



THE OFFICE OF THE INSPECTOR GENERAL

The Global Fund to Fight AIDS, Tuberculosis and Malaria

Audit Report on the Global Fund Grants to Rwanda

Audit Report No.: GF-OIG-10-003

Issue Date: 11 March 2011

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Acronyms

A-lu	Artemether-Lumefantrine (a co-formulated ACT)
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
BK+	Bacille Koch positive (French abbreviation for smear-positive pulmonary tuberculosis)
BCC	Behavior Change Communication
BTC	Belgian Technical Cooperation
CAMERWA	Centrale d'Achat des Medicaments Essentiels du Rwanda (Central Medical Stores)
CBHI	Community-Based Health Insurance
CD4 Count	(Immunological test to establish level of immune depression due to HIV)
CDLS	Commission du District de Lutte contre le Sida
CDT	Centre Diagnostique et du Traitement (tuberculosis diagnosis and treatment centre)
CHW	Community Health Worker (ASC in French)
CNLS	Commission Nationale de Lutte contre le Sida
Cotrimoxazole	(Prophylactic antibiotic for people living with HIV)
CPDS	Common Procurement and Distribution System
CREDI	Centre Rwandais de l'Espoir pour le Développement Intégré (National NGO)
CT	Centre de Traitement (tuberculosis treatment centre without diagnostic laboratory facility)
CTAMS	Cellule Technique d'Appui aux Mutuelles de Santé
CTX	(Prophylactic treatment with Cotrimoxazole)
DOTS	Directly Observed Treatment Short Course (for tuberculosis)
GF	Global Fund for HIV/AIDS Tuberculosis and Malaria
GOR	Government of Rwanda
GTZ	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HBM	Home-based management (of malaria)
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICB	International Competitive Bidding
IEC	Information, education, communication
IPT	Intermittent Preventive Treatment (prophylactic malaria treatment during pregnancy)
LFA	Local Fund Agent
LLINs	Long-Lasting Insecticide-treated Nets
M&E	Monitoring and Evaluation
MDR	Multi-Drug Resistant (Tuberculosis)
MIGEPROF	Ministry of Gender and Family Promotion
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have sex with men
NCB	National Competitive Bidding
NGO	Non-Governmental Organization
NRL	National Reference Laboratory (LNR in French)
NSA	National Strategy Application (for a Global Fund grant)
OAG	Office of the Auditor General of Rwanda

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OIs	Opportunistic Infections
OIG	Office of the Inspector General
OVC	Orphan and vulnerable child
PBF	Performance-Based Financing
PCR	Polymerase Chain Reaction (a molecular laboratory test used to diagnose HIV infection in infants or to quantify the viral load)
PEPFAR	President's (US) Emergency Program for AIDS Relief
PIT	Provider Initiated (HIV) Testing
PLWHA	Person Living with HIV and AIDS
PMI	President's (US) Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PMU	Program Management Unit (for Global Fund)
PNLIP	Programme National Intégré de Lutte Contre le Paludisme (now: Malaria Unit of TRAC Plus)
PNILT	Programme National Intégré de Lutte Contre la Tuberculose (now : Tuberculosis Unit of TRAC Plus)
PR	Principal Recipient
PRO-FEMMES	Collectif des Organisations Rwandaises de Promotion de/ la Femme, de la Paix et du Développement
PSI	Population Services International
PSM	Procurement and Supply Management
PWC	PricewaterhouseCoopers
RCC	Rolling Continuation Channel (for Global Fund grants)
RPPA	Rwanda Public Procurement Authority
RRP+	Réseau Rwandais des Personnes vivant avec le VIH/SIDA
SCMS	Supply Chain Management Systems
S-P	Sulfadoxin-Pyrimethamine (an anti-malarial drug)
SR	Sub-recipient
STIs	Sexually Transmitted Infections
SWAA	Society for Women and AIDS in Africa (Pan-African NGO)
TB	Tuberculosis
TRAC Plus	Centre for Treatment and Research on AIDS, Malaria, Tuberculosis and other Epidemics
UN	United Nations
UPDC	Unité Politique de Développement des Capacités
US	United States
USAID	United States Agency for International Development
USD	United States Dollars
VAT	Value-added Tax
VCT	Voluntary Counselling and Testing for HIV
VCTC	Voluntary Counselling and Testing Centre
WB	World Bank
WHO	World Health Organization

Executive Summary

Introduction

1. This report sets out findings and recommendations of the Office of the Inspector General's (OIG) audit of the Global Fund (GF) grants to Rwanda. The field work for the audit was carried out from March 8 to April 30, 2010.

Background

2. The audit of the Global Fund grants to Rwanda was conducted as part of the OIG work plan for 2010.

Audit Objectives and Scope

3. The objectives of the audit were to (a) assess the efficiency and effectiveness in the management and operations of the grants; (b) measure the soundness of systems, policies and procedures in safeguarding Global Fund resources; (c) assess the risks that the grants are exposed to and the adequacy of measures taken to mitigate them. In doing so, the following four areas were covered: (i) programmatic management; (ii) procurement and supply chain management; (iii) fiduciary management; (iv) program oversight within Rwanda; (v) programme oversight by the Global Fund Secretariat. The OIG therefore deployed a multi-skill team comprising a public health specialist, a procurement and supply management specialist, and audit specialists.

4. The scope of the audit covered ten GF grant programs being implemented by the Ministry of Health (MOH), which is the sole principal recipient (PR) for the grant programs. In addition, the audit covered selected sub-recipients (SRs) of the PR such as the National AIDS Control Commission (CNLS), the Central Medical Stores (CAMERWA) for purchase of medicines and health supplies, the National Malaria Program (PNLIP), the National AIDS Program (TRAC), CTAMS (Community Health Insurance Scheme) as well as selected District Hospitals, Health Centres and some Community-based Organizations.

5. Audit tests and program visits were carried out in four provinces in the South, North, East and Kigali City.

Summary Findings

6. This section briefly highlights the findings and conclusions arising from the audit; but detailed findings are contained in the rest of the report. It is therefore essential that this report is read in its entirety in order to comprehend fully the findings and the resulting recommendations of the audit.

7. The recommendations have been prioritized. However, the implementation of all recommendations is essential in mitigating identified risks and strengthening the internal control environment in which the programs operate. The prioritization has been done to assist management in deciding on the order in which recommendations should be implemented. The categorization of recommendations is as follows:

- a. *High priority:* Material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization's interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management;
- b. *Significant priority:* There is a control weakness or noncompliance within the system, which presents a significant risk and management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal control, or undermine achievement of aims and objectives; and
- c. *Requires attention:* There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization's benefit

A. Program Achievements

8. Rwanda, with the assistance of the Global Fund and other development partners, has established a very effective decentralized HIV treatment program. In February 2010 almost 77,000 people living with HIV were receiving anti-retroviral treatment, representing about 80 percent of the estimated number in need. Among these, 83 percent had been on treatment for longer than one year indicating a high level of treatment adherence. The program for the prevention of perinatal HIV transmission has been equally effective with less than 3 percent of children born to HIV positive mothers testing HIV positive at 18 months of age.¹ HIV testing and counseling services reach very large numbers of the population with 827,000 tests performed at 312 voluntary counselling and testing sites in 2007. There is an effective health information system for HIV care using innovative cell-phone based technology and generating accurate information on a monthly basis.

9. The main strengths of the tuberculosis control program in Rwanda are:
- a. The achievement of treatment success rates between 86 and 87 percent for the last three cohorts (2006-2008) of sputum positive tuberculosis patients;
 - b. A functional system for supervision and quality control of data;
 - c. Successful introduction of community-based DOTS;
 - d. Universal HIV testing of tuberculosis suspects; and
 - e. Full coverage one-stop HIV treatment for dually infected patients.

10. Rwanda achieved a major success in malaria prevention with a rapid decline in incidence in 2007. This achievement was offset by an increase in malaria incidence in 2008, but since the beginning of 2009 appropriate steps are being taken to overcome this set-back. Treatment of uncomplicated malaria with ACT is practiced in all public health facilities, and since December 2009 all diagnoses of malaria are confirmed with microscopy or rapid diagnostic tests before treatment.

¹ Source: TRAC Plus PMTCT data-base 4th quarter 2009 (Accessed March 20 2010)

B. Best Practices

11. This section briefly summarizes best practices noted during the audit.
- a. Rwanda has achieved almost universal HIV testing and counselling of male partners of pregnant women in the context of the prevention of perinatal HIV infection. This is considered to be a major contributing factor to the excellent results achieved by the PMTCT programme in the country.
 - b. The mobile phone-based information system for HIV care established in Rwanda is revolutionary in its simplicity and functionality. It is being expanded to other areas of health care, initially to maternal and child health. It is a practice that merits to be closely monitored with the view of the possibility of replication in other countries supported with Global Fund grants.
 - c. Social support provided with financial contribution of the Global Fund is broadly based on poverty, focusing on access to health care and to education for people most in need. In comparison to the practices in most programmes that target social support on the basis of HIV status, this holds a much greater promise of laying the foundation of a sustainable national social safety net.
 - d. In Rwanda the practice of “one-stop care” for people co-infected with HIV and TB has been successfully implemented. Cotrimoxazole prophylaxis and anti-retroviral therapy is provided in tuberculosis clinic throughout the period of tuberculosis treatment. This has resulted in excellent performance in the response to HIV-TB co-infection and is clearly a practice that merits to be replicated in other countries.
 - e. Rwanda has creatively used Global Fund grants to strengthen critical areas of the health and social system. This applies not only to the Round 5 HSS grant, but also to disease-specific grants that have been used, for instance the use of an HIV grant to consolidate the system of performance-based health care financing.

C. Service Delivery

HIV/AIDS Program

12. HIV treatment and care in the public sector is delivered through 269 clinics providing treatment of good quality with excellent results. The results of the HIV testing program and the program for the prevention of perinatal HIV transmission are equally impressive. In the area of HIV prevention there are weaknesses, primarily related to capacity issues of civil society organizations to address the prevention needs of highly vulnerable populations.

TB Program

13. Tuberculosis control in Rwanda is effective. The Tuberculosis Unit of the Ministry of Health consistently records high treatment success rates which are reported at 87 percent for the 2008 cohort of smear positive tuberculosis patients. The treatment and follow-up of multi-drug resistant tuberculosis and the treatment of HIV and tuberculosis co-infection are well organized. The prevalence of tuberculosis in Rwanda is not known. As a consequence, estimates of tuberculosis

case detection rates are not necessarily reliable. A tuberculosis prevalence survey is planned to start in 2010.

Malaria Program

14. Rwanda has experienced a resurgence of malaria incidence in 2008 and 2009 that has not yet been fully investigated but could be related to a shortage of insecticide treated bed-nets. Steps are being taken to respond to this situation. Malaria treatment is well organized and treatment protocols are being followed. An increasing number of children with fever are treated with anti-malarial drugs by volunteer community health workers. This program should be improved as soon as possible by the introduction of rapid diagnostic tests.

Health Systems Strengthening

15. The most remarkable achievement of the Global Fund grants to Rwanda is the constructive way in which they have been applied to strengthen the national health and social systems. This applies not just to the Round 5 Health Systems Strengthening grant but to the entire grant portfolio. The specific areas where health systems support has been applied productively are:

- a. Health information systems;
- b. Health care infrastructure;
- c. Human resources for health;
- d. Health care financing; and
- e. Social Protection.

D. Procurement and Supply Chain management

Procurement

16. Since the beginning of Global Fund support to Rwanda, about 42 percent of the combined budgets have been allocated to the Central Medical Store (CAMERWA).

17. Procurement of non-health items by the MOH's Program Management Unit generally conforms to national regulations which are strong and well controlled. A delay of eight months in procurement of insecticide-treated bed-nets in 2009 could have been avoided if technical specifications had been established at the beginning of the program and included in the PSM plan.

18. CAMERWA has a strong procurement department but has no formal manual of procedures. The internal tender committee should include a permanent representation of the drug regulatory authority. A weak point in the procurement system of CAMERWA is the receiving area. There is no pharmacist in place to verify that the drugs received meet the expected specifications and quality standards.

Quality Assurance

19. CAMERWA should, as soon as possible, develop and adopt a quality assurance policy for all lines of supply. The purpose of the policy is to assure the quality of health products procured with Global Fund support at dispensing facilities.

Information Systems

20. The change in the enterprise resource planning software made in May 2009 was a failure and the current systems (MACS and SAGE 500) are not meeting the needs

of CAMERWA. A change in systems is planned with support from Supply Chain Management System (SCMS), a US-based contractor under the President's Emergency Program for AIDS Relief (PEPFAR) program. CAMERWA should float an international tender for an enterprise resource planning software meeting its established technical specifications before any further attempt is made to change the software platform.

Supply Chain Management

21. CAMERWA operates nine warehouses in Kigali. The regular distribution system for drugs is from CAMERWA via District Pharmacies to health facilities. HIV drugs and commodities, however, bypass the District Pharmacy and are directly supplied from CAMERWA to health facilities. The District Pharmacy is the weak link in the distribution chain. There is a high risk that the currently functioning drug tracking system from CAMERWA to dispensing points could fail if District Pharmacies in their current state of development take on the role of active distribution points.

22. The pharmacies in the health facilities visited by the OIG team were well managed. They were, however not able to produce essential financial reports on working capital and volume of sales.

23. Expired drugs are stored by CAMERWA in a warehouse in Kigali. There is no tracking system to monitor the value of expired drugs that have been supplied by the malaria, tuberculosis, and HIV programs. There is also an inadequate system to manage the safe disposal of expired drugs at central, district and peripheral level.

E. Financial Management and Control

24. The OIG noted a number of financial management weaknesses at sub-recipients, which can be attributed to inadequate professional skills of program accountants, the increasing number of grants managed by sub-recipients, insufficient knowledge of the Tompro accounting software package, and inadequate capacity of the PMU to provide the level of oversight and supportive supervision needed to address these weaknesses.

25. Financial management and internal control weaknesses found at implementing organizations audited included inadequate supporting documentation for some grant expenditures, program expenditures charged to wrong grant budgets, inter-grant transfers of funds without GF approval, bank reconciliations prepared quarterly instead of monthly, advances to sub-recipients charged to the grants as expenditures and inadequate budgetary control etc.

26. The OIG also noted that significant amounts of grant funds have been tied up to pay value-added taxes (VAT). The grant agreements provide for tax-exemption on goods and services paid with grant funds. Besides, there is slow recovery of VAT paid from the tax authorities. This is the case at the Ministry of Health's Program Management Unit (PMU) and at all SRs audited by OIG. Grant funds that have been tied up in payment of VAT affect the cash flow of the programs and this impacts negatively on the timeliness of implementation of grant program activities. By 31 December 2009, the OIG estimated that approximately USD 870,000 is pending to be recovered by the PMU from the Rwanda Revenue Authority (RRA). This figure does not include VAT paid by sub-recipients.

27. CAMERWA has a simple cash basis accounting system that does not meet the financial management needs of its business of importing drugs and health supplies from international suppliers, selling/distributing them to its many customers. The management of CAMERWA should therefore consider adopting an accrual-based accounting system to meet the complex needs of its business.

28. The OIG also noted that CAMERWA had not reconciled purchase advances given to the World Health Organization (WHO) for anti-malaria medicines, with corresponding invoices received. The OIG calculated that approximately USD 1.2 million needs to be accounted for. CAMERWA has contacted WHO to clarify this matter.

29. However, the OIG noted that steps are being taken by both the PR and the GF Country Programs Cluster to address some of the above-mentioned financial management challenges. For example, the GF grants in Rwanda are being consolidated, which would likely reduce the number of grant budgets and bank accounts to be monitored and managed. In addition, program managers informed the OIG that plans have been made to augment the PMU's capacity to provide increased support and supervision of sub-recipients.

F. Governance and Program Oversight

30. There is strong government commitment, involvement and leadership in planning, implementing and providing oversight of the programs. Key government institutions involved in the oversight of grant programs are the MOH, CNLS, Rwanda Public Procurement Authority (RPPA), Office of the Auditor General (OAG) and the Ministry of Finance and Economic Planning (MINECOFIN).

31. In addition, the CCM is active in providing oversight of the programs. The CCM also sponsors external evaluation studies of the grants before the end of phase one to assist it in making a recommendation to the GF for further funding.

32. Program oversight of health service delivery is achieved through a peer review system amongst districts. There are quarterly supervisory visits and assessments of services and programs at district hospitals. Also, district hospital teams supervise and assess health centres each quarter.

33. Apart from a review of stocks it completed at CAMERWA in 2008, the Internal Audit department of the PMU has not done a comprehensive audit of either the PMU or CAMERWA. The PMU needs to strengthen its capacity to provide adequate oversight of the grants, particularly in the area of audit, training of program accountants and supportive supervision of sub-recipients.

34. Further, the position of internal auditor at CAMERWA has not been filled. In order to provide adequate audit oversight of the operations of CAMERWA, the MOH should ensure that the Board of Directors of CAMERWA appoints an internal auditor for CAMERWA who reports directly to the board.

35. The Local Fund Agent is exercising a tight control over the quality of grant progress reports submitted to the Global Fund. The impending establishment of an in-country office of the LFA is welcomed.

36. There was a funding gap of one year between Phase 1 and Phase 2 of the Round 6 Tuberculosis program. Similarly, there was a funding gap of eight months between Phase One and Two of the Round 6 HIV program. The Country Programs Cluster should ensure that phase two assessments of the grant programs are done on a timely basis. Further, in order not to disrupt implementation of grant programs, the Country Programs Cluster should ensure that it reviews its existing grant processes in order to facilitate the negotiation and signing of approved grants on a timely basis.

Overall Conclusion

37. There have been impressive program achievements in Rwanda. The programs supported by the Global Fund are generally well managed. The OIG noted some weaknesses in financial management pointing to a need to improve the financial management capacity of sub-recipients as well as the PMU's capacity to provide an appropriate level of oversight and supportive supervision.

Background

38. Between May 2003 and March 2010 total funds committed by the GF to HIV/AIDS, Tuberculosis (TB) and Malaria programs in Rwanda amounted to USD 623 million, of which USD 305 million had been disbursed as of March 2010. The GF has a portfolio of twelve grant agreements in Rwanda.

39. The twelve public sector managed grants require a substantial outlay in procurement of drugs, equipment and health supplies at the national level. To this end, the Government of Rwanda (GOR) mandated the Central Medical Stores (CAMERWA), an autonomous organization under the MOH, to be responsible for procurement of medicines and health products. Service delivery under the public sector grants takes place in district hospitals and health centers.

Institutional Arrangements

40. The MOH is the sole PR for twelve GF grants and will have a portfolio amounting to USD 623 million when the National Strategy Application (NSA) grants are signed. The grant agreements signed by the MOH make it responsible for programmatic results and financial accountability of the grants. Hence, the MOH through the HIV Unit, TB Unit and Malaria Unit of TRAC Plus (Treatment and Research on AIDS Centre-TRAC Plus) which are sub-recipients of the grants, implement, supervise and monitor the national response to the three diseases; and semi-annually report on programmatic achievements and financial results. Further, services for the three diseases are provided through a network of health facilities that include four National Hospitals, 40 District Hospitals and 415 Health Centres.

41. At the inception of the first GF grant to Rwanda in 2003, the MOH established a Program Management Unit (PMU) to facilitate coordination of program and financial management of all the GF grants. It provides budgeting, financial management and procurement support to grant implementing units of the MOH. It is staffed by contracted technical, administrative and finance staff under the leadership of a program coordinator. The PMU operates under the direct administrative and financial supervision of the National AIDS Control Commission (CNLS). To improve oversight of the PMU, there are plans to integrate it in the MOH's organizational structure. When these changes are implemented, the PMU Coordinator will report to the Permanent Secretary of the MOH.

42. The CNLS is a public institution established under the Office of the President of Rwanda for coordinating HIV/AIDS activities of all institutions involved in the fight against HIV/AIDS. Key organs of the CNLS are the Board of Commissioners and the Executive Secretariat. However, technical and administrative supervision of the Executive Secretariat of the CNLS is provided by the MOH. On the other hand, the Executive Secretary of the CNLS exercises supervisory, management and control duties over the PMU.

43. Rwanda's Central Medical Store are called CAMERWA (*Centrale d'Achat des Medicaments Essentiels du Rwanda*) and are a major sub-recipient of the GF grants and it plays a key role in grant implementation. It is an autonomous institution responsible for procurement, storage and distribution of medicines, health supplies and equipment under the GF grants. About 50 percent of grant funds are utilized for procurement. From 2003 to date approximately USD 124 million of GF grant funds had been transferred by the MOH to CAMERWA for procurement of medicines, health supplies and medical equipment. CAMERWA does not have any provincial or

district drug depots or warehouses. Neither does CAMERWA have vehicles for delivery of drugs to health facilities. District Hospitals and Health Centres are required to pick up anti-retroviral drugs from CAMERWA in Kigali, the capital city of Rwanda. On the other hand, TB drugs are distributed through district pharmacies. Health facilities replenish their stock of coartem from small district pharmacies which are managed by the district administration. In most cases, these district pharmacies lacked capacity in terms of qualified staff, storage space and equipment. However, in late March 2010, CAMERWA with the technical assistance of Supply Chain Management Systems (SCMS) has started a pilot program of active distribution of medicines and health supplies to five districts pharmacies that are being supported by SCMS. This pilot distribution program has been initiated to reduce costs and in furtherance of the GOR's decentralization program.

44. The Office of the Auditor General (OAG) of State Finances plays an important role in the oversight of GF grants in Rwanda. It was established in 1998, and in 2003 it became the Supreme Audit Institution of Rwanda. It is the auditor of Government Ministries, Districts and Agencies (MDA) involved in implementation of the GF grant programs. The Auditor General is nominated by the President of Rwanda subject to the approval of Parliament. Further, the OAG operations and activities are funded by Parliament.

45. According to the grant agreements between the GF and the MOH, each grant is subject to an annual audit to be performed by an independent auditor. The OIG reviewed the MOH's compliance with this requirement and the effectiveness of the audits performed by the external auditors.

46. Since January 2009 to date, PWC has been the LFA for Rwanda. However, from 2003 to 2008, Crown Agents served as the LFA. The OIG reviewed the effectiveness of the oversight services provided by the LFA in Rwanda. Key oversight services provided by LFAs include initial and repeat PR capacity assessments before grant signature; verification of implementation which in the case of Rwanda is bi-annually; assessment of PR after the initial two years of grant implementation; and on site data verification.

47. The national response to fight the three diseases is supported by other development partners, notably, the US Government-funded programs and its technical partners, namely, PEPFAR, PMI, SCMS and CDC. Also, the institutional arrangements for the GF grants also benefited from experience and lessons learned from the World Bank's USD 40 million Multisectoral AIDS Project (MAP) which ended in 2008. Also, the Belgian Technical Cooperation (BTC) supported the MOH's malaria program until November 2009. That support still continues with remaining funds but the expatriate technical assistance has been withdrawn. The support will probably stop when the new Belgian health strategy is developed.

48. In May 2000 the GOR adopted a policy of progressive decentralization of the management and oversight of public services including health to the 30 district administrative institutions (local government entities) in the country. Some of the objectives of the decentralization program are to increase local participation, transparency and accountability. Hence, District Hospitals and the District Administrative Institutions have both implementation and oversight roles regarding GF grant program activities carried out within their districts. The OIG examined to what extent district local government authorities and institutions are involved in program oversight.

49. The CCM in Rwanda was constituted in 2002. It has 25 members and it is the body that has ultimate responsibility for grant oversight and for all grant program activities. According to the GF's CCM guidelines, "throughout the lifetime of the grant the Country Coordinating Mechanism is responsible for the oversight of implementation by the Principal Recipient."²

² Specific role of the Country Coordinating Mechanism in performance-based funding, GF CCM website

Objectives, Scope and Methodology

50. The objectives of the audit were to (a) assess the efficiency and effectiveness in the management and operations of the grants; (b) measure the soundness of systems, policies and procedures in safeguarding Global Fund resources; (c) assess the risks that the grants are exposed to and the adequacy of measures taken to mitigate them. In doing so, the following four areas were covered: (i) programmatic management; (ii) procurement and supply chain management; (iii) fiduciary management; (iv) program oversight within Rwanda; (v) programme oversight by the Global Fund Secretariat.

51. The scope of the audit covered the following GF grant programs.

Disease & Round	Principal Recipient	Grant Number	Grant Amount (USD)	Amount Disbursed (USD)
HIV/TB	MOH	RWN-102-G01-C-00	14,641,406	14,641,046
HIV	MOH	RWN-304-G02-H	56,646,465	56,646,460
Malaria	MOH	RWN-304-G03-M	38,597,403	32,414,495
TB	MOH	RWN-404-G04-T	17,027,672	10,556,003
HSS	MOH	RWN-505-G05-S	33,945,080	33,397,129
Malaria	MOH	RWN-506-G06-M	39,649,362	39,149,502
TB	MOH	RWN-606-G07-T	7,426,750	2,538,357
HIV	MOH	RWN-607-G08-H	50,808,370	30,196,743
HIV	MOH	RWN-708-G09-H	63,978,011	49,725,380
Malaria	MOH	RWN-809-G10-M	52,835,617	35,985,693
TB - NSA	MOH	RWN-S10-G11-T	33,353,241	0
HIV/AIDS-NSA	MOH	Not yet available	213,800,858	0
Totals			622,709,875	305,250,808

Table 1: GF grants to Rwanda audited by the OIG (Source: GF website, March 2010)

52. The audit covered GF grant programs being implemented by the MOH and its SRs. The audit sampled financial transactions from the initiation of the grant programs through 31 December 2009.

53. The OIG used the following approaches to conduct its work: discussions with program and financial personnel of relevant grant recipients; review of grant

program documents, monitoring/supervision reports, implementation and procurement plans, examination of supporting documents for grant expenditures as well as program and financial progress reports.

54. In addition, apart from audit tests carried out at the national/central level, the OIG team visited program and projects sites at national, district and health facility levels in three provinces: South, North, East and Kigali City. During the field visits, the OIG team made observations and carried out tests at district hospitals, health centres and district pharmacies, local government entities and community-based implementing organizations.

Service Delivery

HIV/AIDS

HIV treatment is highly successful with high coverage and high treatment retention rates. Similar impressive results are being recorded by HIV testing programs and by the program for the prevention of perinatal HIV transmission. In the area of HIV prevention there are weaknesses, primarily related to capacity issues of civil society organizations to address the prevention needs of highly vulnerable populations.

55. Rwanda has a generalized HIV epidemic with a national HIV prevalence of 3.06 percent³. The prevalence in urban areas, particularly in Kigali is considerably higher. In addition, there are some indications of concentrated epidemics associated with commercial sex workers and among men who have sex with men. The knowledge about these concentrated epidemics is limited.

Treatment, Care and Support

56. HIV treatment in Rwanda is decentralized to 269 health facilities. It is highly successful with high coverage and high treatment retention rates. Similar impressive results are being recorded by HIV testing programs and by the program for the prevention of perinatal HIV transmission. Of note is the very high proportion of male partners participating in ante-natal HIV testing of prospective parents. In the 4th quarter of 2009, this proportion was reported as 83 percent.⁴ Of concern is the fact that about one third of these programs are being managed in health centres operated by the Catholic Church and do not have condoms available, even for counselling sero-discordant couples. The approach to social support for people living with HIV and for children affected by HIV is framed in a social protection program that has a wider focus on poverty and need.

HIV Prevention

57. HIV prevention in Rwanda is conducted by national and international NGOs. It has so far had a broad population focus targeting demographic or professional groups (e.g. youth, military) with messages promoting abstinence, faithfulness or condom use. Although there is some mobilization among NGOs for targeted prevention and condom promotion among highly vulnerable individuals such as female sex workers or men who have sex with men, this has not yet translated into effective programs as outlined in the National Strategic Plan for HIV.⁵ The technical capacity among local organizations to conduct targeted harm reduction programs is low.

Monitoring and Evaluation

58. There are two national data collection systems to monitor the response to HIV. Health sector data are collected by TRAC Plus; non-health sector data are collected by the CNLS. In addition there are a health sector and non-health sector data that are collected through special surveys.

³ TRAC Plus 2009; HIV and AIDS in Rwanda - 2009 Epidemiological Update

⁴ TRAC Plus 2010; National PMTCT database

⁵ CNLS; Rwanda National Strategic Plan on HIV and AIDS 2009-2012; March 2009

59. The HIV unit of TRAC Plus has a very well-functioning system of data collection and information management for monitoring the health sector response to HIV. The cornerstone of this system is TRACNet, an interactive mobile-phone based electronic data collection system that allows each of the 269 treatment sites to enter data for about 20 different indicators related to HIV treatment into the national data base each month. The system generates timely and complete monthly reports. The system of patient registration is currently being moved to an electronic platform. In the meantime there is an electronic patient registration and reporting system in operation that has been installed in district hospitals by a US development contractor under the PEPFAR program.

60. Data for Global Fund progress reports are primarily obtained from national information systems operated by the Ministry of Health and by the CNLS. These data are generally reliable although the CNLS data management system still has major weaknesses. Some data are still collected directly from sub-recipient reports. With the development of the national strategy support grant further progress can be made towards the good practice of relying on national data for Global Fund progress reporting.

Recommendation 1 (Significant)

There are some indications that the HIV epidemic in Rwanda has a mixed profile including elements of a generalized and of concentrated epidemics. Too little is known about the concentrated epidemics among female sex workers and among men who have sex with men. The MOH should increase research and epidemiological surveillance of the HIV epidemics among highly vulnerable groups in the country.

Recommendation 2 (Significant)

Rwanda should implement effective programs for HIV prevention among marginalized and highly vulnerable individuals and groups as outlined in the National HIV Strategy. These include female sex workers and men who have sex with men. Programs of this nature are best delivered by national civil society organizations. The MOH should ensure that these organizations have the appropriate technical assistance to acquire the expertise to work in these areas, as well as a supportive environment to allow them to work.

Recommendation 3 (Significant)

The Rwanda CNLS should engage in negotiation with the Catholic Church to assure the availability of condoms for discordant couples in church-operated public health facilities delivering PMTCT programs.

Recommendation 4 (Significant)

The Ministry of Health should accelerate with the introduction of electronic patient registration systems in HIV clinics using a single agreed electronic platform.

Recommendation 5 (Significant)

In the process of grant consolidation and the negotiation of a national strategy grant for HIV, the CCM and the Global Fund Secretariat should jointly develop a performance monitoring framework that monitors meaningful results at the output, outcome and impact level within the context of a national monitoring and evaluation strategy. The framework should not include input indicators, cumulative indicators or indicators that only monitor directly attributable results.

Wherever possible, results should be expressed in terms of rates and proportions rather than absolute numbers. The monitoring of inputs, of budget execution and of work plan implementation should be confined to a management information system that is separate from performance monitoring.

Recommendation 6 (Requires attention)

In the process of grant consolidation and the negotiation of a national strategy grant, the CCM and the Country Programs Cluster of the Global Fund Secretariat should ensure that the task of data collection for Global Fund performance reports is as much as possible delegated to national data management systems. The TRACNet system is reliable enough to provide quality health sector data. The CNLS system for data on non-health sector community level activities requires some strengthening which could be considered with Global Fund support.

Tuberculosis

Rwanda has a very successful tuberculosis program managed by the Tuberculosis Unit of TRAC Plus. The program is consistently achieving high treatment success rates. It is delivered through 190 Diagnostic and Treatment Centres that are organized in a cascade structure for supervision and reporting. Community-based treatment (DOTS) administered by Community Health Workers has recently been introduced with success.

61. Rwanda is among a group of 30 countries considered by WHO to have a very high burden of tuberculosis. However, the tuberculosis prevalence estimates of WHO are not based on solid evidence and there are major doubts about their accuracy. A tuberculosis prevalence survey is scheduled to start in 2010. HIV infection contributes significantly to the burden of tuberculosis in the country. The HIV prevalence among tuberculosis patients is about 34 percent.

Tuberculosis Control

62. Rwanda has a very successful tuberculosis program managed by the Tuberculosis Unit of TRAC Plus. The program is consistently achieving high treatment success rates. It is delivered through 190 Diagnostic and Treatment Centres that are organized in a cascade structure for supervision and reporting. Community-based treatment (DOTS) administered by Community Health Workers was introduced with the implementation of the National Strategic Plan for Tuberculosis 2005-2009 and by the end of 2009 had been rolled out successfully in 24 of the 30 districts in the country.⁶

63. A review of laboratory registers in the facilities visited by the OIG mission confirmed the successful implementation of the national policy of testing and counselling all tuberculosis suspects for HIV. According to national statistics, 42,684 of the 68,172 tuberculosis suspects identified in 2009 were tested for HIV (63 percent). The denominator, however, includes 28,020 suspects identified by community health workers and in primary health centres without laboratory facility (Treatment Centre). In most of these cases, the patients are not seen in the diagnostic laboratory and only the sputum samples are sent. When these are deducted from the denominator, the estimate of complete coverage of HIV testing is confirmed. The impact of the application of this policy is that in 2008 the HIV results for 97.8 percent of all newly diagnosed sputum positive tuberculosis

⁶ TRACPlus TB Unit; Rapport d'activités de l'année 2009; March 2010

patients were available and reported to the national level.⁷ Those who are found to be co-infected are receiving Cotrimoxazole prophylaxis and about half of them are on anti-retroviral therapy. These treatments are administered in the tuberculosis clinic in a practice that assures “one stop care” until the tuberculosis is cured. This approach is effective in assuring treatment adherence and has benefits for improved infection control in health care settings.

64. Multi-drug resistant tuberculosis is treated on an in-patient basis in a specialized unit at Kabutare Hospital. The unit has recently been expanded with Global Fund support and two further units are being constructed with Global Fund support in the country. Sputum negative patients are referred back to the health facility near their home where they are treated as out-patients. The follow-up is well organized with functional controls. The success rate for multi-drug resistant tuberculosis for the 2007 cohort is reported as 87 percent with a mortality rate of 11 percent and a 2 percent rate of loss to follow up. This excellent result is somewhat mitigated by the fact that the laboratory confirmation of tuberculosis cure⁸ was only available for 42 of the 73 patients reported as having successfully completed treatment. A funding gap of one year between Phase One and Phase Two of the Round 6 Tuberculosis grant threatened to disrupt the treatment and follow-up of these patients. The director of the clinic following the largest number of MDR-TB outpatients in the country confirmed that the clinic has been covering the cost of transport and food subsidies for these patients with its own resources over the last six months, and will have to suspend this subsidy if no financial support from the National Tuberculosis Program (funded under the Round 6 TB grant) is received within the month of the OIG visit. Similar funding bottlenecks were reported to the OIG at Kabutare hospital where the funding gap has threatened the in-patient feeding program.

65. The efforts to increase the apparently low case finding rate in Rwanda have been very vigorous without generating significant increases in the case notification rate. The OIG is concerned about an excessive level of suspicion and an excessive use of sputum examinations. Community Health Workers receive a bonus for tuberculosis patients identified. In 2009, only 6.2 percent (367/5920) of suspects referred by CHWs were sputum positive. Of greater concern is a programme by the National Youth Council to combine public education on tuberculosis with sputum screening in schools, including primary schools. In 2009, the Council organised 295 sputum exams among schoolchildren and did not find a single new case of tuberculosis. This is not only a questionable use of resources, but there are also child protection issues when primary school children are tested for tuberculosis and possibly HIV in the school environment.

Monitoring and Evaluation

The data collection system of the Tuberculosis Unit is robust and the level of supervision and data quality control is high. The OIG observed no issues of data quality in the national tuberculosis database. A review of the two Global Fund grant performance monitoring frameworks found that the Tuberculosis Unit was following a total of 6 impact/outcome, and 30 process/output indicators. This generated a significant workload that was of questionable benefit as many of these indicators were tracking inputs rather than results. Furthermore, some indicators

⁷ TRACPlus TB Unit; Rapport d'activités de l'année 2009; March 2010

⁸ 5 negative sputum cultures during the last 12 months of treatment obtained at one month intervals

were reporting performance against work plan targets rather than tracking programme coverage rates.⁹

Recommendation 7 (Requires attention)

The MOH should exercise caution when developing terms of reference for community mobilization and education in the fight against tuberculosis in order to control the proliferation of poorly targeted sputum testing.

Recommendation 8 (Significant)

In the process of grant consolidation and the negotiation of a national strategy grant for tuberculosis, the CCM and the Global Fund's Country Programs Cluster should reduce the number of indicators of the performance monitoring framework by removing all indicators of work plan implementation to a management information system that is separate from performance monitoring.

Malaria

Rwanda has experienced a resurgence of malaria incidence in 2008 and 2009 that has not yet been fully investigated but could be related to a shortage of insecticide treated bed-nets. Steps are being taken to respond to this situation. Malaria treatment is well organized and treatment protocols are being followed.

66. Rwanda conducted a malaria survey in 2007 as part of the interim Demographic and Health Survey. A repeat survey is scheduled for 2010. A major decline in malaria incidence in 2007 raised hopes of the possibility of malaria elimination. However towards the end of 2008 malaria started to resurge. Possible causes are the deterioration of the insecticidal properties of bed-nets distributed in a mass campaign in 2006 together with a shortage of bed-nets for routine distribution throughout 2009.

Malaria Control

67. Malaria control in Rwanda is managed by the Malaria Unit of TRAC Plus. The Unit reacted appropriately to the resurgence of malaria by working with the US President's Malaria Initiative in organizing a mass distribution of bed-nets in the most affected districts, organizing a re-spraying program for houses in areas where previous spraying had started to show signs of losing effectiveness, and asking WHO for assistance in investigating the increase in incidence. A nationwide mass distribution of bed-nets was planned for May 2010.

68. Treatment of uncomplicated malaria with ACT is practiced in all public health facilities. Since December 2009 all diagnoses of malaria are confirmed with microscopy or rapid diagnostic tests before treatment. This practice was confirmed by the OIG team in the health facilities visited.

69. Home-based treatment of fever in children with ACTs by Community Health Workers has been introduced as planned in most districts. An evaluation of home-based treatment was conducted during the pilot phase in 2007 in six districts. This study found that over a six-month period in 2006, 83,203 children were treated by

⁹ A Round 4 indicator result in the in the PUDR of December 2009 reported 337 cases of MDR TB hospitalized against a target of 600. This translate to an achievement of 56% while the program was successful in achieving almost complete treatment coverage for MDR TB.

community health workers and only 32,423 in health facilities.¹⁰ Home-based treatment data are collected in dedicated registers by Community Health Coordinators based in Health Centres and at the District level. In one district visited by the OIG the number of home-based treatments dispensed varied between 2000 and 4000 per month. The treatment numbers did not follow the expected epidemiological profile of malaria (with peaks in June and December) suggesting that many of the fevers that were treated were not due to malaria. The introduction of rapid diagnostic tests into home-based treatment is planned and training has started.

Monitoring and Evaluation

70. The Malaria Unit of TRAC Plus has no dedicated data collection mechanism and relies entirely on malaria treatment data reported by the National Health Management Information System (HMIS). The exceptions are entomological data reported by the sentinel sites, and the information on home-based management that is still reported directly from the District Community Health Coordinators to the Malaria Unit. However a community HMIS system is also under development. The HMIS system in Rwanda is based on monthly paper-based reports prepared by the health centre data managers, submitted to the District HMIS Coordinator who checks the reports for errors, enters the data in an electronic data-base and forwards it to the national level. The system generates timely and reliable data.

71. Information on the distribution of bed-nets at the first ante-natal visit and at the time of measles immunisation is recorded in the monthly HMIS reports, but there is also a parallel system of reporting to the Malaria Unit. The audit mission did not review the system since all facilities visited stated that they had not had any bed-nets for pregnant women in stock for over a year and therefore had nothing to report. However the 2008 and 2009 on-site data verification reports and the 2008 Global Fund data quality audit report indicate that there are problems with the accuracy of these data.

72. The performance monitoring frameworks of the two malaria grants include many indicators that are simply counting inputs. Many performance scores are calculated using planning targets inappropriately as denominators. One of the results of this practice is that the resurgence of malaria incidence is creating very high performance scores for malaria treatment. The disruption of bed-net supply in 2009, however, which is a major issue impacting grant performance, was not picked up by any indicator in the performance framework.

Recommendation 9 (High)

The Malaria Unit of TRAC Plus should launch a thorough epidemiological investigation into the resurgence of malaria incidence in Rwanda in 2008/09 in order to take the necessary steps to avoid a future recurrence.

Recommendation 10 (High)

The Malaria Unit of TRAC Plus should establish a system and procedures to continuously monitor the insecticidal effectiveness of bed-nets available in the country using the entomological surveillance infrastructure of the sentinel sites for malaria.

¹⁰ Rwanda Integrated National Malaria Control Program; External evaluation of the pilot phase of the home-based management of malaria program in Rwanda; 2007

Recommendation 11 (Significant)

The Malaria Unit of TRAC Plus in collaboration with CAMERWA should review its projection of bed-net requirements and establish a timed procurement schedule that assures a continued supply of bed-nets for routine distribution in ante-natal and immunization clinics.

Recommendation 12 (Significant)

The Malaria Unit of TRAC Plus and the Community Health Desk of the Ministry of Health should proceed rapidly with the introduction of rapid diagnostic tests for malaria in home-based management of fever in children, and establish a strong supportive supervision system to ensure that these tests are used consistently and correctly.

Health Systems Strengthening

The most remarkable achievement of the Global Fund grants to Rwanda is the constructive way in which they have been applied to strengthen the national health and social systems. This applies not just to the Round 5 Health Systems Strengthening grant but to the entire grant portfolio.

Health Information Systems

73. Global Fund grants are used extensively for training and systems development for health information. Like all countries on the continent, Rwanda has parallel systems for general health information, for tuberculosis control, and for HIV program information. Health information on malaria is collected almost exclusively by the national health information system.

74. Information reported by the health management information system is generally reliable. The most likely place for error is at the data entry level in the health facility. The volume of data collected at the facility level is very high, and the data managers are sometimes overwhelmed. A large number of registers observed by the OIG are "home made" by dividing a standard copybook into rows and columns. In almost all facilities visited these registers were very well kept, clean and informative. At the time of the mission, pre-printed registers were being introduced for a variety of services. Those observed by the OIG mission were often very large, heavy, cumbersome and generally not as well kept and completed as the home-made version.

Health Care Infrastructure

75. The Round 7 HIV grant has a budget of USD 5.4 million for the rehabilitation of 90 maternity wards. In addition, the Round 5 HSS grant includes the procurement and installation of solar panels for health centres. During the field visits, the OIG team saw many completed and on-going infrastructure developments that clearly met important need for the institutions visited.

Human Resources for Health

76. Combined, the Global Fund grants to Rwanda have budgets for salaries and salary supplements ranging between USD 9 and 10 million per year. The annual budget range for training is between USD 3 and 5 million. Several disease-specific grants include support for positions in key generic areas such as financial control and monitoring and evaluation. For instance the district personnel of the

performance-based financing system is funded through the Round 7 HIV grant and a budget line of the Round 3 malaria grant is used to support the common basket of the Ministry of Health staff retention scheme. Many health professionals have returned to Rwanda in the last 15 years. The strategic use of Global Fund resources is without doubt helping to overcome the human resources constraints to health systems development.

Health Care Financing

77. Global Fund grants to Rwanda support two health care financing initiatives: The community-based health insurance fund is supported by the Round 5 Health Systems Strengthening grant, and the performance-based health financing system by the Round 7 HIV grant.

78. Performance-based financing “rewards” health facilities with central funds according to the level of activity and the quality of services. The quality of services is assessed quarterly through a peer review (at the district hospital) or by a committee of district personnel (at the health centre). The fact that quality of service delivery is linked to financial incentives is clearly making an impact. The level of activity is assessed by the monthly collection of quantitative indicators from the registers of the health facility. Most of these indicators are also collected by the health management information system or by the HIV data collection system. The comparison of the two data sets by the OIG in the facilities visited did not reveal any major variances. Yet, the maintenance of a separate data collection system and database for Performance-based financing is a significant cost and generates additional workload at the health facility level.

79. The expansion of the Community Based Health Insurance supported by the Round 5 HSS grant has clearly had a major impact by making health care accessible to the entire population. The Global Fund grant has significantly contributed to this. The initiative is a success in terms of social and health policy. The funds available to the health insurance scheme through contributions and grant support are, however, insufficient to close the financing gap for health care at the secondary and tertiary level. The system of allocating mutual fund resources to secondary and tertiary health care facilities is not yet functional and a number of possible schemes are under discussion.

80. The Round 5 HSS grant has almost come to its end. There are plans to continue the support of the community health insurance system through one of the national strategy grants. It would be useful to conduct a retrospective analysis on how informative the grant performance framework has been in guiding the financing decisions of the Global Fund. Only two of the four impact/outcome indicators included in the framework provide useful information about health systems performance although a large number of useful indicators and targets are available in the national health strategy and a national health sector plan. At the output level, there are a number of obvious choices for indicators to monitor a grant that is primarily strengthening the health insurance and the health information system. Surprisingly the proportion of mutual fund members among clinic attendees is not monitored. This information is available on a monthly basis from the health management information system. There are also a number of suitable output indicators with which the development of the health management information system could be monitored. Counting the number of people trained is not one of them.

Social Protection

81. The two main social protection initiatives supported with Global Fund grants are the subsidies for health insurance premiums for poor people and a system of subsidies for school fees for educationally marginalized needy students in their 10th to 12th school year. This program is delivered by the Ministry of Gender and Family Promotion (MIGEPROF). It also includes assistance to the families of these students in the form of agriculture-based income generating projects. This portion is delivered by sub-contracted NGOs. The educational support program is potentially the beginning of a national child welfare system. There is, however, little evidence that MIGEPROF is engaged in long-term planning to create an institutional basis for this project

Recommendation 13 (Requires attention)

The Ministry of Health should proceed carefully with the process of integrating HIV and tuberculosis information in the national health management information system. While there will be a need to maintain parallel information systems for these programs for some time, reliable key health management data on HIV and TB should be available through the HMIS. This could initially be achieved by assuring that there are functioning protocols for information exchange between the different electronic data management systems.

Recommendation 14 (Requires attention)

The Ministry of Health should proceed with caution when introducing pre-formatted registers in health facilities. The expected gain in data quality should be weighed against the considerable cost of a system of registers. In some cases the publication of standardized guidelines on how to set up the rows and columns in a generic exercise book may be more cost effective.

Recommendation 15 (Significant)

The MOH should ensure that the Performance-Based Financing Task Force reviews its methods of collecting quantitative data on Health Centre activities. It should adjust its indicators to be fully in line with information reported to the Health Management Information System, and it should use this system to generate its own activity reports. Indicators that are not collected by HMIS should not be used by the PBF system. The District PBF Coordinators would thereby acquire an additional role of assuring the quality of HMIS data without any increase in their work load.

Recommendation 16 (Requires attention)

Global Fund support for the subsidization of insurance premiums based on poverty criteria is good public health policy with a noticeable impact on the response and control of the three Global Fund priority diseases. The MOH and the CCM are encouraged to ensure that it continues under the national strategy grants when the HSS grant ends.

Recommendation 17 (Requires attention)

If Global Fund support for the subsidization of health insurance premiums is continued after 2010 in the National HIV Strategy grant, the main performance indicators to be followed should be the health facility attendance rate and the rate of insurance coverage among those attending health facilities. Data for both indicators are available from the national health management information system.

Recommendation 18 (Requires attention)

While the system of partially financing health care at the primary care level through the mutual health insurance funds is well developed, the system does not have a sufficient financial basis to fund secondary and tertiary care, and the procedures for channeling mutual fund payments to institutions at the secondary and tertiary level are not yet finalized and functioning. The Ministry of Health should further explore options such as the introduction of variable premiums while assuring the system's continued viability and equity.

Recommendation 19 (Requires attention)

The MOH and MIGEPROF should start a process of medium and long-term planning to establish a solid institutional foundation for the program of educational support for needy children after grade nine.

Procurement and Supply Chain Management

Rwanda has developed a strong legal environment for public procurement. The Rwanda Public Procurement Authority (RPPA) has established a series of thresholds and audits for procurement entities that point to zero tolerance for corruption.

Procurement

82. Since the beginning of Global Fund support to Rwanda, about 42 percent of the combined budgets have been allocated to the Central Medical Store (CAMERWA). The OIG audit focused primarily on the procurement and supply chain management (PSM) systems, processes and procedures of CAMERWA. The audit was participative and constructive. The OIG team discussed possible solutions to identified issues with CAMERWA and the MOH's Program Management Unit.

Procurement by CAMERWA

83. CAMERWA benefits from a special provision under the national procurement law that applies to the procurement of pharmaceutical products. It has established a sound procurement department led by an experienced pharmacist. The department receives technical assistance from the Supply Chain Management System (SCMS), a US-based contractor financed through PEPFAR.

84. CAMERWA's tender committee is composed of seven members from CAMERWA as per the national procurement law. CAMERWA is thus entirely responsible for the pre-selection of manufacturers, wholesalers and products. CAMERWA routinely invites external experts for the technical evaluation of tenders, but the regulatory authority that is responsible for pharmaceuticals entering the country, the Pharmacy Task Force of the Ministry of Health, is not a formal member of the tender committee.

85. Imports of pharmaceuticals arriving in the country are only admitted if they arrive with at least 85 percent of their shelf life. Pre-shipment inspection and control is not carried out in countries from where the pharmaceutical are shipped.

86. The OIG found it difficult to track the flow of grant-financed drugs and health products that was received by CAMERWA. The reason is that there is no system to record and match the flow of medicines and health products with corresponding tenders, purchase orders and supplier contracts and delivery receipts. The weakest point of the procurement system of CAMERWA is the receiving area. There is no pharmacist in place to verify that the drugs received meet the expected specifications and quality standards.

87. Further, the OIG noted the following weaknesses in tender and procurement documentation which do not facilitate review, verification and tracking of tenders issued and procurements carried out.

- a. Tender documents do not clearly refer to grant numbers;
- b. Supplier contracts do not refer to purchase order numbers;
- c. Delivery notes to final recipients are not pre-printed to enhance internal control and facilitate verification of deliveries; and
- d. Originals of the final delivery notes are not filed with the tender documents to facilitate verification.

88. The documentation for procurements carried out by the PMU has similar issues as noted for CAMERWA above.

Recommendation 20 (Significant)

The MOH should ensure that the composition of the internal tender committee of CAMERWA is modified to include two pharmacists of the MOH Pharmacy Task Force on a permanent basis.

Recommendation 21 (Significant)

The MOH should ensure that CAMERWA develops and adopts policy and procedures manuals covering the areas of (i) administration and finance, (ii) procurement (iii) warehousing, (iv) distribution and (v) pharmacy, including quality control.

Recommendation 22 (Significant)

The MOH should ensure that CAMERWA develops a data-base of health products with information on line of supply and suppliers. The data-base should include information on weight, volume and cost of products as well as the performance history of suppliers. The data-base could be used to inform pre-qualification decisions.

Recommendation 23 (Significant)

The MOH should ensure that CAMERWA recruits a qualified pharmacist for receiving health products. The terms of reference for this position should include the physical verification of quantity and quality of products received, the implementation of the quality control policy at central level, and the maintenance of the data-base recommended under Recommendation 28.

Recommendation 24 (Significant)

CAMERWA should consider making the following improvements in its procurement documentation and filing system to enhance tracking of procurements.

- (a) Tender documents should clearly refer to the grants, as appropriate;*
- (b) Supplier contracts should refer to purchase order numbers, as appropriate;*
- (c) Delivery notes to final recipients should be pre-printed using the dispatch table in bidding documents in order to avoid manual or unreadable entries of final recipients on the delivery notes; and*
- (d) Originals of the delivery notes should be filed together with the tender documents.*

Other Issues of Global Fund Procurement by CAMERWA

89. All health products procured by CAMERWA with Global Fund financing are pre-qualified by WHO, and in the case of anti-retroviral drugs by WHO and/or the US Food and Drug Authority. For the procurement of HIV commodities CAMERWA advertises tenders after receiving orders from the CPDS quantification committee. The CPDS implementation committee reviews the decisions of the tender committee and authorizes the contract awards. There is no tender process for tuberculosis drugs because of existing contracts for procurement through the Global Drug Facility (GDF) and the WHO Green Light Committee. Also, the anti-malaria medicines, Artemether-Lumefantrine are procured by WHO following an order from CAMERWA.

90. The procurement department of CAMERWA is not aware of the Procurement and Supply Management Plans for Global Fund grants. The department procures

according to orders received and is unable to establish an annual procurement schedule.

Recommendation 25 (Significant)

On the basis of the PSM plans for Global Fund grants, CAMERWA should establish a detailed procurement schedule detailing in chronological sequence each step in the procurement cycle, including the actors involved and the actions to be taken.

The Common Procurement and Distribution System (CPDS)

91. The Common Procurement and Distribution System (CPDS) is a highly successful common basket for the procurement of HIV commodities funded by different international partners. The system promotes proactive quantification of national requirements for anti-retroviral drugs, laboratory reagents, and drugs for the treatment of opportunistic infections.

92. The collaboration between different committees of the CPDS, the HIV Unit of TRAC Plus and CAMERWA can be credited with a functional supply system that has so far avoided major disruptions of drug supplies and major problems of drug expiry. The total value of expired drugs for the period 2008/2009 was about three percent of the total amount procured. CPDS is supported by a specific information system on HIV commodities and by a verification team based at CAMERWA that validates orders from health facilities.

Non-pharmaceutical Procurement by the Program Management Unit of the MOH

93. Rwanda has developed a strong legal environment for public procurement. The Rwanda Public Procurement Authority (RPPA) has established a series of thresholds and audits for procurement entities that point to zero tolerance for corruption. Standard bidding documents developed by the RPPA are inspired by World Bank bidding documents and are in use by the PMU for the procurement of non-health products.

94. The procurement department manages tenders for civil works, namely, rehabilitation of laboratories, construction of maternity clinics/wards and VCT centres and other health facilities. The procurement department of the PMU is staffed with procurement specialists and architects.

95. The PMU managed the procurement of LLINs until 2009. In 2009, Rwanda experienced a prolonged shortage of bed-nets because of procurement delays. The main reason was the cancellation and the re-advertising of a major tender because the technical specifications were incorrect.

96. The OIG reviewed a sample of procurement undertaken by the PMU and noted the following weaknesses.

- a. A contract for purchase and installation of solar panels at 15 health centres in 2007 was inadequately managed and supervised by the procurement department of the PMU. The OIG noted that the PMU did not terminate the initial contract for non-performance by the contractor on a timely basis. Subsequently, the cost of the civil works increased by FRW 35.5 million approximately USD 61,000 after it was retendered.

- b. Lack of certificates of completion in the files for construction projects to provide assurance that such civil works have been completed according to approved technical and quality standards;
- c. Incorrect information on the scheduled date for opening of tenders and inaccurate information on the source of financing for the procurements in the tender/bidding documents due to typing errors;

97. The OIG reviewed three procurement contracts (094/Coord/2006, 095Coord/2006 and 118/Coord/2006) for construction of health centres that had been part of a conflict of interest investigation by the PMU. The district hospitals had been responsible for advertising and evaluating the tenders under the supervision of the PMU. The OIG noted the following weaknesses which indicate a need for a closer monitoring and oversight by the PMU of the procurement actions carried out at the district level.

- a. The supplier awarded the contract submitted its bid on 10 February 2006, that is after the closing date for submission of bids. Opening of bids occurred on 8 February 2006;
- b. Only two and half percent of the contract amount was retained for a period of six months, as guarantee for good performance, while the procurement regulations require five to ten percent retention over twelve months;
- c. The tenders specified contract periods of three months while the contracts awarded stated four months as deadline for completion of civil works.

Recommendation 26 (Significant)

To avoid future procurement delays for critical items such as bed-nets, the MOH should ensure that technical specifications are defined at the start of the program and annexed to the PSM plan.

Recommendation 27 (Significant)

The PMU should strengthen its oversight of procurement for civil works to ensure that procurement regulations/guidelines (for retention fees, deadlines for bid submission and contract periods) are complied with by SRs. Further, the PMU should strengthen its technical supervision of all civil works.

Recommendation 28 (Significant)

The PMU should ensure that tenders advertised by sub-recipients are of high standard by providing standard templates and training.

Quality Assurance

98. CAMERWA has no quality assurance policy. During the period under review only eight drugs procured with Global Fund support were subjected to quality control. Although all results confirmed the good quality of analysed products, the number of samples was insufficient. Recommendations made earlier in this report on strengthening the tender committee, placing a pharmacist at the receiving point, and establishing a data-base for drug flows and supplier performance are all steps to improve quality assurance.

99. The Malaria Unit of TRAC Plus is currently implementing a quality assurance program for anti-malarial drugs as part of an international study conducted by the London School of Hygiene and Tropical Medicine and funded by the Gates

Foundation over a five year period from 2008 to 2013. The following results were recorded for the assessment of active ingredients in drugs tested in 2008:

- a. 100 percent of Artemether-Lumefantrine tablets passed testing (4 samples purchased through GF program);
- b. 77 percent of Sulfadoxin-Pyrimethamine tablets passed testing (9 samples purchased through CAMERWA);
- c. 50 percent of quinine tablets passed testing (2 samples purchased through CAMERWA); and
- d. 62 percent of quinine syrup passed testing (8 samples purchased through CAMERA).

100. Although the number of samples was very low, the test results clearly show that CAMERWA urgently needs to strengthen quality control procedures.

Recommendation 29 (Significant)

The MOH should ensure that CAMERWA, as soon as possible, develop and adopt a quality assurance policy for all types of health products. The purpose of the policy is to assure the quality of health products procured at the point of dispensing medicines. Also the following points are important to note.

- a. *The development of the policy requires a consensus and the participation of all stakeholders;*
- b. *After adopting a quality assurance policy, CAMERWA should launch a tender to procure the services of one or more laboratories to implement the quality control segment of the policy;*
- c. *The MOH should ensure that CAMERWA seeks technical assistance for the development and costing of the quality assurance policy. A review of the pre-qualification procedures for products, manufacturers and suppliers, and of the rating system for pre-qualification should be included in the terms of reference of this assistance.*

Information Systems

101. From 1998 until April 2009 CAMERWA worked with the enterprise resource planning software Exact Globe for Windows. In May 2009 CAMERWA changed to MACS (Warehouse Management Control System) and SAGE 500 (accounting and financial module), two software programs introduced by Supply Chain Management System (SCMS).

102. MACS is a warehouse management system that is not able to comprehensively manage financial and stock flows. Since its introduction, CAMERWA has experienced serious problems in working with MACS. CAMERWA employees spend most of their time checking physical stocks and updating the software. Financial analysis of stock operations and movements is not possible. A decision to abandon MACS and change to a new enterprise resource planning software with assistance from SCMS has now been taken.

103. The product codification system currently used by CAMERWA is obsolete. There is no procedure to construct the codes, and growing activity levels resulted in increasing numbers of codes developed without any framework. The shift from one information system to another is an opportunity to adopt a new efficient product codification system along with its maintenance procedure.

Recommendation 30 (High)

The MOH should ensure that CAMERWA issues an international tender for an enterprise resource planning software meeting its established technical specifications before any further attempt is made to change the software platform. An alternative would be to return to the previously used Exact Globe software in its newest version.

Recommendation 31 (High)

The MOH should request CAMERWA to consider adopting the Médecin Sans Frontières (MSF) international drug coding system. This drug coding system is widely used throughout Central Medical Stores in Africa.

Supply Chain Management

The District Pharmacies are the weak link in the distribution chain. Many are managed by nurses while pharmacists are being recruited. The three facilities visited by the OIG team were not adequately equipped in terms of storage equipment, volume of storage and management tools (no information system). There is a high risk that the currently functioning drug tracking system from CAMERWA to dispensing points could fail if District Pharmacies take on the role of active distribution points in their current state of development.

104. As of March 2010, CAMERWA was using 9 warehouses in different locations in Kigali. Two warehouses (Number 8 and 9) were rented in March 2010 for the storage of bed-nets. Warehouse Number 7 is used for the storage of expired drugs only. There are therefore 6 warehouses available for regular activities. Five of them are rented. The warehouses are insured, but the insurance contract does not cover flood damages.

105. Because of the failure of the currently used electronic warehouse management system, stock management in so many different warehouses is very difficult. CAMERWA undertakes quarterly physical stocktaking in all warehouses. Stock management is based on a bin location system which makes stock management even more complicated.

106. The regular distribution system for essential drugs, tuberculosis drugs, malaria drugs, family planning and community health drugs and commodities is that Health Centres and District Hospital Pharmacies are supplied by the District Pharmacy which in turn is supplied by CAMERWA. For HIV drugs and reagents the Health Centres and District Hospital Pharmacies are directly supplied by CAMERWA, bypassing the District Pharmacy.

107. The District Pharmacies are the weak link in the distribution chain. Many are managed by nurses while pharmacists are being recruited. The three facilities visited by the OIG team were not adequately equipped in terms of storage equipment, volume of storage and management tools (no information system). There is a high risk that the currently functioning drug distribution and tracking system from CAMERWA to dispensing health facilities could fail if District Pharmacies take on the role of active distribution points in their current state of development. At present, their capacity is limited to functioning as relay points for CAMERWA and maintaining a small depot of security stocks that have already been pre-packed by CAMERWA for health facilities.

108. The visit to health facilities by the OIG team (3 health centres, 3 district hospital pharmacies and 3 district pharmacies) showed that a tremendous effort is made at all levels to maintain good drug management practices. Pharmacy maintenance was good at all levels, cleanliness and filing were well done, and the staff was highly committed to its tasks. All facilities visited had adequate stock levels and adequate stock control procedures. Stock cards were well maintained and the re-supply systems were well known by the nurses in charge.

109. Financial management practices of health centre and district hospital pharmacies could be improved. Health facilities are usually owed a considerable sum of money by the community-based health insurance funds. On interviewing the accountants of the health facilities visited, the OIG team was not able to receive information on working capital, outstanding debts or turnover of the pharmacy operation. No annual financial reports were available to assess the financial strength of the health facility.

110. Expired drugs are stored by CAMERWA in Warehouse Number 7 in Kigali. The store has been used since 2008 and contains about 300 cubic meters of expired drugs accumulated over more than 5 years. CAMERWA only monitors the value of expired drugs that were purchased with its own resources for its annual accounts. The value of expired drugs procured under donor programs is not monitored. During the audit, CAMERWA staff took more than one week to estimate the value of expired drugs procured with program resources. The result is presented in the following table. The amounts include expired drugs procured with support from all sources, including Global Fund, PEPFAR and Belgian Technical Cooperation.

Drug group	2008 USD	2009 USD
Anti-retroviral drugs	67,928	68,996
Laboratory tests, reagents and consumables	42,158	170,470
Drugs for opportunistic infections	4, 671	17,129
Malaria drugs	59,226	61,029
Tuberculosis drugs	5,183	4,778
Total	379,166	322,402

Table 2: Value of Expired drugs at CAMERWA warehouse (Source: CAMERWA records)

111. The management and disposal of expired drugs at all levels (peripheral, district, central) is an issue that has not yet been adequately addressed. There is a considerable risk of expired drugs being rerouted into parallel markets.

Recommendation 32 (Significant)

The MOH should ask CAMERWA to consider insuring the stock of health products in its warehouses in Kigali against flood damages.

Recommendation 33 (Significant)

The MOH should consider strengthening the district pharmacies before integrating the supply of ARVs into the district pharmacy system. The strengthening program should at least be composed of:

- a. *Evaluating the quarterly volumes of drugs needed for districts and implementing the changes at district pharmacies to accommodate these needs;*
- b. *Recruiting a pharmacist (ideal minimum staff should be a pharmacist, a nurse and an accountant); and*
- c. *Installing electronic software for pharmaceutical business management and training the district pharmacy staff in its use.*

Recommendation 34 (Significant)

The MOH should ensure that health centres and district hospital pharmacies adopt a monthly financial reporting system that provides information on pharmacy turnover, debt owed by the Community Health Insurance Scheme to the pharmacy, working capital, and cost of goods sold.

Recommendation 35 (Significant)

The MOH should ensure that CAMERWA establishes and maintains a monthly record of expired drugs and commodities for the malaria, tuberculosis and HIV programs valued at cost price.

Recommendation 36 (Significant)

The MOH should develop and implement a program for the management and safe disposal of expired drugs.

Financial Management and Control

The OIG noted a number of financial management weaknesses at SRs audited, which can be attributed to inadequate professional skills and experience of program accountants and inadequate capacity of the PMU to provide sufficient oversight and supportive supervision.

112. The OIG audited grant receipts, expenditures and financial reporting of the PR, the MOH and its PMU, which are jointly responsible for financial management and control of grant funds. In addition, the OIG team audited grant expenditures and receipts of selected SRs and implementing partners of the MOH, namely, CAMERWA, CNLS, CTAMS, CCM, UPDC, PNLIP, TRAC, and selected District Hospitals and Health Centres.

113. The OIG noted a number of financial management weaknesses, particularly at SRs audited, which can be attributed to the following challenges:

- a. Inadequate professional skills of program accountants due to the limited pool of professional accountants in the country. The accounting profession is young and efforts are being made to develop it;
- b. Increased number of GF grants with their budgets and bank accounts to be managed, as well as financial reports to be produced;
- c. Lack of harmonization of the Tompro accounting software, which is used for Global Fund grant transactions, with the GOR's accounting software package;
- d. Inadequate mastery of the Tompro accounting software package by program accountants;
- e. Turnover of accounting staff which means that new staff have to be trained to use the accounting software; and
- f. Inadequate capacity of the PMU to provide sufficient oversight and supportive supervision of sub-recipients.

114. The OIG noted that steps are being taken by both PR and the GF Country Programs Cluster to address some of the above-mentioned challenges. For example, the GF grants in Rwanda are being consolidated, which would likely reduce the number of grant budgets and bank accounts to be monitored and managed. Further, grant consolidation will reduce the number of grant financial reports to be produced by program accountants and program managers.

115. In addition, program managers informed the OIG that plans have been made to augment the PMU's capacity to provide adequate support and supervision of sub-recipients.

Weaknesses in financial management and control

116. The OIG noted the following common financial management and control weaknesses at all grant implementing organizations audited. These audit findings have also been confirmed in annual audit reports of implementing organizations.

- a. Year-end financial closing procedures were not done in the Tompro software to close the accounts, with the risk that general ledger accounts could easily be changed and therefore may not be reliable;

- b. Accounting staff manually produce and record opening account balances, at the start of a grant financial year, instead of these balances being generated by the accounting software;
- c. SR account balances, in their accounting software, differed from those in the PMU's accounting software because SRs did not routinely correct errors noted by the PMU during reviews of SR quarterly financial reports;
- d. Funds were transferred between grants, when there were delays in receiving grant funds from the PR;
- e. Program expenditures not charged to the correct grant budgets;
- f. The budget module in the accounting software is not used to facilitate budgetary control. Consequently accounting staff use spreadsheets (Microsoft Excel) to prepare budget execution reports to the PR;
- g. Bank reconciliations were prepared quarterly instead of monthly at implementing organizations audited; the risk is that irregularities would not be detected on a timely basis;
- h. Errors were found in some bank reconciliations that had been approved by management of the implementing entities;
- i. Lack of evidence of competitive bidding or price comparisons to obtain value for money for purchases of services, particularly for training;
- j. Errors in the calculation of the payroll;
- k. Some supporting documentation could not be found for grant expenditures; and
- l. Filing and storage of payment vouchers and supporting documentation, such as tenders/bids and contracts was inadequate, particularly at sub-recipients audited.

Recommendation 37 (Significant)

To improve the professional skills of its program accountants, the PMU should consider establishing a continuing professional education program for PR and SR accountants as well as refresher training in the use of the accounting software.

Recommendation 38 (Significant)

To improve the system of budgetary control, the PMU should train program accountants to use the accounting software to monitor grant expenditures against approved budgets.

Recommendation 39 (Significant)

The PMU should strengthen its supportive supervision and control of sub-recipients' accounting functions in order to remedy the financial management deficiencies noted above.

Recommendation 40 (Significant)

The PMU should put in place a tool to ensure that SRs routinely correct errors noted by the PMU after reviews of SR quarterly financial reports.

Lack of timely recovery of taxes paid with grant funds

117. The grant agreements provide for tax-exemption on goods and services paid for with grant funds. The OIG noted that significant amounts of grant funds have been tied up to pay VAT. This is the case at the PMU and at all SRs audited by the OIG. Grant funds that have been tied up in payment of VAT affect the cash flow of

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the programs and impact negatively on the timeliness of implementation of grant program activities.

118. Besides, the general ledger control account for VAT was not utilized to facilitate tracking of outstanding VAT due from the RRA.

119. The table below shows that on 31 December 2009 FRW 499,407,581 (approximately USD 870,000) of grant funds utilized by the PMU to pay VAT had not been recovered from the RRA. The above-mentioned figure does not include VAT paid by sub-recipients.

Financial year	VAT to be recovered	VAT recovered		Difference	
		Amount FRW	%	Amount FRW	%
2003	1,082,770	1,039,995	96.0	42,775	4.0
2004	4,462,241	4,323,644	96.9	138,597	3.1
2005	193,702,014	134,836,231	69.6	58,865,783	30.4
2006	145,288,651	130,858,733	90.1	14,429,918	9.9
2007	191,023,095	118,044,483	61.8	72,978,612	38.2
2008	77,399,879	53,445,235	69.1	23,954,644	30.9
Sub total	612,958,650	442,548,321	72.2	170,410,329	27.8
2009	693,981,007	364,983,755	52.6	328,997,252	47.4
Total	1,306,939,657	807,532,076	61.8	499,407,581	38.2

Table 3: VAT paid by the PMU (Source: PMU records)

120. The OIG noted that the non-recovery of VAT taxes can be attributed to rejection of claims filed as non-compliant by the RRA for the following reasons.

- a. Invoices did not have suppliers' VAT numbers;
- b. Invoices did not have names and addresses of suppliers;
- c. Invoices were not included in the claim sent to the RRA;
- d. Invoices were addressed to another unit of the MOH instead of the entity which filed the VAT claim;
- e. Incorrect VAT amounts on invoices; and
- f. Proforma invoices were submitted to the RRA instead of paid invoices.

Recommendation 41 (Significant)

The MOH should ensure that the PMU and all SRs file VAT claims timely, at least on a quarterly basis. Further, it is important that the PMU train program managers and accountants to screen invoices received from suppliers to ensure that they conform to RRA requirements.

Recommendation 42 (Significant)

To ensure accuracy of VAT that has been paid and not yet recovered, the MOH's PMU should train program accountants to use the VAT control account in the accounting software to facilitate tracking/monitoring of VAT to be recovered.

Financial Management: Program Management Unit (PMU) of the MOH

121. Whilst the OIG found that, in general, financial management and internal control at the MOH's PMU is satisfactory, the OIG noted some weaknesses which are detailed below.

- a. Program expenditures not charged to the correct budget categories; and
- b. The PMU did not routinely provide to sub-recipients records/documents concerning payments or purchases made by the PMU on behalf of SRs to enable implementing organizations update their records and include such financial transactions in their budgetary control.

Recommendation 43 (Requires attention)

The MOH's PMU should ensure that appropriate supervisory controls are put in place at the PMU and all sub-recipients to improve coding of financial transactions.

Recommendation 44 (Requires attention)

The MOH's PMU should ensure that it provides relevant information to sub-recipients on payments it makes on their behalf to enable SRs to update their records and budgetary control.

Financial Management: CAMERWA

122. CAMERWA has a simple cash basis accounting system that does not meet the financial management needs of its business of importing drugs and health supplies from international suppliers, selling/distributing them to its many customers and keeping track of financial obligations to/from its many suppliers. Further, CAMERWA does not have a comprehensive accounting and administrative manual that provides guidelines on all aspects of its business operations, including an appropriate chart of accounts, policies for treatment of exchange rates differences and maintenance of accounting records.

123. Some of CAMERWA's international suppliers, particularly those with limited source pharmaceutical products, require 100 percent advance payment before medicines and health supplies ordered are shipped. CAMERWA makes these advance payments without bank guarantees from suppliers. For example, on 17 August 2009 USD 266,640 (FRW 152.3 million) was advanced to an international supplier without a bank guarantee. There is therefore a potential risk of loss of grant funds if suppliers become bankrupt before goods ordered are received. An option is for CAMERWA to use letters of credit but program officials explained that due to the exorbitant fees associated with these financial instruments, the GOR does not allow government entities to use these them.

124. Furthermore, as CAMERWA makes these purchase advances on estimated costs of goods and freight and forwarding charges, it is important that it regularly reconciles these advances against medicines and health supplies received from the suppliers. The OIG also noted that between 2005 and 2009 CAMERWA paid USD 6.6 million to WHO as purchase advances for anti-malaria medicines, but corresponding invoices that have been received amounted to USD 5.4 million, leaving USD 1.2 million unaccounted for. The OIG informed management of the discrepancy. CAMERWA should obtain from WHO requisite invoices to enable it to reconcile the advances. Further, CAMERWA should seek recovery of unused funds from WHO.

125. The OIG also noted that sometimes CAMERWA pre-finances grant medicines and health supplies. Subsequently, these transactions are regularized with funds drawn from grant bank accounts to repay CAMERWA. However, the OIG found the audit trail difficult to establish in matching the refunds from grant bank accounts

with CAMERWA's initial payments of supplier invoices. There is therefore the risk of the grants over paying CAMERWA.

126. CAMERWA provides some medicines such as quinine, budgeted under the malaria grant, to health facilities from existing stock purchased with its own financial resources. However, the OIG noted that CAMERWA invoices/bills the grant programs before these medicines and supplies are collected by the health facilities. There is therefore the risk that medicines and health supplies not collected or orders cancelled by beneficiaries would still be billed to the grants.

127. The September 2006 sub-agreement between the MOH and CAMERWA stipulated an overhead rate of between five and nine percent. Prior to the sub-agreement, CAMERWA had charged the grants overhead rates of between 18 and 20 percent of the total cost of medicines for treatment of opportunistic infections and malaria. Besides, the overhead rates charged to the grants had been calculated on estimated costs of medicines and health supplies on proforma invoices. However, the OIG noted that on receipt of final invoices, the initial charges were not reviewed to ensure that correct amounts had been charged to the grant. The OIG verified overhead charged to the grants between 2005 and 2009 and found that approximately USD 162,000 had been over-billed to the grants.

Recommendation 45 (Significant)

The management of CAMERWA should consider adopting an accrual-based accounting system to meet the complex needs of its business. In addition, it needs a comprehensive accounting and administrative manual that provides guidelines on all aspects of its business operations, including an appropriate chart of accounts, policies for treatment of exchange rate differences and maintenance of accounting records.

Recommendation 46 (High)

CAMERWA should regularly reconcile advances to its suppliers with goods received and invoiced. In addition, CAMERWA should obtain from its suppliers all additional supporting documentation, such as freight and forwarding charges.

Recommendation 47 (High)

To facilitate financial control of grant expenditures, CAMERWA should, as far as possible, pay for grant-financed goods and services from grant bank accounts.

Recommendation 48 (Significant)

To establish a clear audit trail, CAMERWA should bill the grants for medicines and health supplies after beneficiaries collect the health products.

Recommendation 49 (Significant)

The MOH should ensure that CAMERWA reimburses the grants for overhead it over-billed. Further, the MOH should ensure that CAMERWA seeks recovery of unutilised funds from WHO.

Financial Management: CNLS

128. The Office of the Auditor General (OAG) audited the CNLS in 2008 and qualified its accounts due to serious lapses in book-keeping and financial management. Similarly, the OIG noted deficiencies in the accounting of grant funds

managed by the CNLS from 2003 through 2008. To improve financial management, the CNLS replaced its accountant in 2009.

129. The OIG found the following financial management weaknesses in the audit of the CNLS.

- a. Financial transactions charged to wrong expenditure/budget categories, making budgetary control unreliable;
- b. Some expenditures were charged to the grant programs that were not provided for in the approved budgets. For example, painting of the office, rehabilitation of the vehicle parking lot, and laptops purchased in 2006. These expenditures were charged to the Round 3 HIV/AIDS grant;
- c. Some purchase advances were made to suppliers without bank guarantees, putting grant funds at risk in the event of a default or bankruptcy of the supplier;
- d. Some contracts were awarded to suppliers without evidence of competitive bidding; and
- e. Errors in the calculation of the payroll.

130. In addition, the OIG noted several cases of missing or inadequate supporting documentation for some grant expenditures as documented in Annex 1 of this report.

131. The OIG also found some journal/correcting entries that did not have adequate supporting documentation to explain the purpose of the transactions. Further, in some cases the original transactions could not be found. Examples are detailed in Annex 2 of this report.

132. Similarly, as stated in paragraph 117 above, the CNLS sought to recover VAT it paid from 2005 through 2007 only in March 2010. Further, a claim for reimbursement of VAT it paid from 2008 through 2009 was filed at the end of April 2010.

Same recommendations as given in recommendations 37 to 42 above.

Recommendation 50 (Significant)

The MOH should ensure that the CNLS traces missing supporting documentation for grant expenditures as noted above within three months of receipt of the final report. Failing that, CNLS should reimburse the grants for these expenditures.

Recommendation 51 (High)

The MOH's PMU should strengthen its capacity to perform regular financial reviews of all its sub-recipients including the CNLS.

Financial Management: CCM Secretariat

133. The CCM received funding from the GF from August 2004 through March 2008. Total funding received by the CCM from GF amounted to USD 453,000. The CCM funding was included in the budgets of the various grant programs.

134. Similarly, the OIG noted the following financial management and internal control weaknesses in its review of grant expenditures. The weaknesses noted

below can be attributed to inadequately trained accounting staff and inadequate supervision and oversight by the PMU.

- a. Invoices that have been paid by the CCM secretariat, but which were addressed to other units of the MOH;
- b. Inadequate supporting documentation for payment vouchers e.g. missing invoices or payments made using photocopies of invoices. Refer to Annex 3 of this report which details some examples;
- c. Program expenditures charged to wrong budget lines;
- d. Wrong calculations of employee and employer contributions to social security and health insurance schemes; and
- e. Missing bank statements for October through December 2004.

135. Like all other SRs, the CCM secretariat has outstanding VAT taxes to be recovered from the RRA. For fiscal years 2004 and 2005 only FRW 6.3 million (approximately USD 10,900) has been recovered out of FRW 13.2 million (approximately USD 22,800) million VAT taxes paid. The OIG noted that approximately 50 percent of the invoices submitted to the RRA were rejected as being non-compliant for the same reasons stated in paragraph 114. Besides, at the end April 2010 when the OIG completed its field work in Rwanda, the CCM secretariat had been unable to provide the OIG information on VAT, paid but not yet recovered, from 2006 through March 2008.

Recommendation 52 (Significant)

The MOH should ensure that the CCM Secretariat traces missing supporting documentation for grant expenditures, as shown above, within three months of receipt of the final report. Failing that, the CCM Secretariat should reimburse the grants for these expenditures.

Recommendation 53 (High)

Although the CCM Secretariat no longer receives funding from the Global Fund, the MOH's PMU should ensure that it follows up on the above findings, particularly the need for recovery of VAT taxes and missing supporting documentation.

Financial Management: UPDC

136. Like other SRs, the OIG noted the following weaknesses in its financial review of UPDC.

- a. Errors in the preparation of the payroll; for example, employer contributions to health insurance were wrongly deducted from employee salaries;
- b. Staff payroll deductions for health insurance and social security were not posted to their respective accounts in the general ledger;
- c. Budget overruns without approval for salary budget category;
- d. Errors in bank reconciliations that had been approved by management for fiscal years 2006 and 2007.
- e. VAT paid during fiscal years 2006 and 2007 has not been recovered for some grants;
- f. VAT refund claim filed in 2009 did not include FRWs 30.8 million (approximately USD 53,000) VAT paid on a purchase charged to the grant;

- g. Inter-grant transfers of funds: For example, FRW 247.8 million (approximately USD 427,000) was transferred from the malaria program bank account to the Round 7 HIV/AIDS program account.

137. The OIG also noted that some program goods and services were purchased without documented evidence that value for money had been obtained through open and competitive solicitation of suppliers. Some key examples are cited below.

- a. FRW 10.6 million (approximately USD 18,300) in additional costs were incurred by the UPDC for procurement of fifty thousand caps because of the decision to split the purchase among four suppliers, at an average price of the four bids, instead of awarding the contract to the lowest bidder;

138. Advance of grant funds to organizations for program implementation activities and travel advances to staff were treated as expenditures and therefore posted to expenditure accounts in the general ledger. This practice does not provide accurate financial information to program managers regarding absorption of grant funds by implementing organizations. In addition, this practice does not facilitate the tracking of outstanding advances by financial managers. Some examples are cited below.

- a. An advance of FRW 581.1 million (approximately USD 1.0 million) was transferred to health centres for disbursement to cooperatives established for PLWHA (HIV/AIDS Round 7 program) was treated as expenditure although the OIG found during field visits that these funds had not been disbursed to the cooperatives by the health centres; and
- b. An advance of FRW 48 million (approximately USD 82,000) transferred to the districts for supervision and communication costs (HIV/AIDS Round 7 program).

Recommendation 54 (Significant)

The MOH's PMU should ensure that advances made to implementing organizations are not treated as expenditures until the program activities are implemented. Further, these advances should be monitored in a control account until a full accounting is provided by the recipient of funds.

Recommendation 55 (Significant)

To ensure that there are no cost overruns, the MOH's PMU should ensure that sub-recipients use the budgetary control module of the accounting software. Further SR program and finance officials should analyse and explain variances every quarter and bring significant issues to the attention of senior management.

Financial Management: District Hospitals and Health Centres

139. The OIG selected a sample of hospitals and health centres in four districts (Musanze, Rwamagana, Bugesera and Gakenke) for audit. In addition, the OIG audited three community health insurance programs in the first three districts mentioned above.

140. In all the district hospitals visited by the OIG team accounting staff concurrently used manual cash books and the Tompro accounting software, for grant financial management. The OIG also noted that the accounting software is not fully utilized because of inadequate expertise of staff. And

quarterly financial reports to the PMU are prepared using financial information obtained from the manual cash books instead of the accounting software. Hence, the OIG noted discrepancies between financial information in Tompro and the quarterly financial reports produced by the district hospitals. There is therefore the risk that financial reports to the PMU are incorrect.

141. Contrary to good practice, bank reconciliations were prepared quarterly instead of monthly in all district hospitals and health centres audited by the OIG. The reason is that accounting staff prepare bank reconciliations only when quarterly financial reports are due. There is therefore the risk that errors and irregularities on grant bank accounts would not be found and corrected on a timely basis.

142. Similarly, as stated in paragraph 117 above, the district hospitals and health centres have not sought to recover VAT paid for program goods and services.

143. Further, the OIG noted discrepancies in total salaries reported by some district hospitals in quarterly financial reports when compared with payroll salaries for the same three-month period. Two examples are cited below:

- a. At Ruhengeri district hospital whilst the total payroll for the period October to December 2009 was FRW 5 million, the corresponding figure in the financial report of the hospital was FRW 15.8 million; and
- b. At Nyamata district hospital, whilst the total payroll for the period July to September 2008 was FRW 10.1 million the corresponding figure in the financial report of the hospital was FRW 9 million.

144. The OIG also noted that expenditure made through the petty cash was not reviewed regularly by a designated senior staff member. Further, maximum limits have not been established for the petty cash fund and for disbursements to ensure that program managers have appropriate control and oversight of petty cash disbursements.

145. Accounting entries for grant funds received from the PMU are made on the basis of the bank statements instead of credit advice from the bank. Hence, there is the risk that the district hospitals would not take into account in their financial reports bank charges deducted from grant receipts.

146. The OIG noted that Nemba District Hospital did not follow GOR procurement policies and regulations for purchase of program goods and services. There was no procurement committee in place; and goods and services were procured through solicitation of only one supplier instead of at least three suppliers.

147. Back-ups of data were not performed regularly for the accounting software. And there was no policy for off-site storage of backed-up data to mitigate the risk of loss of important data in case of a fire or a natural disaster.

148. The OIG noted that at the community health insurance entities, bank reconciliations were not prepared regularly to ensure that errors and theft of program funds could be identified on a timely basis.

149. The OIG found that payment vouchers were not routinely used to process expenditures in three health centres, namely, Nemba, Rwamagana and Nyamata. The OIG was therefore unable to confirm that expenditures reported had gone through appropriate review and approval procedures. Further, payment and receipt vouchers were not pre-numbered to facilitate financial control and entries of financial transactions in the cash books.

150. At the health centres, there was no segregation of duties in stock management of medicines and health supplies because the staff person in charge of the stocks was also responsible for physical counts. In addition, there were no delivery receipts from CAMERWA available in the health facilities to verify that correct quantities of medicines and supplies had been entered in the institution's stock cards. The OIG verified a sample of supplies received by four district hospitals and found some discrepancies between the quantities shipped by CAMERWA and those recorded in the stock records of the hospitals.

151. The OIG noted that medicines and health equipment as well as high value civil works such as health centres are not insured against fires, natural disasters or theft. Program officials said that the GOR cannot afford the substantial costs involved. Current GOR policy requires that only vehicles are insured.

Recommendation 56 (Significant)

The MOH's PMU should ensure that all district hospitals use financial information from the Tompro accounting software to prepare the quarterly financial reports.

Recommendation 57 (Requires attention)

The MOH's PMU should ensure that all accountants at its SRs and implementing organizations make regular back-ups of the Tompro accounting software.

Recommendation 58 (Significant)

The MOH's PMU should ensure that all accountants at its SRs and implementing organizations prepare monthly bank reconciliations.

Recommendation 59 (Significant)

The MOH's PMU should ensure that incompatible stock management and control duties at the health centres are segregated.

Financial Management: PNILP

152. The OIG noted the following weaknesses in financial management and internal control at the PNILP.

- a. Some disbursements in fiscal year 2005 were mistakenly entered twice in the accounting software. Further, these errors were not found and corrected during preparation and review of bank reconciliations;
- b. Use of spreadsheets (Microsoft Excel) to monitor grant budgets against expenditures instead of the accounting software's budget control module;
- c. Budget versus actual expenditure reports did not include financial commitments i.e. expenditures incurred but not yet paid, to enable program managers have comprehensive financial information on the program's budget execution;

- d. Unexplained discrepancies between account balances in the PNILP's accounting software and those of the PMU, which raise questions about the reliability of the PMU's financial reports; and
- e. Grant funds used to pre-finance other non-GF programs. To cite a few examples, the following funds loaned to a program financed by another development partner: FRW 12.4 million (approximately USD 21,000) in April 2009 and FRW 4 million (approximately USD 6,800) in December 2008. The OIG however confirmed that these funds have been reimbursed to GF grant bank accounts.

Same recommendations as given in recommendations 37 to 42 above.

Financial Management: CTAMS

153. Like other SRs, the OIG noted the following weaknesses in the financial review of CTAMS.

- a. FRW 312 million (approximately USD 537,000) in bank transfers had been left in a suspense account instead of being posted into appropriate expenditure accounts;
- b. Some payment vouchers have not been approved by the program coordinator as required by financial management policies and procedures;
- c. Payment vouchers were not pre-numbered and budget lines were not stated on the vouchers to mitigate the risk of errors in data entry in the accounting software;
- d. Exchange rate losses had not been calculated and entered in the accounting system. The OIG calculated that FRW 29.6 million (approximately USD 51,000) needs to be entered in the accounts for the period 2006 to 2009;
- e. Absence of documented evidence of VAT recovery claims it had sent to the RRA.

Same recommendations as given in recommendations 37 to 42 above.

Financial Management: TRAC

154. The OIG also noted the following weaknesses in its financial review of TRAC

- a. Program expenditures charged to the wrong budget lines, because budget/expenditure categories were sometimes not indicated on purchase orders and payment vouchers to facilitate correct account coding of financial transactions;
- b. Use of spreadsheets for budgetary control instead of the budget module of the Tompro software;
- c. Inter-grant transfers of funds without GF approval;
- d. Errors found in bank reconciliations that have been approved;
- e. Purchase advances to suppliers without bank guarantees; and
- f. Purchase advances to suppliers are treated as grant expenditures.

Same recommendations as given in recommendations 37 to 42 above.

Governance and Program Oversight

There is strong government commitment, involvement and leadership in planning, implementing and providing oversight of the programs. Key government institutions involved in the oversight of grant programs are the MOH, CNLS, Rwanda Public Procurement Authority (RPPA), OAG and the Ministry of Finance and Economic Planning (MINECOFIN). In addition, the CCM is active in providing oversight of the programs.

CCM Oversight of Grant Programs

155. As per CCM guidelines, the OIG noted that there is adequate representation of all sectors in the CCM. Further, while the CCM Chair is from the government sector, the first Vice-Chair is from the international development sector. The OIG noted that the CCM meets regularly. There is a conflict of interest policy; and there are transparent procedures for screening and selection of sub-recipients.

156. To enhance CCM technical oversight of grant implementation, technical working groups in the following areas were established: HIV/AIDS and Tuberculosis, Malaria, Health Systems Strengthening (HSS) and Behaviour Change Communication (BCC).

157. The CCM also sponsors external evaluation studies of the grants before the end of phase one to assist it in making a recommendation to the GF for further funding.

Oversight Role of the GOR, the MOH and other Government Institutions

Besides the CCM which has responsibility for grant oversight, the OIG noted that the GOR, through the MOH and other central and local government institutions, play important roles in the oversight of the GF grants. There is strong government commitment, involvement and leadership in planning, implementing and providing oversight of the programs. For example, the Permanent Secretary of the MOH currently serves at the Chair of the Rwanda CCM. Key government institutions involved in the oversight of grant programs are the MOH, CNLS, Rwanda Public Procurement Authority (RPPA), OAG and the Ministry of Finance and Economic Planning (MINECOFIN).

Ministry of Health

158. Generally, the GF program activities are implemented by the program units of the MOH such as Treatment and Research on AIDS Centre (TRAC), National Tuberculosis Program (PNLIT) and the National Malaria Program (PNLIP). For purposes of integration and harmonization of program approaches, the foregoing implementing units of the MOH have been combined into one organization called TRAC Plus, led by an Acting Director-General. Other units of the MOH such as the CTAMS and UPDC play important roles in program coordination and oversight.

159. There are quarterly supervisory visits and assessments of services and programs at district hospitals through a peer review system amongst district

hospitals. Also, district hospital teams supervise and assess health centres each quarter. Standardized assessment tools put in place by the Performance Based Funding (PBF) program are used for supervision and assessment of District hospitals and Health centres. Under the PBF program, the quarterly assessment reports and scores are used for making funding decisions regarding health facilities in the country.

The Program Management Unit (PMU) of the MOH

160. The size of the grant portfolio and the numerous grant bank accounts to be managed and progress reports to be prepared, consolidated and verified pose oversight challenges for the PMU.

161. To facilitate financial management, control and reporting, the PMU requires sub-recipients to have one accountant, paid from grant resources, who handles GF program activities. Further, key SRs such as the MOH's national program units, CAMERWA and District Hospitals are required to use Tompro accounting software. But as noted in the financial management section, program accountants lack expertise in the use of the accounting software.

162. The Operations Manual of the PMU specifies norms, ethics and guidelines for the Internal Audit (IA) department which the OIG found to be in line with professional auditing standards. Further, although the Head of Audit reports to the PMU Coordinator, audit reports issued by the IA department go to the Executive Secretary of the CNLS with copies to the CCM Secretary and the PMU Coordinator.

163. The OIG assessed the adequacy of the oversight of the programs by the internal audit department of the PMU. The Internal Audit (IA) department is staffed by four auditors including the Head of Audit. In the OIG's view, the staff strength of the IA is quite limited given the large number of SRs and implementing organizations to be audited.

164. Due to the large number of SRs and implementing organizations, the IA department uses a risk based approach for the selection and prioritization of organizations to be audited. The OIG learnt that due to weak institutional and governance systems in the civil society sector, the IA department puts more emphasis on non-governmental organizations in its audit plans. Hence, apart from a stock review work it completed at CAMERWA in 2008, the IA department is yet to audit the PMU and CAMERWA.

165. In addition, the IA department is responsible for follow-up of audit recommendations of SRs. The IA department said that civil society organizations have found it challenging in implementing agreed audit recommendations due to human resource capacity limitations.

166. The procurement department of the PMU is staffed with procurement specialists and architects. It has managed tenders for procurement of LLINs and civil works, namely, rehabilitation of laboratories, construction of maternity clinics/wards and VCT centres and other health facilities. There were some control shortcomings in oversight of civil works as noted in paragraphs 96 and 97.

Same recommendations as given in recommendations 27 and 37 to 39

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National AIDS Control Commission (CNLS)

167. The Executive Secretary of the CNLS has supervisory responsibility over PMU. Further, the Executive Secretary of the CNLS is a co-signatory of the PMU's program bank accounts. As the administrative and finance supervisor of the PMU, the Secretariat of the CNLS receives audit reports from the IA department of the PMU. These audit reports are analysed by the Secretariat of the CNLS; and subsequently the Executive Secretary writes to each auditee stressing the importance of implementing agreed audit recommendations.

Rwanda Public Procurement Authority (RPPA)

168. The GOR through the RPPA provides oversight of the procurement activities of all public entities including CAMERWA. To enhance transparency, competition and efficiency in public procurement, the GOR in 2008 established the RPPA to replace the National Tender Board.

169. According to the law, all public procurement actions/tenders whose values exceed 300 million RWF (approximately USD 530,000) are awarded by the RPPA. However, in order to facilitate grant program implementation, the MOH got a waiver for CAMERWA to manage tenders for all pharmaceutical products, health supplies and health equipment.

170. The audit of CAMERWA's procurement activities by the RPPA for the period July to December 2007 found that more than 50 percent of the tenders did not have evaluation reports. Further, about 93 percent of goods and supplies ordered lacked goods received note.

The Central Medical Stores of Rwanda (CAMERWA)

171. Given the important role CAMERWA plays in grant implementation and the substantial grant funds it manages, the OIG reviewed the effectiveness of the oversight arrangements of CAMERWA to ensure that medicines, health supplies and equipment purchased with grant funds are accounted for.

172. The position of Internal Auditor is provided for in CAMERWA's approved organizational, but the post has been vacant since 2009. Further, there were no internal audit reports of CAMERWA available for the OIG's review.

Recommendation 60 (High)

In order to provide adequate audit oversight of the operations of CAMERWA, the MOH should ensure that the Board of Directors of CAMERWA appoints an internal auditor for CAMERWA who reports directly to the board.

The Office of the Auditor General of Rwanda

173. Established in 1998, it became the Supreme Audit institution of Rwanda in 2003. It assists parliament to exercise its oversight role over government activities and programs. All donor funds disbursed to public institutions are considered government funds. The Auditor General therefore conducts audits of the following entities implementing GF grant programs: MOH, district administrative entities, and other line ministries involved in grant program implementation.

174. The OAG has total staff strength of 90 including 80 auditors. It is responsible for auditing all Ministries, Districts and Agencies of the GOR. Its capacity is therefore limited, given the magnitude of its responsibilities. The OAG has embarked on a program to build its capacity and its effectiveness with the assistance of the Swedish National Audit Office. It also receives technical assistance from some audit firms.

175. The OIG noted that the OAG has conducted audits of the following institutions that receive grant funds: CNLS, CAMERWA, TRAC Plus, PMU, and the National Hospitals. However, due to capacity limitations, it is unable to cover a large number of institutions involved in grant implementation.

The Ministry of Finance and Economic Planning (MINECOFIN)

176. GF grant funds are part of the national development budget and therefore monitored by the MINECOFIN. Each public institution receiving state and donor funds is required to submit monthly financial reports to MINECOFIN by the 15th day of the following month. The financial reports are prepared according to national budget lines. To this end, the PMU's financial reports on the GF grant programs are consolidated by MINECOFIN into the GOR's consolidated financial statements for the financial year. Further, the MINECOFIN provides feedback on key areas of concern and rates the completeness and accuracy of the PRs submitted financial reports.

177. In addition, each semester MINECOFIN publishes the Development Projects Implementation Report which highlights the implementation and disbursement progress of development projects including each GF grant program. In its 2008 first semester report, the MINECOFIN noted that most of the programs funded by development partners "are managed by Project Implementation Units which are responsible for the implementation activities on a day-to-day basis. There has been improved oversight from the technical Ministries which in most cases had always regarded PIUs as not part of the Ministries. However, there is need for more oversight and integration of PIUs in the technical Ministries management."¹¹

District Hospitals

178. To facilitate financial management and financial and program reporting at the district level, the GF grants fund/support one accountant and one M&E staff at the GF-supported district hospitals. The OIG confirmed that the GF-supported accountants and M&E staff monitor program activities carried out at the health centres within their district. In addition, the district GF-financed accountants and M&E staff undertake supportive supervision to health centres. And each quarter, they consolidate progress and financial reports received from the health centres.

District Administrative Authorities

179. Under the GOR's decentralization program initiated in 2006, local government authorities, namely, District Administration would assume pre-eminent/leading roles in oversight of programs and institutions within their

¹¹ Ministry of Finance and Economic Planning; Central Public Investments and External Finance Bureau; Development Projects Implementation Report; First Semester 2008; July 2008.

jurisdiction. The OIG therefore assessed the effectiveness of the oversight the district administrative authorities provide over grant programs in general and particularly over the Community Health Insurance program, a major component of the GF Round 5 Health Systems Strengthening grant.

180. In general, district administrative institutions have one district internal auditor who is responsible for auditing all district level programs and institutions such as hospitals, health centres, community health insurance schemes, and schools etc. Officials at the health facilities the OIG visited confirmed that district internal auditors carried out audits at their institutions, but there was no feedback to the institutions audited in the form of audit reports. The OIG noted that given the magnitude of their responsibilities and the limited staff strength, district auditors would not be able to provide adequate oversight of all grant programs in the districts.

Effectiveness of the Oversight Role of the External Auditors

181. The OIG established that independent annual audits of the grants are performed as required by the grant agreements. A tender is advertised annually to select external auditors for each grant program. From 2006 the GOR financial regulations required external auditors to be changed each year. Hence, an audit firm contracted to audit a grant program may not have the institutional memory of the grant recipient acquired from previous audit of that organization.

182. A review of a sample of external audit reports of the GF grants showed common and recurring internal control weaknesses across all grants. The causes of these weaknesses can be attributed to inadequate capacity of accounting staff at implementing organizations and workload issues. But it also shows lack of follow-up of previous audit recommendations and inadequate supervision and oversight of accounting staff.

- a. Failure to recover value-added tax (VAT) paid on goods and services;
- b. Dormant bank accounts with bank balances;
- c. Inter-program borrowing due to delayed receipts of grant funds
- d. Program expenditures charged to wrong budget categories. etc.

183. Further, OIG did not find separate annual external audits of sub-recipients. However, the OIG confirmed that external auditors included a sample of SRs in their audit work, but comprehensive SR financial review was not the focus of these audits.

Oversight Role of Development Partners

184. The development partners have representatives in the CCM. Hence, they participate in the oversight of the programs. Further, a Common Procurement and Distribution System (CPDS) was established in 2005 to coordinate and harmonize procurement and distribution of medicines and health supplies by development partners and the GOR.

185. The Implementation Committee of the CPDS, which include representatives of development partners, review and approve CAMERWA's tender committee evaluation decisions/reports before the award of procurement contracts. Further, development partners are represented on the resource management committee of CPDS which is the decision-making body within the CPDS. Also, through the semi-

annual joint health sector support reviews, development partners provide oversight of the health programs being implemented by the GOR.

LFA Oversight of Grant Programs

186. PWC has multi-disciplinary team comprising specialists in M&E, PSM, public health and finance. The team travels to Rwanda as necessary as the LFA team was not based in the country, but the OIG learnt that plans are far advanced for PWC to open a country office in Rwanda by the middle of this year.

187. PWC exercises tight control over the quality of grant progress reports submitted to the Global Fund. Much effort is spent on re-counting and assuring the accuracy of submitted counts, usually resulting in insignificant adjustments. The LFA does, however, not comment on the appropriateness and usefulness of numbers being counted and reported.

188. The On-Site Data Verifications conducted by the LFA followed Global Fund guidelines, were exhaustive and generally well executed. However, the on-site data verification for Tuberculosis conducted by the LFA in 2009 scored data quality very low despite evidence of good data quality. Examination of the LFA report revealed that this was primarily due to a flaw in the OSDV tool. Both PWC and the Global Fund Secretariat were aware of this problem. Qualitative assessments included in the OSDV reports are often very informative. Recommendations are, however, not always appropriate. It was, for instance, inappropriate for PWC to demand a change in the National Health Management Information System by March 2010¹² in order to capture information required for the Global Fund Performance Framework, a change which would not add any useful health management information and generate a considerable amount of additional work at all levels.

189. The LFA's oversight work did not focus on financial management reviews at the level of sub-recipients where OIG found most of the financial management weaknesses. However, the LFA oversight plan prepared in September 2009 recognizes the need to selectively assess major SRs to ensure that they have requisite systems for program implementation. Spot audits of sub-recipients are also foreseen in the LFA oversight plan.

Recommendation 61 (Requires attention)

The Country Programs Cluster of the Global Fund Secretariat should review the role of the LFA in verifying the data reported by the Principal Recipient in the six-monthly project update reports. Consideration should be given to asking the LFA to use its local knowledge to comment on the usefulness and significance of the information that is being collected.

Recommendation 62 (High)

The Global Fund Secretariat should review the method of calculating error margins in on-site data verifications and make the necessary corrections to avoid generating erroneous results. The Global Fund's Country Programs Cluster should carefully review the conclusions, requirements and recommendations made by the LFA OSDV reports as to their feasibility and appropriateness before communicating the results to the CCM.

¹² PWC - LFA On-Site Data Verification 2009 - Malaria (page 17)

GF Secretariat Oversight of Grant Programs

190. As mentioned in paragraph 64 above, there was a funding gap of one year between Phase 1 and Phase 2 of the Round 6 Tuberculosis program. Similarly, there was a funding gap of eight months between Phase One and Phase Two of the Round 6 HIV program.

- a. Phase 1 of the Round 6 Tuberculosis ended in February 2009 and its Phase 2 was approved in April 2009. But a phase two grant for the Round 6 Tuberculosis program was not signed until February 2010, resulting in a funding gap of almost a year.
- b. Phase 1 of the Round 6 HIV/AIDS program ended in June 2009, but its Phase 2 was not approved until November 2009. A phase two grant for the Round 6 HIV/AIDS program was signed in February 2010, resulting in a funding gap of eight months.

191. At the time of the OIG audit, Rwanda was negotiating single-stream strategy based support by the Global Fund for its tuberculosis and HIV/AIDS programs. This was an opportunity to overcome the many weaknesses in the Performance Frameworks identified during the mission. Since these discussions were still ongoing, the OIG could not assess to what extent this opportunity was realised. For malaria, no such opportunity existed, but the audit nevertheless found the same need for a review of the performance monitoring framework. In summary, these common weaknesses included (a) the inclusion of indicators that tracked budget execution and work plan implementation rather than programmatic results; (b) the inclusion of indicators directly tied to Global Fund resources; (c) the use of work planning targets rather than incidence or prevalence estimates as denominators for indicator achievement; (d) the collection of cumulative numbers where results can only be understood in terms of quarterly incidence or coverage. Although the Global Fund Secretariat assured the OIG that the analysis of these results is sophisticated enough to provide a true picture of performance, (i) the grant recipients are unaware of this and are focusing intensely on generating the "right numbers"; (ii) this is labour intensive and contributes little to the national programs; (iii) the Grant Performance Reports published on the Global Fund Web Site that are the public window to programme performance show no sophistication of analysis and treat all indicators in the same fashion.

Recommendation 63 (High)

The Country Programs Cluster should ensure that phase two assessments of the grant programs are done on a timely basis. Further, in order not to disrupt implementation of grant programs, the Country Programs Cluster should ensure that it reviews its existing grant processes in order to facilitate the negotiation and signing of approved grants on a timely basis.

Recommendation 64 (Requires attention)

The Global Fund's Country Programs Cluster should at the earliest possible opportunity enter into negotiation with the CCM to review and revise the performance monitoring frameworks of the two active malaria grants. Indicators that are simply counting inputs should be removed and followed through an appropriate management information system. For the output indicators appropriate denominators should be selected based on real epidemiological and demographic information rather than on planning targets.

Conclusion - GF Secretariat and LFA Oversight of the GF grants

192. As noted above there are shortcomings, particularly the lack of timely grant renewals on the part of the GF Secretariat and inadequate LFA oversight of SR financial management function. However, the OIG has noted efforts by the GF Secretariat to improve its grant processes. And the LFA is planning to increase oversight of SRs through spot audits. These are all steps in the right direction. Hence the OIG conclude that despite the above shortcomings, the GF and LFA oversight of the grants was generally satisfactory although further efforts would further strengthen their oversight.

Annex 1: Expenditures with missing/inadequate supporting documents (Source: CNLS accounting software and records)

Grant / Financial Year	Date	Voucher Number	Amount FRW	Expenditure Description	Comment
HIV Round 3 2006	09/11/2006	56030/197	1,954,080	Payment of radio spots/announcements	Proforma invoice used for payment
HIV Round 3 2008	13/03/2008	DC26/2008	637,200	Internet costs	No invoice
HIV Round 3 2008	12/08/2008	DC53/2008	90,000	Purchase of frame	Missing supporting documentation
HIV Round 3 2006	2/05/2006	56030/71	500,800	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
HIV Round 3 2006	30/08/2006	56030/149	578,680	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
HIV Round 3 2007	14/09/2007	DC17/2007	415,909	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
HIV R3 /2007	30/03/2007	dc06/2007	277,515	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
HIV R3 /2007	30/03/2007	DC07/2007	390,333	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
HIV R3 /2007	26/04/2007	DC14/2007	334,662	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
TB R4 /2006	9/08/2006	56030/131	838,460	Travel tickets	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
TB R4 /2007	11/01/2007	TB04/2007	624,328	Hospitality costs	Missing/inadequate supporting documentation to justify that this was GF grant program-related expenditure
Total			6,641,967*		

*Approximately USD 11, 450

Annex 2: Accounting entries with missing/inadequate supporting documents (Source: CNLS accounting software and records)

Grant / Financial Year	Date	Voucher Number	Amount FRW	Expenditure Description	Comment
TB Round 4 2007	31/12/2007	CNLS/CORR	100,000	Joint charge account 2006	Missing supporting documentation
TB Round 4 2007	31/12/2007	CORR/CNLS	1,439,560	Charge account 2006 not entered	Missing supporting documentation
TB Round 4 2007	15/01/2007	TB05/2007	-109.216	Unspent travel allowances	Missing supporting documentation
TB Round 4 2007	31/12/2007	CORR/CNLS	250,000	Charge account 2006 accounted for	Missing supporting documentation
HIV Round 3 2006	10/005/2006	56030/97	-2,500,000	Return to account	Initial advance could not be found in the accounting software

Annex 3: Payment vouchers with missing supporting documents (Source: CCM Secretariat accounting software and records)

Disease	Date	Voucher number	Amount (FRW)	Expenditure description	Comments
HIV R3	18/11/2004	CCM0018/05	352,453	Communication	Invoice not found
HIV R3	15/12/2004	CCM0026/04	331,787	Communication	Invoice not found
HIV R3	26/11/2004	CCM0023/04	570,000	Consultancy fees	Invoice not found
HIV R3	11/10/2004	CCM0014/05	570,000	Consultancy fees	Invoice not found
HIV R3	4/02/2005	CCM009/05	570,000	Consultancy fees	Invoice not found
HIV R3	18/03/2008	CCM09/08	123,900	communication	Invoice not found
HSS 2007	1/09/2007	HSS01/07	244,260	Advertisement in a newspaper	Invoice not found
TB R4	1/05/2005	CCM003/05	200,000	Communication	Invoice not found
HIV R3/ 2005	9/02/2005	CCM0010/05	1,052,500	Supervision visit to Ngali and Byumba	The supporting documentation does not fully liquidate the travel advance
Total			4,014,900*		

**Approximately USD 6900*

Annex 4: Government of Rwanda Response to the Recommendations and Management Action Plan

Prioritization of recommendations

a. High priority: Material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization’s interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management.

b. Significant priority: There is a control weakness or noncompliance within the system, which presents a significant risk and management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization’s interests, weaken internal control, or undermine achievement of aims and objectives.

c. Requires attention: There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization’s benefit.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
HIV/AIDS	<p>Recommendation 1(Significant)</p> <p>There are some indications that the HIV epidemic in Rwanda has a mixed profile including elements of a generalized and of concentrated epidemics. Too little is known about the concentrated epidemics among female sex workers and among men who have sex with men. The MOH should increase research and epidemiological surveillance of the HIV epidemics among highly vulnerable groups in the country.</p>	<p>In line with the National Strategic Plan 2009-2012, most at risk groups are addressed, thus the MOH/TRAC Plus has initiated specific prevention activities targeting the identified most at risk populations (MARPS) and currently the behavioural sentinel surveillance (BSS) among female commercial sex workers (FCSW), Truckers and youth are held every 2 years. The Rwanda 2009 BSS among the FCSW and truckers will also determine the HIV prevalence among the group of FCSW and truckers which also help in developing strategies to improve the HIV prevention among those groups. CNLS have also undertaken specific study on the group of men who have sex with men (MSM) and the results will be used for the strengthening the MSM program in Rwanda. Prevention messages targeting the above stated groups are being developed and the training of providers and counsellors on the management of HIV in the MARPS are being held.</p>	MOH, CNLS and TRAC+	It will be a continuous activities starting Jan 2011

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>Recommendation 2 (Significant)</p> <p>Rwanda should implement effective programs for HIV prevention among marginalized and highly vulnerable individuals and groups as outlined in the National HIV Strategy. These include female sex workers and men who have sex with men. Programs of this nature are best delivered by national civil society organizations. The MOH should ensure that these organizations have the appropriate technical assistance to acquire the expertise to work in these areas, as well as a supportive environment to allow them to work.</p>	<p>Those programs exist (cfr recommendation 1) and need strengthening measures and new strategies guided by the HIV trend data and behaviour status as shown by different BSS+ that are implemented in those groups.</p> <p>Not only, the FCSW, Truckers and MSM (men who have sex with men) groups are targeted but also, MOH TRAC Plus is looking at extending those services to other groups like street vendors, household maids, separated widows and fishermen.</p> <p>The civil society is being empowered through SSF (single stream funding) GF project as well as PEPFAR to be able to deliver those services and implementing partners are providing technical assistance to those organizations</p>	MOH, CNLS and TRAC+	It will be a continuous activities starting Jan 2011
	<p>Recommendation 3 (Significant)</p> <p>The Rwanda CNLS should engage in negotiation with the Catholic Church to assure the availability of condoms for discordant couples in church-operated public health facilities delivering PMTCT programs.</p>	<p>In addition to secondary health posts that have been introduced close to catholic church based health facilities to address this issue, advocacy through the CNLS umbrella network of religious leaders (RCLS) is continuously advocating for condom use among discordant couples. RCLS is an active member of the steering committee for the current World AIDS Day whose theme is around promotion of condoms use. His Excellency the arch bishop and president of the board of RCLS, participated in the press conference for the launch and different other activities.</p>	CNLS/	On-going
	<p>Recommendation 4 (Significant)</p> <p>The Ministry of Health should accelerate with the introduction of electronic patient registration systems in HIV clinics using a single agreed electronic platform.</p>	<p>The open medical records system (MRS) has been chosen by MOH to be used national wide. It is funded under government of Rwanda budget, HIV SSF project and PEPFAR. The initial phases were to develop the system and the integration of the HIV modules and has been completed, the primary care module still in development. The computers and accessories have been procured and distributed to the Health facilities, User training is planned ahead. The roll out is planned to start in 2011 and will gradually extent in all health facilities.</p>	MOH, TRAC Plus	Starting Jan 2011 and expected to be rolled in Health facilities in 3 years
	<p>Recommendation 5 (Significant)</p> <p>In the process of grant consolidation and the negotiation of a national strategy grant for HIV, the CCM and the Country Programs Cluster of the Global Fund Secretariat should jointly develop a performance monitoring framework that monitors meaningful results at the output, outcome and impact level within the context of a national monitoring and evaluation strategy. The framework should not include input</p>	<p>The SSF HIV PF has been completed and the negotiations were taking into account all the above OIG suggestions; however GF still wants to collect some inputs indicators and recommended to the PR, results cumulating over program term or annually. The results in the SSF HIV PF are expressed in rates and proportions and are in line with the GOR M&E system.</p> <p>This has to be addressed to M&E Geneva and LFA. Because they continue to argue for the inputs indicator and cumulating results</p>	CNLS, TRAC Plus, GF	By June 2011

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>indicators, cumulative indicators or indicators that only monitor directly attributable results. Wherever possible, results should be expressed in terms of rates and proportions rather than absolute numbers. The monitoring of inputs, of budget execution and of work plan implementation should be confined to a management information system that is separate from performance monitoring.</p>	<p>over program term and annually.</p> <p>The monitoring of inputs, of budget execution and of work plan implementation is in the revised tasks of the Program management unit (PMU) and the M&E team will help in that exercise.</p> <p>GF Secretariat comment: During the HIV SSF negotiation, the teams worked together to identify the most pertinent output, outcome, and impact indicators and achieve a good balance for the programme (there are no input indicators in the performance framework). These indicators were in Rwanda's HIV national M&E plan.</p> <p>The presentation of targets as cumulative which is indicator-specific should not cause confusion during data analysis as cumulative results are analysed against cumulative targets. Specific targets for continuum type of services are better presented cumulatively to avoid issues of double counting, under-reporting e.g. patients on ART who will continue with therapy over time, etc.</p>		
	<p>Recommendation 6 (Requires attention)</p> <p>In the process of grant consolidation and the negotiation of a national strategy grant, the CCM and the Country Programs Cluster of the Global Fund Secretariat should ensure that the task of data collection for Global Fund performance reports is as much as possible delegated to national data management systems. The TRACNet system is reliable enough to provide quality health sector data. The CNLS system for data on non-health sector community level activities requires some strengthening which could be considered with Global Fund support.</p>	<p>CNLS has already defined 11 indicators to be collected at community level (non-health). These indicators are related to the National Strategic Plan (NSP) results. The database was also revue and the Technical Assistants in charge of collecting these indicators at District level were trained. The new system is in place since 2 months.</p>	<p>CNLS/ Planning, Coordination Monitoring and Evaluation Unit</p>	<p>Done</p>
<p>Tuberculosis</p>	<p>Recommendation 7 (Requires attention)</p> <p>The MOH should exercise caution when developing terms of reference for community mobilization and education in the fight against tuberculosis in order to control the proliferation of poorly targeted sputum testing.</p>	<p>TB unit developed a strategic plan on Advocacy Community and Social Mobilization which detail the mobilization and education activities in order to control the poorly targeted sputum testing. This strategic plan is funded by SSF TB and it is implementing.</p>	<p>TB unit and Partners</p>	<p>On going</p>
	<p>Recommendation 8 (Significant)</p> <p>In the process of grant consolidation and the negotiation of a national strategy grant for tuberculosis, the CCM and the Global Fund's Country Programs Cluster should reduce the number of indicators of the performance monitoring</p>	<p>During the negotiation of TB national strategy application, the indicators were discussed in order to maintain the reasonable number of indicators. For the national strategic plan with the 6 objectives, we considered 20 key indicators which can show the level of implementation of the project.</p>	<p>Global Fund, PR, CCM</p>	<p>Done</p>

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	framework by removing all indicators of work plan implementation to a management information system that is separate from performance monitoring.			
Malaria	<p>Recommendation 9 (High)</p> <p>The Malaria Unit of TRAC Plus should launch a thorough epidemiological investigation into the resurgence of malaria incidence in Rwanda in 2008/09 in order to take the necessary steps to avoid a future recurrence</p>	Malaria Unit analyzed data on malaria morbidity from 2005 to 2009 through HMIS and entomological data and it's clear that there is an increasing of malaria cases. Among hypothesis on this situation, the decrease of immunity could be retained. It is clear as well the delay in replacement of LLIN has got a negative impact. The Malaria Unit is planning to conduct deep entomological and epidemiological investigations.	Malaria Unit/TRAC Plus	June 2011
	<p>Recommendation 10 (High)</p> <p>The Malaria Unit TRAC Plus should establish a system and procedures to continuously monitor the insecticidal effectiveness of bed-nets available in the country using the entomological surveillance infrastructure of the sentinel sites for malaria.</p>	The Malaria Unit acknowledge the comment and the activity is actually implemented (bioassay,colorimetric test in 6 sites)	Malaria Unit/TRAC Plus	In Progress
	<p>Recommendation 11 (Significant)</p> <p>The Malaria Unit of TRAC Plus in collaboration with CAMERWA should review its projection of bed-net requirements and establish a timed procurement schedule that assures a continued supply of bed-nets for routine distribution in ante-natal and immunization clinics</p>	The Malaria Unit in collaboration with CAMERWA and PMU began the procurement procedures on time and contract were signed on time the delay was due to the non-respect of the contract by the suppliers and those events are not predictable. A sustainable solution will be to multiply the number of suppliers accredited.	Malaria Unit/CAMERWA/ PMU	NA
	<p>Recommendation 12 (Significant)</p> <p>The Malaria Unit of TRAC Plus and the Community Health Desk of the Ministry of Health should proceed rapidly with the introduction of rapid diagnostic tests for malaria in home-based management of fever in children, and establish a strong supportive supervision system to ensure that these tests are used consistently and correctly.</p>	<p>The PR acknowledges the comment and actually RDTs are fully implemented in 27 out of 30 districts; and by the end of the first quarter of 2011 this activity will be implemented countrywide.</p> <p>The supervision system is in place and is done by the lab technician or the in charge of community health workers at health centre level.</p>	Malaria Unit/Community Health Desk	April 2011
Health Systems Strengthening	<p>Recommendation 13 (Requires attention)</p> <p>The Ministry of Health should proceed carefully with the process of integrating HIV and tuberculosis information in the national health management information system. While there will be a need to maintain parallel information systems for these programs for some time, reliable key health management data on HIV and TB should be available through the HMIS. This could initially be achieved by</p>	<p>We agree: For the short term, we've created an Access database that will be entered by the team at the TB program. By the end of January, we should be able to add these indicators into the PBF web database.</p> <p>But for a long-term intervention; Integration with the HMIS will only happen when we move to a new platform; Web enabled and with a functional interoperability layer application with other multiple data bases. It is a process; we have planned to finish the selection and</p>	HMIS	On going

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	<p>assuring that there are functioning protocols for information exchange between the different electronic data management systems.</p>	<p>definition of the minimum indicators mid Jan, 2011. With help from WHO, a consultant from AFRO (Africa regional office of the World health Organization) is helping in a process of developing a metadata dictionary, and a dash board. In early January, we plan to organize a workshop facilitated by this consultant to help define functional specifications of the platform, and to technically input on the best way to customize the open source options we already consider. We plan to have achieved a significant portion of this process in a span of two years.</p>		
	<p>Recommendation 14 (Requires attention) The Ministry of Health should proceed with caution when introducing pre-formatted registers in health facilities. The expected gain in data quality should be weighed against the considerable cost of a system of registers. In some cases the publication of standardized guidelines on how to set up the rows and columns in a generic exercise book may be more cost effective.</p>	<p>We agree and we appreciate the advice: But considering both sides of the situation, we opted to introduce pre-formatted registers in health facilities. Reason being that the use of generic exercise books would not be sustainable; creates increased and additional work load to the users and hence risks complicate staff turn-over, notwithstanding the way it compromises data quality. Besides, the printing burden was critically analysed and found to be cost effectiveness, not only in terms of the monetary cost but also the value of uniformity is we stand to gain is important.</p>	HMIS	<p>By End of Jan, 2011 printing will be completed. Distribution and training of users should be finished by End of April, 2011.</p>
	<p>Recommendation 15 (Significant) The MOH should ensure that the Performance-Based Financing Task Force should review its methods of collecting quantitative data on Health Centre activities. It should adjust its indicators to be fully in line with information reported to the Health Management Information System, and it should use this system to generate its own activity reports. Indicators that are not collected by HMIS should not be used by the PBF system. The District PBF Coordinators would thereby acquire an additional role of assuring the quality of HMIS data without any increase in their work load.</p>	<p>We Agree. Actions planned: However we cannot adjust the indicators we currently remunerate by reducing their number, because they are committed to be achieved in the new national strategic plan and in the performance framework of the GF SSF-HIV. But most of them are in the health management information system. This is because, we want a continuous improvement of quality of services delivered. Among all the indicators for each supervision a fixed number of them will be evaluated randomly. We have designed plans to strengthen the concept of integrated supervision and evaluation from the central level by reviewing ToRs of supervisors to ensure they align to the new generation of indicators. We plan to introduce innovative and user-friendly tools to strengthen the performance of routine information system management (PRISM) at peripheral Health facilities. Through the PRISM assessment tools, we hope to review and enrich our periodic Data Quality Audit (DQA) interventions and we expect to foster ownership of DQA at the DH level, by not only focussing on</p>	<p>Action system: 1.HMIS, 2.Decentralization and Integration, 3.PBF</p>	<p>Started already, expected to be functional by end May.</p>

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		technical determinants of data quality but also looking at behavioural as well as organisation determinants.		
	<p>Recommendation 16 (Requires attention)</p> <p>Global Fund support for the subsidization of insurance premiums based on poverty criteria is good public health policy with a noticeable impact on the response and control of the three Global Fund priority diseases. The MOH and the CCM are encouraged to ensure that it continues under the national strategy grants when the HSS grant ends.</p>	<p>It is planned in the new policy that the category one and two from UBUDEHE* will be supported every year by the Government of Rwanda. The category one and two are the indigents and the very poor.</p> <p>*A Kinyarwanda concept. It is a program based at the Ministry of Local Administration which is working on a detailed assessment at the field level of Rwandese according their socio economic categories. This will help in different domains including the stratification of population according their respective community health insurance premium in order to ensure equity.</p>	CTAMS	1st July 2011
	<p>Recommendation 17 (Requires attention)</p> <p>If Global Fund support for the subsidization of health insurance premiums is continued after 2010 in the National HIV Strategy grant, the main performance indicators to be followed should be the health facility attendance rate and the rate of insurance coverage among those attending health facilities. Data for both indicators are available from the national health management information system.</p>	We agree: The Health Facility attendance rate cab is and will continue to be monitored through the HMIS as well as rate of insurance coverage among those attending health facilities.	HMIS	On-going.
	<p>Recommendation 18 (Requires attention)</p> <p>While the system of partially financing health care at the primary care level through the mutual health insurance funds is well developed, the system does not have a sufficient financial basis to fund secondary and tertiary care, and the procedures for channelling mutual fund payments to institutions at the secondary and tertiary level are not yet finalized and functioning. The Ministry of Health should further explore options such as the introduction of variable premiums while assuring the system's continued viability and equity.</p>	<p>The mutual policy has been revised and the new policy is based on the premium according to the revenues of membership</p> <p>This option will make up equity and viability of the mutual system. This policy will start on 1st July 2011.</p>	CTAMS	Done
	<p>Recommendation 19 (Requires attention)</p> <p>The MOH and MIGEPROF should start a process of medium and long-term planning to establish a solid institutional foundation for the program of educational</p>	We agree: MIGEPROF has already developed a Strategic plan of action for orphans and vulnerable children. They will continue improving the implementation of the strategy into a clear operational plan.	MIGEPROF	On going

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	support for needy children after grade nine.			
Procurement and Supply Chain Management	<p>Recommendation 20 (Significant)</p> <p>The MOH should ensure that the composition of the internal tender committee of CAMERWA is modified to include two pharmacists of the MOH Pharmacy Task Force on a permanent basis.</p>	This recommendation will be discussed with the RPPA as the internal tender committee is established by the public procurement regulation.	CAMERWA & MOH	31 March 2011
	<p>Recommendation 21 (Significant)</p> <p>The MOH should ensure that CAMERWA develops and adopts policy and procedures manuals covering the areas of (i) administration and finance, (ii) procurement (iii) warehousing, (iv) distribution and (v) pharmacy, including quality control.</p>	CAMERWA management has decided to review / update or develop all policies and procedures manuals and this activity is included in the 2011 Plan of Action.	CAMERWA DG	30 June 2011
	<p>Recommendation 22 (Significant)</p> <p>The MOH should ensure that CAMERWA develops a data-base of health products with information on line of supply and suppliers. The data-base should include information on weight, volume and cost of products as well as the performance history of suppliers. The data-base could be used to inform pre-qualification decisions.</p>	This recommendation is very useful. CAMERWA management will assess the feasibility of its implementation.	Procurement and Warehouse Departments / CAMERWA	31 March 2011
	<p>Recommendation 23 (Significant)</p> <p>The MOH should ensure that CAMERWA recruits a qualified pharmacist for receiving health products. The terms of reference for this position should include the physical verification of quantity and quality of products received, the implementation of the quality control policy at central level, and the maintenance of the data-base recommended under Recommendation 28</p>	CAMERWA intends to establish a broader quality assurance system which will focus on all aspects of the quality of commodities, systems, suppliers prequalification and service delivery. Currently, the evaluation of the bids is underway in order to recruit a consultant who will help in establishment of the quality assurance system at CAMERWA. The activity will be done in two phases: assessment and then implementation of the assessment recommendations. Meanwhile, CAMERWA is developing visual inspection standard operating procedures (SOPs) which will be followed in the Receiving area and hiring one pharmacist in charge of inspection and control of deliveries in the receiving area.	CAMERWA DG	31 March 2011
	<p>Recommendation 24 (Significant)</p> <p>CAMERWA should consider making the following improvements in its procurement documentation and filing system to enhance tracking of procurements.</p> <p>(a) Tender documents should clearly refer to the grants, as appropriate;</p> <p>(b) Supplier contracts should refer to purchase order</p>	So far, purchase order bears the reference of grant and reference of the tender document and the contract bears the reference of the tender document and it the contract is always together with the purchase order.	Procurement Department / CAMERWA	31 March 2011

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	<p>numbers, as appropriate;</p> <p>(c) Delivery notes to final recipients should be pre-printed using the dispatch table in bidding documents in order to avoid manual or unreadable entries of final recipients on the delivery notes; and</p> <p>(d) Originals of the delivery notes should be filed together with the tender documents.</p>			
	<p>Recommendation 25 (Significant) On the basis of the PSM plans for Global Fund grants, CAMERWA should establish a detailed procurement schedule detailing in chronological sequence each step in the procurement cycle, including the actors involved and the actions to be taken.</p>	<p>This recommendation will be implemented starting from February 2011.</p>	<p>Procurement Department / CAMERWA</p>	<p>31 March 2011</p>
	<p>Recommendation 26 (Significant) To avoid future procurement delays for critical items such as bed-nets, the MOH should ensure that technical specifications are defined at the start of the program and annexed to the PSM plan</p>	<p>The MOH (MALARIA PROGRAM) ensures that technical specifications will be defined at the start of each malaria project and annexed to the PSM plan which will be already approved by the Global Fund.</p>	<p>PMU coordinator</p>	<p>Immediate</p>
	<p>Recommendation 27 (Significant) The PMU should strengthen its oversight of procurement for civil works to ensure that procurement regulations/guidelines (for retention fees, deadlines for bid submission and contract periods) are complied with by SRs. Further, the PMU should strengthen its technical supervision of all civil works.</p>	<p>The PMU will improve its oversight by training, providing technical support if needed to the SRs. Actually, the PMU is in process of recruitment of one additional engineer to support the existing team and will contract supervision firm for each construction. The supervision of construction will be on daily basis and paid accordingly.</p>	<p>PMU coordinator</p>	<p>Immediate</p>
	<p>Recommendation 28 (Significant) The PMU should ensure that tenders advertised by sub-recipients are of high standard by providing standard templates and training.</p>	<p>PMU will validate the procurement plan of all sub recipients and will monitor the quality of tenders. PMU will assure that sub recipients are trained in proper procurement procedures.</p>	<p>PMU coordinator</p>	<p>On going</p>
	<p>Recommendation 29 (Significant) The MOH should ensure that CAMERWA, as soon as possible, develop and adopt a quality assurance policy for all types of health products. The purpose of the policy is to assure the quality of health products procured at the point of dispensing medicines. Also the following points are important to note.</p> <p>(a) The development of the policy requires a consensus and the participation of all stakeholders;</p> <p>(b) After adopting a quality assurance policy, CAMERWA</p>	<p>CAMERWA has commissioned a study to assess a current situation to help Ministry of Health to design a quality assurance Policy according to WHO standard. The PMU will monitor the compliance of CAMERWA to the procurement law and according to MOH Policy and WHO standards.</p>	<p>MOH and CAMERWA</p>	<p>End of Feb 2011</p>

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	<p>should launch a tender to procure the services of one or more laboratories to implement the quality control segment of the policy;</p> <p>(c) The MOH should ensure that CAMERWA seeks technical assistance for the development and costing of the quality assurance policy. A review of the pre-qualification procedures for products, manufacturers and suppliers, and of the rating system for pre-qualification should be included in the terms of reference of this assistance.</p>			
	<p>Recommendation 30 (High) The MOH should ensure that CAMERWA issues an international tender for an enterprise resource planning software meeting its established technical specifications before any further attempt is made to change the software platform. An alternative would be to return to the previously used Exact Globe software in its newest version</p>	<p>CAMERWA, in collaboration with SCMS/USAID, extended the use of SAGE Line 500 to Warehouse management. SAGE Line 500 was customized to meet CAMERWA functional requirements and the go live took place on October 19th, 2010. The system is working quite ok and has enabled the solution to issues that CAMERWA had been experiencing in terms of warehouse management.</p>	CAMERWA DG	Done
	<p>Recommendation 31 (High) The MOH should request CAMERWA to consider adopting the Médecin Sans Frontières (MSF) international drug coding system. This drug coding system is widely used throughout Central Medical Stores in Africa</p>	<p>There is a project that is being carried out by MOH on national recording system. The system shall be integrated.</p> <p>National Medical Products Coding process is on-going and already medicines coding is already completed and we are continuing with other products like laboratory products etc.</p> <p>Our coding system is based on WHO system and which we find easily applicable and user friendly, as it is simple to understand and to use.</p>	MOH/Pharmacy	By Nov 2011, system should be functional
	<p>Recommendation 32 (Significant) The MOH should ask CAMERWA to consider insuring the stock of health products in its warehouses in Kigali against flood damages.</p>	<p>The floods have never occurred in Kigali given the altitude. CAMERWA tried to include this aspect in the insurance request for quotation, but it made the cost very high and there is no provisional fund for this kind of risk.</p>	CAMERWA	NA
	<p>Recommendation 33 (Significant) The MOH should consider strengthening the district pharmacies before integrating the supply of ARVs into the district pharmacy system. The strengthening program should at least be composed of:</p> <p>(a)Evaluating the quarterly volumes of drugs needed for districts and implementing the changes at district pharmacies to accommodate these needs;</p> <p>(b)Recruiting a pharmacist (ideal minimum staff should be a pharmacist, a nurse and an accountant); and</p>	<p>A number of initiatives by MOH and its DPs to strengthen district pharmacies are on-going and ARVs, with medical products like lab products will managed through district pharmacies after thorough assessment on the capacities</p> <ul style="list-style-type: none"> • of the 30 district pharmacies, 25 already have qualified pharmacist and all the staff as mentioned and we are still staffing • Though still challenging, quarterly evaluations are being carried out and we are working on continuous improvements 	MOH/Pharmacy	On going

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	(c)Installing electronic software for pharmaceutical business management and training the district pharmacy staff in its use.	<ul style="list-style-type: none"> By June 2013 all district pharmacies will have obtained medical products management software's, trainings have been on-going and still have to continue 		
	Recommendation 34 (Significant) The MOH should ensure that health centres and district hospital pharmacies adopt a monthly financial reporting system that provides information on pharmacy turnover, debt owed by the Community Health Insurance Scheme to the pharmacy, working capital, and cost of goods sold.	The Ministry of Health will work with the Ministry of Finance to develop a financial system for all Health facilities.	MOH/Pharmacy	June 2012
	Recommendation 35 (Significant) The MOH should ensure that CAMERWA establishes and maintains a monthly record of expired drugs and commodities for the malaria, tuberculosis and HIV programs valued at cost price.	SAGE Line 500 offers this option and the recording is done through the system in a special account and monthly reports are kept.	Finance and Warehouse Departments / CAMERWA	Done
	Recommendation 36 (Significant) The MOH should develop and implement a program for the management and safe disposal of expired drugs.	Health Waste Management Policy is available and the strategic Plan is approved by the Ministry of Health, and will be fully implemented in June 2011 Health Waste management tools, a national industrial incinerator is acquired. The procurement process is almost complete and installation site is being prepared by the Ministry of Health	MOH/ Pharmacy/ Environmental Health Desk/	Strategic plan to be fully operation by FY 2011/2012 Incinerator will be operational by June 2012
Financial Management and Control	Recommendation 37 (Significant) To improve the professional skills of its program accountants, the PMU should consider implementing on-the-job training programs which should include refresher training in the use of the accounting software	The important training budget is allocated in SSF HIV grant for that purpose. A PMU training plan is done on PMU level and it will be the same on SR's Level.	PMU coordinator	31/03/2011
	Recommendation 38 (Significant) To improve the system of budgetary control, the PMU should train program accountants to use the accounting software to monitor grant expenditures against approved budgets	A new Budget control section (5 staff) has been put in place under Administration and finance unit , with clear terms of reference focused on budget control and supportive supervision	PMU coordinator	31/03/2011
	Recommendation 39 (Significant) The PMU should strengthen its supportive supervision and control of sub-recipients' accounting functions in order to remedy the financial management deficiencies noted above.	A new Budget control section (5 staff) has been put in place under Administration and finance unit , with clear terms of reference focused on budget control and supportive supervision	PMU coordinator	Done
	Recommendation 40 (Significant) The PMU should put in place a tool to ensure that SRs	A supervision tool is already elaborated , the training of the budget controllers and auditors newly recruited is planned in Jan 2011	PMU coordinator	31/01/2011

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	routinely correct errors noted by the PMU after reviews of SR quarterly financial reports			
	Recommendation 41 (Significant) The MOH should ensure that the PMU and all SRs file VAT claims timely, at least on a quarterly basis. Further, it is important that the PMU train program managers and accountants to screen invoices received from suppliers to ensure that they conform to RRA requirements	The updated procedure manual and the MOU's stipulate that the VAT must be recovered on quarterly basis. PMU will make sure that the SR's recover VAT timely and train the SR's accountants on how to screen invoices from suppliers to ensure that they conform to RRA requirements.	PMU coordinator	Immediate
	Recommendation 42 (Significant) To ensure accuracy of VAT that has been paid and not yet recovered, the MOH's PMU should train program accountants to use the VAT control account in the accounting software to facilitate tracking/monitoring of VAT to be recovered.	The updated procedure manual and the MOU's stipulate that the VAT must be recovered on quarterly basis. PMU will make sure that the SR's recover VAT timely and train the SR's accountants on how to screen invoices from suppliers.	PMU coordinator	31/12/2010
	Recommendation 43 (Requires attention) The MOH's PMU should ensure that appropriate supervisory controls are put in place at the PMU and all sub-recipients to improve coding of financial transactions.	A new Budget control section (5 staff)has been put in place under Administration and finance unit , with clear terms of reference focused on budget control and supportive supervision	PMU coordinator	Immediate
	Recommendation 44 (Requires attention) The MOH's PMU should ensure that it provides relevant information to sub-recipients on payments it makes on their behalf to enable SRs to update their records and budgetary control.	A new Budget control section (5 staff) has been put in place under Administration and finance unit , with clear terms of reference focused on budget control and supportive supervision	PMU coordinator	immediate
	Recommendation 45 (Significant) The management of CAMERWA should consider adopting an accrual-based accounting system to meet the complex needs of its business. In addition, it needs a comprehensive accounting and administrative manual that provides guidelines on all aspects of its business operations, including an appropriate chart of accounts, policies for treatment of exchange rate differences and maintenance of accounting records	CAMERWA has been running its financials based on cash basis. The recommendation will be implemented before issuing 2010 Financial Statements.	Finance Department / CAMERWA	31 July 2011
	Recommendation 46 (High) CAMERWA should regularly reconcile advances to its suppliers with goods received and invoiced. In addition, CAMERWA should obtain from its suppliers all additional supporting documentation, such as freight and forwarding charges.	This recommendation will be implemented on monthly basis.	Finance Department / CAMERWA	31 December 2010
	Recommendation 47 (High) To facilitate financial control of grant expenditures, CAMERWA should, as far as possible, pay for grant-	This recommendation has been implemented for all expenditures.	Finance Department / CAMERWA	Done

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	financed goods and services from grant bank accounts.			
	<p>Recommendation 48 (Significant) To establish a clear audit trail, CAMERWA should bill the grants for medicines and health supplies after beneficiaries collect the health products.</p>	<p>This recommendation can only be applied for commodities procured through internal purchases in CAMERWA (from CAMERWA owned stock into GF funded stock) and but commodities procured through normal procurements.</p>	<p>Commercial and Finance Departments / CAMERWA</p>	<p>January 2011</p>
	<p>Recommendation 49 (Significant) The MOH should ensure that CAMERWA reimburses the grants for overhead it over-billed. Further, the MOH should ensure that CAMERWA seeks recovery of unutilized funds from WHO.</p>	<p>For the unutilized funds from WHO, CAMERWA has recovered all the funds and reported this to the PR.</p> <p>a) What is called "over-billed" in this report is really not so because we have discovered that in the OIG report the calculation of the management fee was based on the value of the goods at the supplier invoice payment while at CAMERWA the calculation of the management fee is based on the value of the products at the date of the reception in the warehouse of CAMERWA ("valeur des produits rendus" CAMERWA). This is in line with MoU that was signed between CAMERWA and PMU/GF. Please refer to article 3, point 3.2.1 of the MoU signed on September 15, 2006 and article 3, point 3.1.2 of the MoU signed on March 16, 2009. This has been found as the major source of the US \$162,000 which constitutes the discrepancy in this report.</p> <p>We found that there was nothing wrong with the basis of the calculation based on the clauses of the MoU. However, if the OIG calculation basis is the recommendation, then the MoU shall be amended and implemented accordingly.</p> <p>b) Another source of the discrepancy reported (see Round 5 Malaria, phases 1 and 2; pages 18-20 of the detailed report) is related to the ACTs and RDTs orders (2 for RDTs and 1 for ACTs) that were still in pipeline when the OIG team was at CAMERWA. The orders were delivered in 2010 we can provide you with the documents related to these orders.</p> <p>Conclusion: Since our calculation basis differs from the audit team calculation basis, we recommend that LFA comes to verify and then recommend the way forward.</p> <p><u>OIG Comment</u> Since there appears to be a discrepancy between OIG and CAMERWA's calculation we agree with MOH & CAMERWA's recommendation that the LFA should re-verify the calculations and</p>	<p>CAMERWA</p>	<p>Done</p>

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		come to a definite conclusion.		
	<p>Recommendation 50 (Significant) The MOH should ensure that the CNLS traces missing supporting documentation for grant expenditures as noted above within three months of receipt of the final report. Failing that, CNLS should reimburse the grants for these expenditures.</p>	<p>After the record checking and verification of physical vouchers, we find that all hospitalities costs and mission allowances are supported by justifications documents. Which is means that there are no missing documents to support expenses.</p> <p>On expenditures related to radio spots and internet costs the services providers are public companies (Rwandatel and ORINFOR) which ask the payment in advance. There is no definitive invoice but there are other documents supporting expenses.</p> <p>Considering these explanations, there is no need to reimburse the grants because the expenses were supported and related to the objectives of grants.</p>	CNLS/Administrati on and Finance Department	immediate
	<p>Recommendation 51 (High) The MOH's PMU should strengthen its capacity to perform regular financial reviews of all its sub-recipients including the CNLS.</p>	<p>For accounting errors there are no specifics comments and there is no impact on Global Fund's financing because every month we make reconciliation.</p> <p>To avoid these multiple errors and improve financial management, CNLS have replaced the accountant.</p>	CNLS	Done
	<p>Recommendation 52 (Significant) The MOH should ensure that the CCM Secretariat traces missing supporting documentation for grant expenditures, as shown above, within three months of receipt of the final report. Failing that, the CCM Secretariat should reimburse the grants for these expenditures.</p>	<p>Missing supporting documentation are available now (CCM office)</p> <p><u>OIG Comment</u> We recommend that the Secretariat should ask the LFA to verify the availability of the missing supporting documentation.</p>	CCM Secretariat	Done
	<p>Recommendation 53 (High) Although the CCM Secretariat no longer receives funding from the Global Fund, the MOH's PMU should ensure that it follows up on the above findings, particularly the lack of recovery of VAT taxes and missing supporting documentation.</p>	<p>The MOH's PMU will ensure that it follows up on the above findings, particularly the lack of recovery of VAT taxes and missing supporting documentation.</p>	PMU coordinator	immediate
	<p>Recommendation 54 (Significant) The MOH's PMU should ensure that advances made to implementing organizations are not treated as expenditures until the program activities are implemented. Further, these advances should be monitored in a control account until a full accounting is provided by the recipient of funds</p>	<p>The MOH's PMU will ensure that advances made to implementing organizations are not treated as expenditures until the program activities are implemented.</p>	PMU coordinator	immediate

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	<p>Recommendation 55 (Significant) To ensure that there are no cost overruns, the MOH's PMU should ensure that sub-recipients use the budgetary control module of the accounting software. Further, SR program and finance officials should analyse and explain variances every quarter and bring significant issues to the attention of senior management</p>	<p>The MOH's PMU will ensure that sub-recipients use the budgetary control module of the accounting software (essentially in new government software) through the supportive supervision that will be done by budget controllers</p>	PMU coordinator	31/07/2011
	<p>Recommendation 56 (Significant) The MOH's PMU should ensure that all district hospitals use financial information from the Tompro accounting software to prepare the quarterly financial reports.</p>	<p>The MOH's PMU will ensure that sub-recipients use the budgetary control module of the accounting software (essentially in new government software) the supportive through the supervision that will be done by budget controllers</p>	PMU coordinator	31/07/2011
	<p>Recommendation 57 (Requires attention) The MOH's PMU should ensure that all accountants at its SRs and implementing organizations make regular back-ups of the Tompro accounting software.</p>	<p>The MOH's PMU will ensure that sub-recipients make regular back-ups of accounting data thru the supportive supervision that will be done by budget controllers</p>	PMU coordinator	immediate
	<p>Recommendation 58 (Significant) The MOH's PMU should ensure that all accountants at its SRs and implementing organizations prepare monthly bank reconciliations</p>	<p>The MOH's PMU will ensure that all accountants at its SRs and implementing organizations prepare monthly bank reconciliations through the budget controllers' regular supervision.</p>	PMU coordinator	Immediate
	<p>Recommendation 59 (Significant) The MOH's PMU should ensure that incompatible stock management and control duties at the health centres are segregated.</p>	<p>The MOH's PMU will ensure that incompatible stock management and control duties at the health centres are segregated.</p>	PMU coordinator	31/03/2011
Governance and Program Oversight	<p>Recommendation 60 (High) In order to provide adequate audit oversight of the operations of CAMERWA, the MOH should ensure that the Board of Directors of CAMERWA appoints an internal auditor for CAMERWA who reports directly to the board.</p>	<p>CAMERWA is in the process of recruiting a professional audit company which will be performing internal audit and reporting to the Board of Directors on quarterly basis. The contract will be signed not later than January 31st, 2011.</p>	CAMERWA DG	31 January 2011.

Annex 5: Global Fund Secretariat's Overall Comments and Responses

11 March 2011

John Parsons
Inspector General
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The Global Fund
Chemin de Blandonnet 8
1214 Vernier
GENEVA
Switzerland

Dear John

Country Audit of Grants Financed by the Global Fund in Rwanda

The Secretariat would like to thank the Office of the Inspector General (OIG) for its collaboration during the audit of the 10 grants financed by the Global Fund in Rwanda. The feedback provided by the Secretariat during the review of the Rwanda Audit Report is a result of combined efforts from the Country Coordinating Mechanism (CCM), Principal Recipient (PR), Local Fund Agent (LFA), and the dedicated team of professionals within the Secretariat.

The CCM and the PR, in collaboration with partners and the Secretariat, have already started carrying out measures to mitigate identified risks related to program oversight as well as financial and procurement and supply chain management. The Secretariat will continue working closely with the Rwanda CCM and the LFA to monitor the implementation of the agreed-upon audit recommendations.

A. Contextual background

In Rwanda, the Global Fund has significantly invested resources in HIV/AIDS, tuberculosis, malaria, and health systems strengthening. The funding complemented partners' support and helped achieve noteworthy results, among which the following:

- As of 31 March 2010, key results attributable to the GF include over 30,000 people on ARVs (one third of the national outcome).
- The achievement of treatment success rates spanned between 86 and 87 percent for the last three cohorts (2006-2008) of sputum positive tuberculosis patients.

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- HIV testing of tuberculosis suspects has become universal.
- Case management of malaria has improved thanks to the provision of effective ACTs, provision of Long lasting insecticide treated bednets (LLINs), promotion of community-based interventions, such as home-based management of fever, management of malaria epidemics, and indoor residual spraying.
- All public health facilities confirmed diagnosed cases with microscopy or rapid diagnostic tests before treatment, as of the end of 2009.

B. Summary of key risks identified and actions to be taken by the Secretariat

The following section summarizes key risks and challenges identified and comment from the Secretariat.

Challenges and key risks noted by the OIG	Secretariat comments, measures to address the identified risks
<p>1. Weak oversight on sub-recipients (SR) by the Programme Management Unit (PMU)</p>	<p>The consolidation of 3 HIV grants and 3 TB grants reduces the number of grant budgets and bank accounts to be monitored and managed. This should alleviate the burden of work of the PR/PMU.</p> <p>In November 2010, the PMU recruited budget comptrollers and internal auditors to strengthen its SR oversight and internal audit functions. In addition, training sessions were conducted for the new staff to ensure the effective use of the accounting software to monitor grants' expenditures and track VAT to be recovered from the Rwanda Revenue Authority. The PMU also developed finance related monitoring tools.</p> <p>The LFA and the Secretariat will follow up on the PMU's performance in these areas throughout 2011.</p>
<p>2. Expenditures with missing/inadequate supporting documents</p>	<p>The Secretariat requests that the OIG provides the final list of items to be recovered as the auditee has provided information on supporting documents between April 2010 and now.</p> <p>The Secretariat also requests the collaboration of the OIG to define the scope of work of the LFA so the disputed or/and justified items can be reviewed and recovered in the most efficient manner.</p>
<p>3. Review of the method of calculating error margins of on-site data verifications (OSDV) and appropriateness of recommendations before sharing with the CCM</p>	<p>In parallel to its work conducted to enhance the OSDV tool, the Secretariat will continue the practice of carefully reviewing recommendations issued by the LFA and sharing them with the PR as it was done in the past.</p> <p>A revised OSDV tool has been developed and is being piloted to improve the previous one.</p>
<p>4. Review and revision of the performance monitoring frameworks of the two active malaria grants. Indicators that are simply counting inputs should be removed and followed</p>	<p>The Secretariat, as a follow up to the Global Fund 5 year evaluation, initiated systematic efforts to address M&E related weaknesses.</p> <p>The main actions implemented include (i) the use of national targets where possible, (ii) a clear definition of denominators</p>

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<p>through an appropriate management information system. For the output indicators appropriate denominators should be selected based on real epidemiological and demographic information rather than on planning targets.</p>	<p>and clear assumptions for indicators included in Performance Frameworks, and (iii) support for national M&E system strengthening.</p> <p>In Rwanda, a comprehensive review of the programme life cycles helped define an appropriate set of results-based national indicators. The performance frameworks of the recently signed single stream grants for HIV and tuberculosis encompass these changes. A similar process will be conducted for malaria grants in 2011.</p>
<p>5. LFA grant oversight and role in verifying the data reported by the Principal Recipient in the six-monthly project update reports</p>	<p>The LFA opened an office in Rwanda in June 2010. Its in-country presence will certainly allow for greater interactions with the PRs, SRs, and partners thereby strengthening the quality of verification, analysis and risk management.</p> <p>The Secretariat has taken note of the concern and would like to confirm that the LFA data verification process goes beyond counting of numbers.</p> <p>Though it is important to verify that the country reports accurate data (which is important to propel it to achieve good results at outcome and impact levels), the LFA also analyses the data in the narrative section of the PU/DR and provides contextual information to explain variances and discrepancies. This is followed by the formulation of recommendations aimed at enhancing data quality which is used for planning and especially quantification of health products, which are shared with the PR.</p>
<p>6. Timely completion of phase two assessments of the grants.</p>	<p>We take note of this recommendation.</p> <p>The Secretariat will enhance the joint work with the CCM, PR, and LFA to ensure the negotiation and signing within minimal timelines.</p>

The Secretariat thanks the Office of the Inspector General for the completion of this report and is looking forward to a constructive engagement on matters raised in this letter.

Sincerely,

Jonathan Brown
Acting Director of Country Programs

Annex 6: Global Fund Secretariat's Response to the Secretariat and LFA Oversight Recommendations and Management Action Plan

Prioritization of recommendations

a. High priority: Material concern, fundamental control weakness or non-compliance, which if not effectively managed, presents material risk and will be highly detrimental to the organization's interests, significantly erodes internal control, or jeopardizes achievement of aims and objectives. It requires immediate attention by senior management.

b. Significant priority: There is a control weakness or noncompliance within the system, which presents a significant risk and management attention is required to remedy the situation within a reasonable period. If this is not managed, it could adversely affect the organization's interests, weaken internal control, or undermine achievement of aims and objectives.

c. Requires attention: There is a minor control weakness or noncompliance within systems and proportional remedial action is required within an appropriate timescale. Here the adoption of best practice would improve or enhance systems, procedures and risk management for the organization's benefit.

Audit Area	Recommendation	Response and action	Responsible official	Completion Date
GF Secretariat and LFA oversight	Recommendation 61 (Requires attention) The Country Programs Cluster of the Global Fund Secretariat should review the role of the LFA in verifying the data reported by the Principal Recipient in the six-monthly project update reports. Consideration should be given to asking the LFA to use its local knowledge to comment on the usefulness and significance of the information that is being collected.	We take note of this recommendation and would like to share the following factual information: <ul style="list-style-type: none"> - The LFA data verification process is not only limited to counting of numbers which is a standard approach to data quality assurance. Though it is important to verify that the country reports accurate data (which is important to propel it to achieve good results at outcome and impact levels), the LFA also analyses the data in the narrative section of the PU/DR and provides contextual information to explain variances and discrepancies. This is followed by the formulation of recommendations aimed at enhancing data quality which is used for planning and especially quantification of health products, which are shared with the PR. For one to appreciate the results, the data has to be assessed together with the narrative section. - The LFA now has an in-country presence in Kigali which can only help strengthen the quality of its work, which is already appraised as satisfactory by the EAIO Team. 	CP and M&E	Completed
	Recommendation 62 (High) The Global Fund Secretariat should review	We take note of this recommendation and would like to provide the following comments: <ul style="list-style-type: none"> - The OSDV limitations have been identified internally by the Global Fund Secretariat and a process is already on-going to revise the OSDV tool, make it more comprehensive, revise 	CP and M&E	Completed

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Audit Area	Recommendation	Response and action	Responsible official	Completion Date
	<p>the method of calculating error margins in on-site data verifications and make the necessary corrections to avoid generating erroneous results. The Global Fund's Country Programs Cluster should carefully review the conclusions, requirements and recommendations made by the LFA OSDV reports as to their feasibility and appropriateness before communicating the results to the CCM.</p>	<p>the sample size, and make the results statistically significant to be generalizable across the grants and system. The revised tool is being piloted in a few countries including Rwanda and India.</p> <ul style="list-style-type: none"> - The results of previous OSDV conducted in Rwanda were carefully reviewed and analysed before recommendations were sent to the Principal Recipient. The Secretariat will ensure that this practice continues. 		
	<p>Recommendation 63 (High) The Country Programs Cluster should ensure that phase two assessments of the grant programs are done on a timely basis. Further, in order not to disrupt implementation of grant programs, the Country Programs Cluster should ensure that it reviews its existing grant processes in order to facilitate the negotiation and signing of approved grants on a timely basis.</p>	<p>We take note of this recommendation. GF Secretariat will enhance the joint work with the CCM, PR, and LFA to ensure the negotiation and signing within minimal timelines, as they do not only lay within the timeliness of phase 2 reviews.</p>	CP	Continuous - At the time of renewal of grants
	<p>Recommendation 64 (Requires attention) The Global Fund's Country Programs Cluster should at the earliest possible opportunity enter into negotiation with the CCM to review and revise the performance monitoring frameworks of the two active malaria grants. Indicators that are simply counting inputs should be removed and followed through an appropriate management information system. For the output indicators appropriate denominators should be selected based on real epidemiological and demographic information rather than on planning targets.</p>	<p>As a follow up to the Global Fund 5 year evaluation, systematic efforts were initiated with countries receiving Global Fund grants, including Rwanda to address M&E related weaknesses. Among these is a denominator definition for indicators included in Performance Frameworks (PF) with clear assumptions, the use of national targets wherever possible, support for national M&E system strengthening with the move away from grant specific M&E plans and monitoring systems that resulted in parallel systems in a number of countries.</p> <p>In Rwanda, World Bank GAMET was brought on board to assist in the overall system assessment and the development of a road map for implementation of priority interventions. This process is now owned by the country.</p> <p>The GF Secretariat places an emphasis on deriving a good balance across output, outcome and impact level measurement. The selection and inclusion of indicators in the PF is largely guided by the programme life cycle and in the case of health systems strengthening by the nature of interventions. Naturally, new initiatives will require the tracking of lower level indicators during the formative stage and gradually move to tracking interim to long term results-based indicators.</p> <p>As completed for the TB and HIV SSF grants, a full review of indicators is being conducted for the phase 2 of Round 3 RCC malaria recently approved by the Board. The same process will be applied to Round 8 continued funding.</p>	CP and M&E	At the phase 2 renewals of Round 3 RCC and Round 8 malaria grants