Centre "COVID-19 Cases" accessed on: 05 July 2024
[8] Global Fund Data Explorer, https://data.theglobalfund.org/location/RWA/access-to-funding, accessed 2 July 2024; Expenditure: Signed-Disbursed - Tableau Server (theglobalfund.org), accessed 10 July 2024
[9] The undisbursed amount related to C19RM funding that ends on 31 December 2025

2.5 The Three Diseases in Rwanda

HIV / AIDS	TUBERCULOSIS	MALARIA
An estimated 230,000 people are living with HIV as of 2023, of whom 96% know their status. **96%** are on antiretroviral treatment, **94%** have suppressed viral loads. **Annual new infections decreased by 54%** from 6,900 (2015) to 3,200 (2023). New infections are concentrated in KP. AIDS-related deaths decreased by 38% from 4,200 (2015) to 2,600 (2023). 94% of pregnant women living with HIV were accessing antiretrovirals in 2023, down from 100% in 2015.	**In 2022/23, there was an estimated incidence** of 56 cases of drug susceptible TB, 7.5 of TB/HIV per 100K population and estimated 120 RR/MDR-TB cases. **Notifications for DSTB increased** from 69% of estimated cases in 2021/22, to 91% in 2022/23. **WHO recommended rapid diagnostics uptake increased** from 50% of notified cases in 2021/22, to 70% in 2022/23. **Treatment success rate** among new and relapse cases drug-susceptible TB registered in 2021 was 87%, below the WHO target of 90%. For RR/MDR-TB, treatment success rate was 95%.	There has been a **positive downward trend in malaria cases.** The incidence also fell from 112 to 47 per 1,000 persons per year. **97% (29 out of 30)** of Rwanda's districts achieved **pre-elimination with** incidence less than 100 per 1,000 people in Fiscal Year 2022-23. The country's performance is supported by strong Community based interventions with **58% of uncomplicated malaria cases currently managed at community level.**
Source: 2024 UNAIDS Data; HIV Program data	*Source:* 2023 WHO Data, Global TB Report 2023; MOH RBC TB Annual Report 2022/23	*Sources: World Malaria Report and RBC 2023 annual report (for district and case management)*

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

GC6 (July 2021 – June 2024) grant performance and grant ratings are shown below[10]:

Component	Grant	Principal Recipient	Total Signed (million USD)	Disbursement [1] (million USD)	(%)	Jun 22		Jun 23		Jun-24	
HIV/TB	RWA-C-MOH	Ministry of Health	222.99 [11]	194.68	87.30%	B	4	A	3	A	1
Malaria	RWA-M-MOH	Ministry of Health	65.82	65.82	100%	A	4	A	1	A	1
TOTAL			**288.81**	**260.50**	**90.19%**						

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels for the key risk categories covered in the audit objectives with the residual risk identified in the OIG's assessment, mapping risks to specific audit findings for the Rwanda program. The full risk appetite methodology and explanation of the differences are provided in Annex B of this report.

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit issues
Programmatic and monitoring and evaluation	HIV: program quality	Low	Low	4.1 & 4.2
	TB: program quality	Low	Low	4.1 & 4.2
	Malaria: program quality	Low	Low	4.1 & 4.2
M&E	M&E	Low	Low	4.3
Governance	In-Country Governance	Low	Low	4.1 & 4.2
Health Financing	Health Financing	Low	Moderate	4.4

[10] Effective January 2022, Global Fund Revised PU/DR and Performance Ratings with programmatic performance assessed via alphabetic ratings while financial performance assessed via numerical ratings. The Global Fund, "Revised Progress Update and Disbursement Requests (PU/DR) and Performance Ratings", accessed 22 April 2024, https://www.theglobalfund.org/en/updates/2022/2022-02-23-revised-progress-update-and-disbursement-request-and-performance-ratings/. The portfolio performance figures are based on total disbursements processed for the 2020-2022 Implementation Period as of 30 June 2024, against the total signed amounts. These do not include the initial cash balance at the beginning of the implementation period.

[11] The signed amount for GC6 HIV/TB is USD139.5 m – with the additional amount relating to C19RM funds.

4. Findings

4.1 RBF model incentivizes strong country ownership and effective use of national systems resulting in programmatic impact, which could be replicated in comparable settings, where appropriate.

With the Result-based Financing (RBF) model, Rwanda has achieved most of their National Strategic Plan (NSP) targets for HIV and Malaria, with good progress made in TB. Underpinning the success of the model are effective national institutions, strong leadership in the health sector and robust country systems that provide effective checks throughout the lifecycle.

Global Fund Grants, under the RBF model in Rwanda, have supported strong programmatic results in HIV and malaria, as well as some positive results in TB. Most National Strategic Plan impact goals for HIV and Malaria were achieved, in advance of the target dates. The HIV program achieved a 56% reduction in new HIV infections and a 36% reduction in AIDS-related deaths between 2015 and 2022.[12] In addition, Rwanda is one of five African countries that achieved the 95:95:95 UNAIDS targets, reaching 95:97:97[13], and achieved strong prevention of mother-to-child transmission, with 99% of exposed infants are HIV-free.[14] For malaria, cases dropped by 67% between 2015 and 2022[15] and the country met national targets to halve malaria morbidity and mortality from 2018 levels. TB is behind on national targets to reduce morbidity and mortality, but there have been successes in reducing missing cases for DS-TB, increases in cases tested with WHO-recommended diagnostics and high levels of treatment success for both DS and DR-TB. These successes were supported by the RBF model, which has been in place in Rwanda since 2014. The RBF approach has allowed Rwanda to rely on country-owned strategies, systems and solutions to tackle the three diseases.

These achievements, together with the effective use of the RBF model, are due to several critical success factors. These include strong governance and oversight from both the Ministry of Health and wider Government institutions, effective and robust country ownership and leadership, robust systems and processes for financial, programmatic and health financing data, and geographic access to services. These have been established in the context of Rwanda being a low-income country, with significant fiscal constraints.

Institutional governance and accountability are supported by independent institutions that monitor the MoH's activities. A competent and independent Office of the Auditor General (OAG) holds the MoH to account on the implementation of its mandate. It has an independent reporting line to Parliament, providing assurance to the legislative and public on the operations of the MoH. Several additional independent bodies also ensure there is effective oversight to regulate and supervise the

[12] *2023* UNAIDS Data "HIV Program data", accessed on 21 June 2024, https://www.unaids.org/sites/default/files/media_asset/data-book-2023_en.pdf , page 150

[13] 95% of people living with HIV in Rwanda (230,000) know their HIV status, and 97% of people who know their HIV status are on treatment, and 97% of people on treatment have a suppressed viral load, UNAIDS 2023 report, ibid.
[14] Rwanda Biomedical Centre, "HIV, STIs, and Viral Hepatitis Programs. Annual Report 2022-2023", accessed on 21 June 2024, https://www.rbc.gov.rw/fileadmin/user_upload/report23/HIV%20Annual%20report%202022%20-2023.pdf
[15] World Health Organization, "World Malaria Report 2023", accessed on: 21 June 2024, https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2023

work of the MoH, including the Rwanda Governance Board, Rwanda Public Procurement Authority (RPPA), Rwanda National Prosecution Authority (NPPA), and the Office of Ombudsman.[16]

Effective country ownership and leadership in the health response have been established through strong engagement from the executive level on health financing as well as the development of well designed and implemented NSPs for the three diseases, health financing, health systems and an overall national health sector strategy. This has allowed the country to direct the work and resources of donors to support Rwanda's vision of how health development should be implemented in the country. In addition, NSPs for the three diseases have been fully costed with well-defined implementation plans and targets allowing Global Fund grants to align to the NSPs.

Robust systems and processes for financial, programmatic and health financing data have been developed by the GoR, resulting in quality data for decision making and oversight. Strong systems, tools, processes and human resources have been established to support high levels of programmatic data quality (see finding 4.3) and a robust approach to health financing and the generation of health financing data (see finding 4.4.). For financial management, the national Public Finance Management (PFM) system, the Integrated Financial Management Information & System (IFMIS) is used across all ministries to support public financial management. The national PFM law ensures all ministries follow a consistent and transparent approach to budgeting, expenditure and reporting which is also applied to Global Fund Grants. IFMIS is used by all ministries and covers all aspects of PFM. These strong national systems mean that Global Fund grants under RBF can fully leverage country systems, avoiding the need to develop parallel systems and reporting lines.

Additionally, the relatively small size of the country[17] is an important factor as well as the good geographic access to services, driven by the Government's efforts to expand service delivery by creating more health posts and establishing more health facilities in remote rural areas.

The RBF model can be replicated in other portfolios where the appropriate conditions exist. The model has proven it can help achieve good programmatic results with an effective use of Global Fund grants. However, it is only a feasible approach where most of the above critical success factors are materially present. There is a need for the Global Fund Secretariat to define how RBF can be more broadly considered and implemented as a model.

In the 10 years since RBF was established in Rwanda, only a small number of additional countries have used an RBF approach. Currently, there is limited Global Fund guidance on when, where and how the RBF model can be leveraged. In the 2023 OIG Audit of Global Grants to the Republic of India[18], there was an Agreed Management Action (AMA) to develop an operational policy note on RBF, to establish a framework and guiding principles to help future design and implementation in other geographic settings. However, despite the action due date being 30 September 2023, it has not yet been completed, impacting how the model can be further enhanced and leveraged both within Rwanda and beyond.

[16] The RGB is a public institution mandated to promote good governance principles and monitor service delivery across public and private sector institutions as well as civil society organizations. The RPPA monitors and implement best practices in procurement activities. The NPPA is responsible for investigating and prosecuting offences throughout the country. The Office of the Ombudsman aligns and contributes to the Justice, Rule of Law-and-Order priorities outlined on the strategic plan.
[17] It is the 148th largest country out of 232 in terms of size, a total of 26,338 square kilometers.
[18] The Global Fund "Global Fund Grants in the Republic of India" (2023), accessed on 26 July, 2024 https://www.theglobalfund.org/media/13066/oig_gf-oig-23-011_report_en.pdf

No Agreed Management Action (AMA) has been proposed by the Global Fund Secretariat for this finding, due to the positive nature of the finding as well as the on-going work undertaken by the Secretariat to address the previously mentioned AMA raised in the 2023 OIG Audit of Global Grants to the Republic of India. This AMA and associated work by the Secretariat aim to respond to the issue raised on the limited Global Fund guidance on when, where, and how the RBF model can be leveraged.

4.2 RBF model can be further evolved and refined to enhance governance, target setting and indicator selection in specific areas to further maximize performance.

The reliance on national systems for the design, implementation, monitoring, and assurance of RBF grants has helped support strong programmatic results. However, there are specific opportunities to further enhance the governance, indicator selection and target setting to maximize the impact of the model in areas where relatively weaker performance persists.

Rwanda RBF approach leverages the National Strategic Plans (NSPs) for the three diseases to form the basis of the Global Fund grants in-country. This ensures strategic alignment between domestic and global fund investments. The NSP priority areas, performance indicators and targets are leveraged to develop the Global Fund performance frameworks and agreement. In addition, rather than using Global Fund specific reporting tools such as the PU/DR[19], the detailed annual reports on progress that produced by the national programs and validated by CCM are used by the Global Fund Secretariat to assess performance and determine disbursements.

National institutions are involved in the RBF grants: the Ministry of Finance and Economic Planning (MINECOFIN) is the grant signatory, the MoH is the main implementer, and the OAG provides financial assurance over the grants. This eliminates duplications and the use of parallel systems, as well as ensuring better efficiency and institutional sustainability. Overall, this approach has supported strong programmatic performance and, for most key programmatic areas, has incentivized strong results. However, there are opportunities to further enhance the RBF approach in Rwanda to maximize the impact of the model.

Opportunities to enhance indicator selection and target setting.

Overall, the approach to select indicators and targets under the RBF grants have supported strong programmatic results during GC6. However, there are opportunities to establish more tailored performance indicators for three specific areas in HIV and TB. For Key Population (KP) interventions, no indicators were established for HIV testing and treatment for these populations. For Drug Resistant (DR) TB, there were no specific indicators for DR-TB treatment coverage and notifications as well as more complex DR-TB diagnostic testing[20]. Lastly, there were no TB prevention indicators for all disaggregated age groups, treatment completion and contact investigation[21]. These were not established despite specific implementation challenges and relatively weaker results for these areas.

This is due to the NSPs not including specific indicators and targets for these areas. As the Global Fund Secretariat only leveraged NSP indicators for the RBF grant, there was a missed opportunity to establish more tailored indicators to incentivize the country to better address challenges in these areas. The Global Fund Secretariat was also not involved in the development of the NSPs, despite their significance in the design of the RBF grants, highlighting an additional opportunity to provide guidance and support. However, it is important to note there is no Global Fund internal guidance that requires their involvement.

[19] For standard grants, implementers use the PU to report on the latest completed period of program implementation, the duration of which is defined in the Performance Framework, and the Disbursement Request to define financial needs for the coming execution and buffer periods. The Global Fund, "Progress Update and Disbursement Request" (2022), accessed on 30 July 2024, https://www.theglobalfund.org/media/11754/fundingmodel_pudr_instructions_en.pdf

[20] This includes indicators in the Global Fund Modular framework such as DR-TB notifications (DRTB-2M), resistance testing (DRTB 5-7), enrolment (DRTB 3M) and coverage (TBO-6), to the current RBF indicator on treatment success (DRTB-9).

[21] This includes indicators in the Global Fund Modular framework such as TBP 1M (all-inclusive covering all age groups <5 years, 5-15 years and 15+ years), TBP-2 to track completion of TPT treatment, and TBP-3 to include Contact Investigation coverage.

In addition, there was an unclear approach and criteria for how the broader set of NSP indicators were translated into the smaller set for the Global Fund Performance Framework and what informed disbursement decisions. Differences were noted between the three diseases on how many indicators from the NSPs were included in the performance framework and were reported in the annual reports to calculate disbursement.

These issues are linked to a lack of clear guidelines from both the Global Fund and the country on NSP development, and how indicators and targets are established and finalized in the context of the RBF model. The lack of a more comprehensive indicator development plays a contributing role in allowing challenges to persist in these specific areas:

- **HIV**: Whilst the overall programmatic results for HIV have been strong, there are significantly lower 95:95:95 cascade results for KP groups as well as higher prevalence.[22] Specifically, female sex workers show 82-89-97 cascade results and a 35% prevalence rate, and men who have sex with men show 43-99-76 cascade results and a 7% prevalence rate.
- **DR-TB**: Diagnosis continues to face high levels of missing cases (ranging from 35% to 72% during 2018-2022), underachievement of UN High Level Meeting (UNHLM) DR-TB targets, and gaps in diagnostic coverage for GeneXpert which affect DR-TB detection efforts.[23]
- **TB**: While prevention for Latent TB infections (LTBI) has been expanded, achieving the NSP targets set, the UNHLM targets remain unmet.[24]

The current approach to KP groups can impact Rwanda's long-term ability to maintain the strong programmatic HIV results achieved to date. For TB, sub-optimal DR-TB coverage and TB prevention coverage has hindered progress towards TB incidence and mortality in alignment with NSP targets (incidence reduction was only 8% vs a target of 29%, while mortality reduction was only 35% vs a target of 47%).

Opportunity to enhance the CCM governance and oversight by tailoring existing guidance.

The role and focus of the Rwanda CCM have not been tailored to align to the specific needs of the RBF model. Currently, the CCM does not have a clear role in RBF design or RBF indicator and target selection. During implementation, the CCM does not have a clear role regarding programmatic oversight, data quality and assurance, and does not hold frequent discussions on programmatic performance and challenges. This is despite these components being critical risk areas in an RBF approach. In addition, during GC6, the CCM operated without an agreed schedule of routine meetings but met in an ad-hoc manner. While there is an active CCM oversight committee, the reports and concerns of the oversight committee are not routinely discussed by the CCM. Consequently, certain underperforming program areas were not effectively addressed, in comparison to the overall positive results. Since the start of GC7 (July 2024), a CCM meeting calendar for 2024-25 has been established to guide the scheduling of its meetings.

No Agreement Management Action (AMA) has been proposed by the Global Fund Secretariat for this finding given that the advanced progress Rwanda has already made in developing updated National Strategic Policy (NSP)s. These NSPs will link to the new M&E plan which is aligned to partner guiding principles. The actions being taken in Rwanda align to the principles of the RBF

[22] This has been linked to a lack of available disaggregated data for KP groups, limited prioritization of KP related activities and limited multi-sectoral engagement with non-health sector stakeholders.
[23] This has been linked to policy national guidelines not fully aligned with WHO normative guidance on use of recommended diagnostics, gaps in financing the roll out of recommended diagnostics to cover all presumptive cases and weaknesses in the maintenance and monitoring of GeneXpert utilization as well as limitations in 1st and 2nd line drug resistance laboratory testing. It is important to note that COVID-19 disruption also impacted performance in this area.
[24] This was linked to programmatic challenges around commodity availability due to global shortages, limited availability of LTBI tests (IGRA, Mantoux), and the impact of COVID-19 pandemic that affected contact investigation.

operational policy and guidance for countries implementing within an RBF model approach. In addition, CCM engagement within an RBF model approach will continue to align and remain compliant with the overarching CCM Oversight model.

4.3 A robust control environment over programmatic data has led to good data quality to inform programmatic decisions, with opportunities to further enhance data management.

Critical to the success of the RBF model is accurate programmatic data. The OIG found very high levels of data accuracy and integrity with variances below 5% for most indicators. There is an opportunity to ensure that data management is strengthened for HIV viral load data.

Very high levels of data accuracy were noted in all sites visited by the OIG for several key HIV, TB and malaria indicators. Data accuracy (verification factor) was found to be above 95% in five out of six sampled indicators across the three diseases.[25] This has supported accurate disbursement of funds by the Global Fund and ensured that the MoH can make timely data led health management decisions, resulting in the achievement of very strong programmatic results (see finding 4.1). This high level of data accuracy was also observed in several MoH led data reviews throughout GC6, highlighting the effectiveness of MoH oversight.

These positive results were achieved through the strong internal control environment put in place by the MoH. Data quality has been effectively managed at the health facility level with monthly data validation meetings led by the heads of facilities, implemented at all sites visited by the OIG. This ensures data is correctly reported into the national health management information system (DHIS2) which has been rolled out at all health facilities, removing the need for manual reporting. Standardized national data tools were also available at 85% of sites visited by OIG to support the collection and reporting of accurate data. There are also well designed MoH data management standard operating procedures, which were available at 100% of sites visited by the OIG. In addition, 92% of visited sites had dedicated staff responsible for data and there were high levels of trained staff in data systems usage. Lastly, there was also effective supervision and oversight over data provided by the sub-recipient Rwanda Biomedical Centre and the MoH at all sites visited by the OIG.

Specific opportunities to strengthen data management of HIV viral load indicators.

Some moderate variances (between 7-15% over and under reporting) were observed for HIV viral load indicators[26] when comparing DHIS2 to primary record at sites visited by the OIG.[27] In addition, HIV viral load results[28] are not calculated in line with normative guidance and did not follow the grant performance framework. These specific issues with HIV viral load data were caused by fragmented systems, lack of standard tools available and gaps in oversight:

- HIV viral load data is fragmented across health registers, laboratory specific data systems and DHIS2. Differences in results are due to the lack of interoperability and integration between these data sources.

[25] Moderate variances ranging from 7% to 15% observed for viral load indicators, minor differences in the 1% range for malaria indicators and minor differences in the 1% to 4% range for TB indicators.
[26] Number of patients eligible for a viral load test, the number of viral load tests done/samples collected and the number of patients with suppressed viral load.
[27] During the OIG audit, a number of adjustments were made to correct historic HIV viral load data in DHIS2 by MoH staff. Although these adjustments were made to correct the underlying data, the changes were not made in a timely manner, and did not follow the standard procedures for making corrections to the underlying data, including documenting approvals for the changes. These changes reduced the variances that were detected by the OIG.
[28] (1) Indicator definition: Percentage of people living with HIV on antiretroviral therapy (ART), whose viral load test results are <1000 cp/ml in the reporting period. (2) Numerator: Number of people living with HIV on ART whose viral load test results are <1000 cp/ml in the reporting period
(3) Denominator: All vital load test done and reported in the current reporting period (cohort).The audit noted: The viral load denominator is the number of tests done and not those that are eligible for a test during the reporting period (WHO), while the performance framework points out that health facility registers as the data source for this indicator, the centralized lab results from the system are used i.e. all viral load tests done with no regard to the cohort.

- While overall standard tool availability was strong, 23% of visited sites did not use standard registers for HIV viral load.
- While data reviews were being routinely conducted by health facilities and national staff, they did not cover HIV viral load indicators. This is linked to the HIV program not rotating the indicators being assessed. This gap in rotation of HIV indicators was highlighted in the 2019 OIG audit and not yet fully addressed. This is also linked to the lack of a wider codified monitoring and evaluation plan that describes the roles and frequency of data quality reviews at each level including what data is selected for assessment. In addition, there are no finalized and approved standard procedures covering late changes to data in DHIS2 after reporting deadline. This means there are no guidelines on how late changes are routinely reviewed to ensure they are appropriate and in line with guidelines.

Overall, the OIG found a strong data management environment, despite these issues regarding HIV Viral Load data which had no overall material impact on Global Fund disbursements.

Agreed Management Action 1
The Secretariat will work with the PR to further strengthen accuracy and integrity in data management by ensuring the existing standard operating procedures (SOPs) are enhanced to capture the evolving nature of data collection, management and reporting and are implemented. SOPs will be updated to include a provision for rotation of indicators sampled for planned routine data quality audits and a provision on how late data changes are managed.
OWNER: Head of Grant Management Division
DUE DATE: 30 June 2026

4.4 There have been strong efforts to increase domestic health financing and meet co-financing requirements, but declining external funding and the need for more operational sustainability planning increase sustainability risks that could erode gains made.

The Global Fund Secretariat and GoR have supported several initiatives to improve domestic financing, including community-based health insurance and innovative financing mechanisms to maximize funds available for health. However, in the context of declining health financing, there are opportunities to strengthen sustainability planning and governance to mitigate risks.

Rwanda is a unique portfolio, being a low-income country with significant programmatic progress achieved resulting in reducing disease burden. This drives reductions in external funding, including from the Global Fund. In this context, there have been significant efforts made by the Global Fund Secretariat and GoR to increase the amount of DFH. During GC6, the Global Fund has supported a 2023 National Health Financing dialogue to advocate for increased domestic financing and help improve the online reporting of government expenditure. For GC7, there has been Strategic Initiative funding earmarked to support updating the NHF strategy. In addition, the Global Fund has made efforts to reduce rapid funding declines in allocation cycles through qualitative adjustments[29] during the fund allocation process.

The GoR has also provided strategic direction through the development of the NHF Strategic Plan. This has been coupled with the development of the community-based health insurance (CBHI) scheme, and several other innovative approaches to improve domestic funding for health. 88% of the population is enrolled in CBHI, which covers 100% of malaria services. TB and HIV services are already freely accessed regardless of insurance status. In addition, there have been efforts to obtain additional loan financing from other development institutions to support DFH.[30] There have also been examples of successful transfers of human resources costs from Global Fund to domestic budgets, including midwife costs and community environmental health officers' costs.

The GoR has also developed very robust systems, tools and processes to support timely, complete and accurate health financing data. Health budgets and expenditures are publicly available and are regularly updated. Global Fund grants are "on budget" and are included in all national budgets and expenditure reports. This has been supported by a strong MoH health financing department with clear accountability over health financing data. This has supported the Rwandan government to promptly report on co-financing requirements, meeting and exceeding GC5 and GC6 requirements.

Increased sustainability risks due to declines in external funding and sustainability planning.

There are growing financial sustainability risks due to the declining of external funding[31] and lack of sustainability planning. While the government funding has increased significantly, it has not been able to off-set the significant declines in external financing.[31] This is linked to the country successfully reducing their disease burden (see finding 4.1) and external funding - including that of the Global Fund - being reduced in line with this declining trend. Comprehensive detailed operational sustainability planning has yet to be completed to cover the interventions of all three disease

[29] The qualitative adjustment process allows for formula derived amounts to be adjusted and address key epidemiological, programmatic and country characteristics, on a case-by-case basis, to determine final country allocations. The Global Fund, "GF/B47/03" (10 May 2022) accessed on 21 June 2024, https://www.theglobalfund.org/kb/board-decisions/b47/b47-dp03/

[30] Efforts were made to obtain loans from several sources e.g. World Bank, Korean Government, and European Investment Bank

[31] Global Fund grant amounts have reduced by 57% (US$223.7 million) since GC4 (2014). US Government funds have reduced by 12% (US$11.9 million) since 2015. GoR funding has increased by 88% (US$29.7 million) since 2015.

programs, although efforts from the MoH and bilateral partners have led to the start of developing a HIV sustainability plan. Under current Global Fund STC[32] policies, a low-income classification country like Rwanda is not required to have sustainability plans in place.

Consequently, the overall funding gaps and UQD for the three diseases have been increasing between GC5 and GC7. The short-term impact of these funding gaps includes a lack of financing for activities[33] previously funded by the Global Fund in GC5, which could not be transferred to domestic or alternative funding in GC6.

Regarding sustainability planning, there are gaps in Global Fund guidelines and policies to deal with Rwanda's unique scenario, as a low-income country, with strong programmatic performance that faces sustainability challenges due to funding gaps. The current Global Fund STC policy does not require low-income countries to develop comprehensive sustainability plans to mitigate financial sustainability risks. In line with the current policy, the Global Fund Secretariat has not requested comprehensive operational sustainability plans to the country stakeholders. In addition, as the National Strategy for Transformation 2 (NST2) and Health Sector Strategic Plan (HSSP V) are not yet complete, timelines to complete sustainability plans have not been determined yet.

The GoR also delayed in completing key activities in the NHF Strategy. While there has been an overall absolute increase in Government health budgets, as a percentage of the national budget, health spending is still below the national target and has declined below the 2016 base line.[34] Even so, the percentage reached (15.3%) is above the Abuja declaration target[35]. Implementation of income generating activities (IGAs)[36] were also delayed impacting resource mobilization efforts.

There were also opportunities to increase the focus of the CCM on sustainability planning and health financing. The Global Fund Secretariat recommendation to the CCM is to engage other stakeholders and discuss the sustainability of Indoor Residual Spraying (IRS) and the overall program for 2023-2025 allocation not implemented[37]. In addition, sustainability and health financing risks are not routinely discussed in CCM main meetings[38].

No Agreement Management Action (AMA) has been proposed by the Global Fund Secretariat for this finding. The Secretariat notes that the Rwanda has already progressed in its efforts to strengthen sustainability planning and in the revision of the National Health Financing Strategy. The Global Fund Secretariat will apply its revised operational policies, including the Board approved Sustainability, Transition, and Co-Financing (STC) Policy of November 2024 and will strategically leverage multiple avenues within the Secretariat's control to advocate for greater sustainability planning in Rwanda.

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[32] The Global Fund, "The Global Fund Sustainability, Transition and Co-financing Policy", (12 December 2022), accessed on: (date), https://www.theglobalfund.org/media/14383/core_sustainability-transition-cofinancing_policy_en.pdf; The Global Fund, "Guidance Note: Sustainability, Transition and Co-financing", (12 December 2022), accessed on 31 July 2024, https://www.theglobalfund.org/media/5648/core_sustainabilityandtransition_guidancenote_en.pdf

[33] Examples include the procurement of lab equipment: US$0.5 million; procurement of condom kiosks US$0.1 million and support human resources for health faculty and running costs under HIV grant: US$5.7 million.

[34] The National Budget allocated to health is at 15.3% for 2023 and was below the NHF Strategy's 17% (2016) baseline and target of 20%.

[35] According to the Abuja Declaration of 2001, African countries pledged to set a target of allocating 15% of national annual budget to the health sector. Organization of African Unity "Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases" (April 2001), accessed on 24 June 2024, https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf, 5.

[36] IGAs) are projects by public health facilities and institutions to raise more internal revenues to meet the needs of the population they serve.

[37] Letter on additional funding for Rwanda malaria through portfolio optimization dated 5 December 2022.

[38] Only 18% (2 out of 11) CCM main meetings held in GC6 included discussions on sustainability and health financing risks.

Annex A: Audit rating classification and methodology

Effective	No issues or few minor issues noted. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	Moderate issues noted. Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Needs significant improvement	One or few significant issues noted. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness. Until they are addressed, there is no reasonable assurance that the objectives are likely to be met.
Ineffective	Multiple significant and/or (a) material issue(s) noted. Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised.

The OIG audits adhere to the Global Institute of Internal Auditors' definition of internal auditing, as well as international standards for the professional practice of internal auditing and the code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of OIG's work.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems determine whether risk is managed appropriately. Detailed testing is used to provide specific assessments of these different areas. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the Impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.

Annex B: Risk appetite and risk ratings

In 2018, the Global Fund operationalized a Risk Appetite Framework[39], setting recommended risk appetite levels for eight key risks affecting Global Fund grants, formed by aggregating 20 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the eight key risks which fall within the audit's scope. In addition, a narrative explanation is provided every Time the OIG and the Secretariat's sub-risk ratings differ. For risk categories where the organization has not set formal risk appetite or levels, OIG opines on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Rwanda: comparison of OIG and Secretariat risk levels

The updated Secretariat risk levels assessment (April 2024) is aligned with the OIG audit rating except for Health Financing.

Health Financing: The Global Fund Secretariat rated as "Low". The OIG has raised relevant observations on the sustainability and efficiency sub-risk under this risk area. This is due to the increased sustainability risks highlighted in finding 4.4. due to the evolving funding landscape for investments in the three diseases. Therefore, this raises the overall risk level to 'moderate'.

[39] The Global Fund, "Risk Appetite Framework" (2018), accessed on: 5 July 2024, https://www.theglobalfund.org/media/7461/core_riskappetite_framework_en.pdf