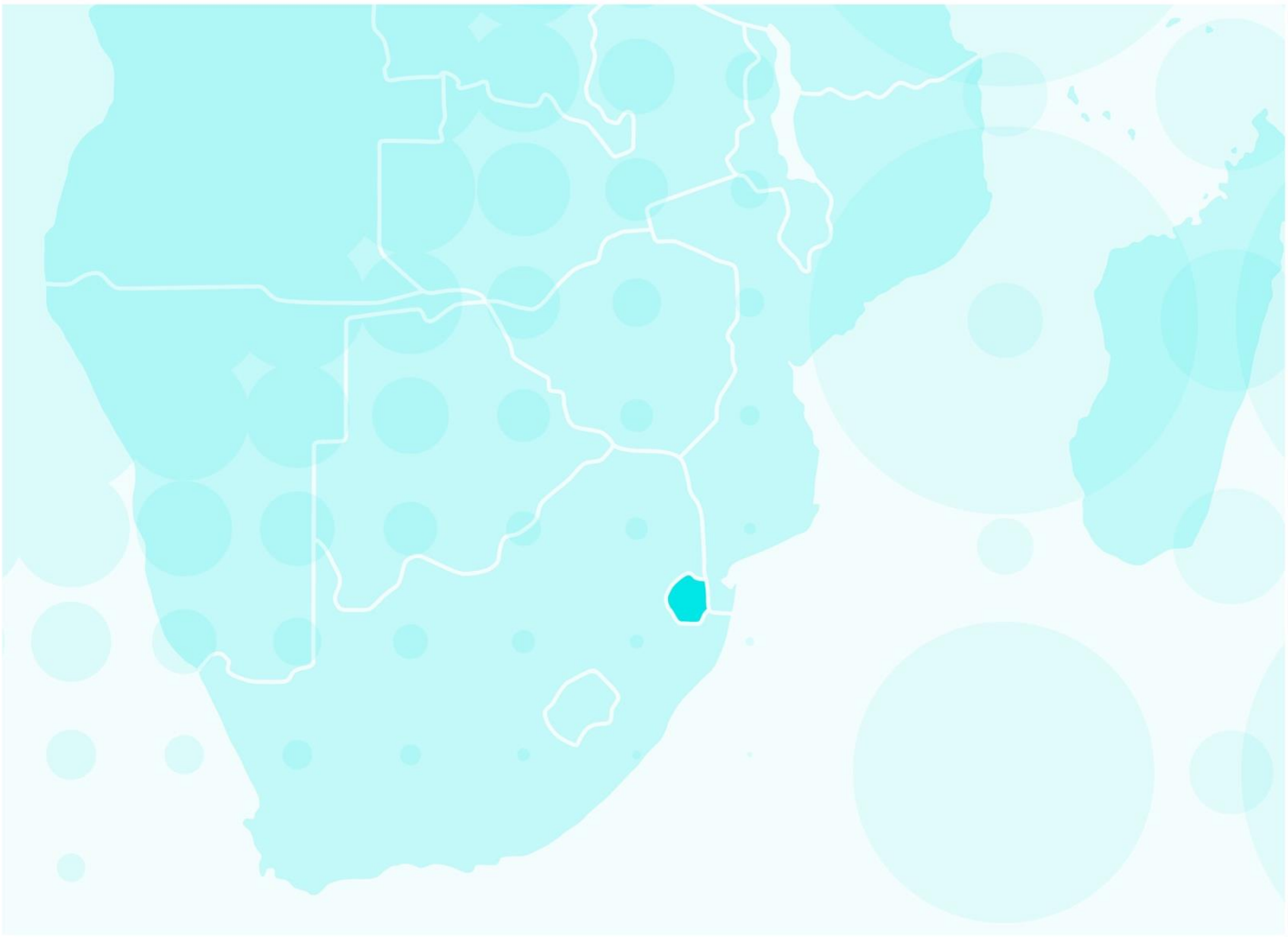

Audit Report

Global Fund Grants to the

Kingdom of Eswatini

GF-OIG-24-018
5 December 2024
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Eswatini is making significant strides in the fight against HIV, Tuberculosis (TB) and malaria. The country has surpassed UNAIDS' 95-95-95 targets, reporting 99-97-98 in 2023.[1] It is among the Elimination 8 (E8) countries working to eliminate malaria by 2030, and has surpassed the 2020 WHO End TB milestones in reducing TB incidence.

The performance of the HIV grants is mostly positive, showing a strong trend in key impact indicators. There have been significant reductions in both new HIV infections and AIDS-related deaths, which decreased by 71% and 55% respectively, between 2010 and 2022.

Despite these achievements, some areas require improvement. Specifically, there is a need to address the low coverage, limited oversight, commodity stock-outs, and operational challenges in HIV interventions targeting Adolescent Girls and Young Women (AGYW), HIV Exposed Infants (HEIs) as well as people living with HIV coinfected with TB. While AGYW constitute 15% of Eswatini's population, they accounted for 69% of new HIV infections in 2023. In the same year, 40% of HEIs were not tested or did not receive Early Infant Diagnosis (EID) test results at birth. The country also has high co-infection rates: 65% for drug-sensitive TB (DS-TB) and 68% for drug-resistant TB (DR-TB). AGYW, Prevention of Mother to Child Transmission, and HIV/TB interventions are rated as **partially effective**.

The Global Fund and partners have made significant investments towards strengthening data systems in Eswatini.[2] A Client Management Information System has been rolled out to 73% of health facilities and integrated with the laboratory information system. Despite the investments, design gaps and significant delays in their roll out have led to continued reliance on multiple non-interoperable and manual data systems. This affects the timely availability of reliable programmatic and logistics data, and compromises end-to-end visibility of the supply chain. Inadequate governance arrangements and national policies on data systems, as well as suboptimal project management, impact the timely delivery and implementation of these critical data systems. Resilient and Sustainable Systems for Health and COVID-19 Response Mechanism interventions to ensure timely availability of quality programmatic and logistic data **need significant improvement**.

The Global Fund Secretariat has supported financial and grant management for Principal Recipients through technical assistance, and by funding a financial accounting and reporting system. The Country Coordinating Mechanism is fully constituted and is developing a performance monitoring dashboard. However, gaps in oversight, coordination, and financial management persist. Sub-optimal stakeholder coordination leads to duplicated efforts and missed synergies, while inadequate monitoring of government co-financing causes delays in health commodity disbursements and service disruptions. The adequacy and effectiveness of procurement and financial controls to safeguard grant resources are **partially effective**.

[1] UNAIDS Data, 2023. 95-95-95 target refers to 95% of people living with HIV knowing their HIV status, 95% of people who know their status receiving HIV treatment, and 95% of people on treatment virally suppressed.
[2] In Grant Cycles 5 and 6 (GC5, GC6), the Global Fund allocated 94% of its resilient and sustainable systems for health (RSSH) investments towards strengthening data systems

1.2 Key Achievements and Good Practices

Significant progress made in the fight against the three diseases

In 2020, Eswatini was the first African country to achieve the UNAIDS "95-95-95" HIV targets.[3] Between 2010 and 2022, new HIV infections decreased by 71% and AIDS-related deaths by 55%.[4] On the prevention front, Eswatini scaled up Pre-Exposure Prophylaxis (PrEP) during Grant Cycle 6 (GC6) and plans further scale-up in Grant Cycle 7, with new prevention modalities such as the dapivirine vaginal ring and injectable cabotegravir.

Eswatini exceeded WHO's End TB Strategy target[5] by reducing TB incidence by 50% and TB mortality by 31% between 2015 and 2022.[6] The country rolled out shorter TB Preventive Treatment (TPT) regimens and, with Global Fund support, conducted a TPT surge campaign that increased coverage among people living with HIV (PLHIV). With support from the Global Fund and partners, Eswatini has improved its diagnostic capacity by installing 64 GeneXpert machines,[7] genome sequencing machines, and 19 m-PIMA point-of-care testing machines.

Eswatini is part of the E-2025 initiative for malaria elimination. Estimated malaria cases and malaria-related deaths both decreased between 2010 and 2022,[8] with malaria incidence per 1,000 population at 0.6 in 2022, the lowest in the preceding 5 years.

Strong government financial commitment and multi-stakeholder involvement in disease programs

The government of Eswatini funds first-line TB and malaria medicines for adults and partly funds first-line adult antiretroviral medicines. The government allocates approximately US$15 million annually for antiretroviral medicine procurement and has established the End Malaria Fund to mobilize sustainable domestic resources for malaria elimination. Multiple partners, both multilateral and bilateral, are involved in the fight against the three diseases and in health systems strengthening in Eswatini.

Efforts to improve data systems to support availability of quality data

Through Global Fund and partner support, Eswatini is currently rolling out a Client Management Information System (CMIS) that captures patient-level data. Through GC6 grants, CMIS has been integrated to the laboratory information system, enabling lab test results to be linked to patient records. Additionally, the country is currently piloting an electronic Logistics Management Information system (eLMIS). These initiatives should improve the timely availability of quality data to support real-time eLMIS and improved decision-making.

1.3 Key Issues and Risks

Inadequate supervision, stock-outs and operational issues in interventions for vulnerable populations could undermine HIV gains

Several challenges hinder the impact of Eswatini's interventions for vulnerable populations, including TB/HIV co-infected patients, adolescent girls and young women (AGYW), and children. In 2023, only

[3] WHO - Eswatini achieves the 95-95-95 HIV treatment target - a decade ahead of 2030 goal - accessed (30 Aug 2024)
[4] UNAIDS data, 2023
[5] The WHO End TB Strategy aims for a 90% reduction in TB deaths and an 80% reduction in the TB incidence rate by 2030, compared to the 2015 baseline. Milestones for 2020 include a 20% reduction in the TB incidence rate and a 35% reduction in TB deaths.
[6] WHO Global TB program data
[7] National TB Program data
[8] World Malaria Report, 2023

6% of presumptive TB cases among PLHIV had sputum samples collected and/or tested, leading to high co-infection rates of 65% for drug-sensitive TB (DS-TB) and 68% for drug-resistant TB (DR-TB). In 2023, 40% of HIV Exposed Infants (HEIs) were not tested or did not receive Early Infant Diagnosis test results at birth, and only 32% received Nevirapine prophylaxis. Consequently, 50% of Mother-to-Child Transmission (MTCT) infections occurred during breastfeeding, and only 85% of HIV-positive infants were initiated on antiretroviral treatment.

Although AGYW constitute 15% of Eswatini's population, they accounted for 69% of new HIV infections in 2023. AGYW interventions are not implemented in all constituencies, leaving 12% of AGYW without coverage. There has been a decline in AGYW initiated on PrEP, and no tailored interventions for AGYW who are sex workers. Consequently, HIV incidence among AGYW has only marginally declined, from 1.7% to 1.6%. Limited oversight and supervision, commodity stock-outs and operational challenges contributed to these issues.

Implementation of RSSH and C19RM interventions needs to improve, to ensure timely availability of quality health and supply chain data

While the Global Fund has invested significantly to strengthen systems for health and supply chain data, design gaps and delays in rolling out critical systems such as the Client Management Information System and electronic Logistics Management Information System have resulted in continued reliance on multiple non-interoperable and manual data systems.

This affects the timely availability of reliable data and compromises end-to end visibility of the supply chain. Suboptimal project management practices, along with inadequate governance structures and national guidelines for data systems, contributed to the delays in the data systems roll-out.

Better oversight and coordination is needed to ensure effective and efficient use of grant resources

The Global Fund Secretariat has strengthened finance and grant management for Principal Recipients, using a system for processing financial and procurement transactions to enhance controls and automation, and the Country Coordinating Mechanism (CCM) is developing a dashboard to monitor grant performance.

However, gaps in oversight, coordination, and procurement and financial management persist. Sub-optimal stakeholder coordination, including government and donor partners, has led to duplicated efforts and missed synergies. Inadequate monitoring of government co-financing commitments has caused delays in health commodities disbursements, resulting in shortages and service disruptions. Delays in reporting and communication between Principal Recipients and the CCM hinder timely decision-making and corrective actions, potentially compromising programmatic gains and grant resources over time.

1.4 Objectives, Ratings and Scope

The overall objective of the audit was to provide reasonable assurance to the Global Fund Board on the adequacy and effectiveness of Global Fund grants to the Kingdom of Eswatini. The audit's specific objectives, ratings and scope are outlined in the table below:

Objectives	Rating	Scope
AGYW, PMTCT and HIV/TB interventions to ensure the achievement of grant objectives	**Partially Effective**	**Audit period** January 2022 to December 2023
RSSH and C19RM interventions to ensure timely availability of quality programmatic and logistic data	**Need Significant Improvement**	**Grants and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund-supported programs.
Procurement and financial controls to safeguard grant resources	**Partially Effective**	

OIG auditors visited five health facilities in five *tinkhundla* (constituencies) across the four regions of Eswatini, which collectively account for 21% of people living with HIV receiving antiretroviral treatment in 2023, and 24% of TB cases in the same year. The OIG also visited the Central Medical Store in Matsapha.

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

2. Background and Context

2.1 Country Context

The Kingdom of Eswatini, a low-middle-income country in Southern Africa, has a population of 1.2 million with an annual growth rate of 0.8%. Its gross domestic product (GDP) per capita was US$3,987 in 2022, showing a growth of 0.5% compared to 3% in 2021. Administratively, the country is divided into four regions, further subdivided into 55 *tinkhundla* (constituencies).

Eswatini's HIV prevalence rate of 27% among adults aged 15-49 is among the highest globally. Additionally, Eswatini ranks among the top 30 countries in the world with a high burden of TB/HIV co-infection.

Eswatini faces challenges in its healthcare systems, impacting healthcare services delivery. Human Resources for Health are strained, characterized by a very low doctor-to-patient ratio. As of 2020, there was only one doctor per 10,416 people.

Country data[9]	
Population	1.2 million (2024)
GDP per capita	US$3,987
Corruption Perception Index	130/180
UNDP Human Development Index	142/193 (2022)
Government spending on health (% of GDP in 2021)	7.04

[9] UNFPA World population dashboard (https://www.unfpa.org/data/world-population/SZ) , World Bank Eswatini Country profile (https://data.worldbank.org/country/eswatini), UNDP Human Development Index - Eswatini Country profile (https://hdr.undp.org/data-center/specific-country-data#/countries/SWZ), Transparency International Corruption Perception Index (https://www.transparency.org/en/cpi/2022/index/swz) (all accessed on 5 July 2024)

2.2 Global Fund Grants in Eswatini

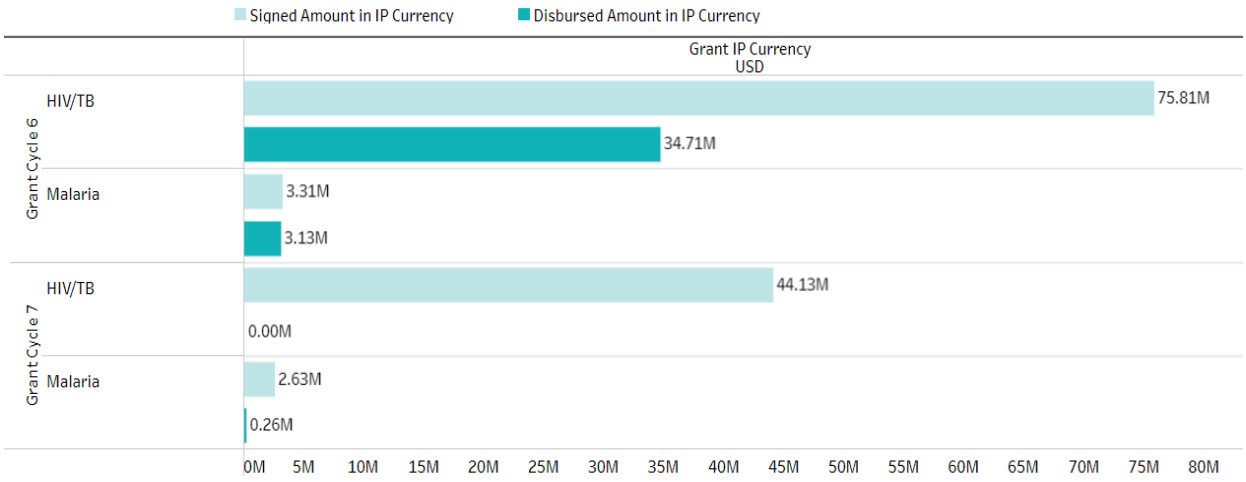
Since 2003, the Global Fund has signed grants totalling over US$422 million and disbursed more than US$341 million to the Kingdom of Eswatini.[10] Grants for the funding allocation period 2020-2022 amount to US$80 million, of which 47% has been disbursed.[11]

For Grant Cycle 6, the National Emergency Response Council on HIV/AIDS (NERCHA) and Coordinating Assembly for NGOs (CANGO) are the Principal Recipients for the following Global Fund grants:

- Combined HIV/TB grant: US$55 million
- COVID-19 Response Mechanism (C19RM) grant: US$22 million
- Malaria grant: US$3 million[12]

The national disease programs (i.e., Swaziland National AIDS Program, National Tuberculosis Program, and Malaria National Malaria Control Programme) are the implementers for the HIV/TB, malaria and C19RM grants, and report to NERCHA. In addition to the national disease programs, there are four other sub-recipients under CANGO for the HIV/TB grants. Overall, the grants are implemented either directly by dedicated national disease programs or through sub-implementers from civil society organizations, coordinated and overseen by NERCHA and CANGO as Principal Recipients.

Figure 1: Funding allocation (GC6 & GC7 as of June 2024)



[10] Global Fund's Data Explorer, Eswatini profile (https://data.theglobalfund.org/location/SWZ/financial-insights) (Accessed 30 Aug 2024)
[11] i.e., October 2021 to September 2024 implementation period
[12] Implementation period for the Malaria grant is January 2021 to December 2023

2.3 The Three Diseases

HIV / AIDS

Eswatini has the **highest adult HIV prevalence** globally.

Eswatini demonstrated a marginal reduction in prevalence from 28% in 2010 to 26% in 2022.

220,000 people are living with HIV in Eswatini, of whom 99% (217,067) know their status. Among identified people living with HIV (PLHIV), 97% (211,483) were on treatment and 98% (207,835) were virally suppressed.

Annual **new infections decreased** by **71%** between 2010 and 2022.

AIDS-related deaths reduced by **55%** between 2010 and 2022.

Source: UNAIDS Data, 2023

TUBERCULOSIS

Eswatini is among the **WHO 30 high HIV/TB burden** countries list.

In 2022, Eswatini had an estimated incidence of 325 cases of Drug Susceptible TB, 19 of MDR/RR TB and 187 TB/HIV per 100,000 population.

TB treatment success rate was **79% (DS TB)** and **78% (DR TB)** in 2022, below WHO End TB strategy targets.

2022 **Tuberculosis case notifications** (% all forms) was 61%.

Source: WHO Global TB Report 2023; 2022 WHO TB profile for Eswatini

MALARIA

Eswatini is part of **E-2025 initiative** of the malaria eliminating countries for 2025 with a nationwide elimination programme.

20% reduction in estimated **malaria cases** between 2010 and 2022.

50% reduction in estimated **malaria-related deaths** between 2010 and 2022.

Source: World Malaria Report 2023

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

GC6 Grant performance and grant ratings are shown below:[13]

Comp	Grant	Principal Recipient	Grant Period	Total Signed Amount (USD)	Total Budget Amount (USD)	Budget as at Dec. 23 (USD)	Expenditure as at Dec. 23 (USD)	Absorption as at Dec. 23	June 2021	Dec 2021	June 2022	Dec 2022	June 2023	Dec 2023
HIV and TB	SWZ-C-NERCHA	National Emergency Response Council on HIV and AIDS (NERCHA)	1 Oct 21 - 30 Sept 24	68,661,783	69,231,838	37,071,923	17,934,568	48%	N/A		C 5	C 5	C 5	C 5
HIV and TB	SWZ-C-CANGO	Coordinating Assembly of Non-Governmental Organizations (CANGO)	1 Oct 21 - 30 Sept 24	7,152,464	7,562,026	5,324,086	4,394,824	83%	N/A		C 5	B 5	A 4	B 2
Malaria	SWZ-M-NERCHA	National Emergency Response Council on HIV and AIDS (NERCHA)	1 Jan 21 - 31 Dec 23	3,307,624	3,307,624	3,307,624	3,072,915	93%	A1	C 5	C 5	B 4	C 4	C 2
Total				**79,121,871**	**80,101,488**	**45,703,633**	**25,402,307**	**56%**						

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels of the key risk categories covered in the audit objectives for the Eswatini portfolio, with the residual risk that exists based on the OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanation of differences are detailed in Annex B of this report.

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit issues
Programmatic	HIV: program quality	**Moderate**	**Moderate**	4.1
Monitoring and evaluation and supply chain management	Monitoring and evaluation	**Moderate**	**High**	4.2
	In-country supply chain	**Very High**	**Very High**	
Financial and procurement controls, and Governance	Procurement	**High**	**Moderate**	4.3
	In-country governance	**Moderate**	**Moderate**	
	Accounting and financial reporting	**Moderate**	**Moderate**	

[13]Effective January 2022, Global Fund Revised PU/DR and Performance Ratings with programmatic performance assessed via alphabetic ratings while financial performance assessed via numerical ratings. (Accessed 25 June 24)

4. Findings

4.1 Significant progress made against HIV, but gaps persist in interventions for vulnerable populations

Eswatini has made significant strides in its fight against HIV, with some of the highest rates of testing and treatment coverage in the world. However, inadequate supervision, stock-outs and operational issues in interventions for vulnerable populations could undermine these gains.

Eswatini has one of the highest HIV prevalence rates globally, with an estimated 220,000 people living with HIV (PLHIV) in the country. Eswatini has surpassed the UNAIDS 95-95-95 target, achieving 97-99-98 in 2023 compared to the Eastern and Southern Africa average of 92-83-77 and the global average of 86-89-93. HIV prevalence has declined from 27% to 24%, and HIV incidence among adults has dropped from 1.13 to 0.62.[14] New HIV cases also decreased by 22% between 2022 and 2023.[15] However, inadequate supervision, commodity stock outs and operational challenges limit the impact of interventions targeting vulnerable populations, including TB co-infected patients, adolescent girls and young women, and children.

TB/HIV co-infection interventions: Eswatini has a robust HIV testing program among TB patients, achieving a 99% testing rate and 98% antiretroviral treatment coverage in 2023. Additionally, 97% of PLHIV were screened for TB in the same year. However, the effectiveness of the HIV/TB interventions was hampered by significant leakages. Sputum samples were collected and/or tested in only 6% (1,541/23,910) of TB presumptive cases among PLHIV.[16]

This high leakage hinders progress against HIV/TB coinfection; TB/HIV co-infection remains high at 65% (DS-TB) and at 68% for drug resistant TB.[17] Consequently, Eswatini continues to be classified among the 30 high-burden countries for TB/HIV co-infection.[18] Furthermore, Eswatini missed its target of reducing the TB mortality among PLHIV to 31 per 100,000 population, achieving 54 per 100,000.

Early Infant Diagnosis (EID) implementation: Eswatini has made significant progress towards eliminating Mother-to-Child Transmission (MTCT), reducing rates from 6.3% to 1.3% between 2017 and 2022.[19] Antiretroviral treatment coverage among pregnant women is 97%, supported by a mentor mothers' program funded by the Global Fund. However, in 2023, 40% of HIV Exposed Infants (HEIs) were not tested and/or did not receive the required EID test results at birth. Prophylaxis coverage remains low, with only 32% of HEIs being initiated on Nevirapine. 50% of MTCT infections occurred during breastfeeding,[20] and 85% of HIV-positive infants were initiated on antiretroviral treatment in 2023.[21]

Adolescent Girls and Young Women (AGYW) interventions: AGYW interventions are not implemented in 10 *tinkhundla* (constituencies), leaving approximately 21,931 (12%) AGYW without coverage. Additionally, there has been a decline in the number of AGYW initiated on Pre-exposure prophylaxis (PrEP), and an increase in PrEP refusal among AGYW in Global Fund-supported *tinkhundla.*[22]

[14] Swaziland HIV Incidence Measurement Survey (SHIMS 3 and SHIMS 2) (accessed 26 June 24)
[15] Annual HIV Program Report, 2023
[16] National HIV Program data
[17] National TB Program data
[18] 2023 WHO Global TB Report
[19] Eswatini PMTCT Impact Measurement Survey, 2022
[20] Eswatini PMTCT Impact Measurement Survey, 2022
[21] 2023 Annual HIV Program Report
[22] PrEP refusal rate among eligible AGYW increased from 27% (2022) to 75% (2023) GF supported Tinkudla (CANGO program data)

Despite 45% of Female Sex Workers (FSW) being below 25 years old and having an HIV prevalence of 59%,[23] there are no tailored interventions for AGYW who are FSWs. The audit noted service provision gaps for AGYW. These include the lack of a mandate for youth supporters/facilitators to provide biomedical support and assist AGYW after HIV testing services referral (i.e. treatment initiation, adherence, and viral load suppression). Additionally, there are no referral mechanisms for preventive and curative services for AGYW reached through in-school interventions.

These gaps have contributed to a disproportionately higher impact of HIV among AGYW in Eswatini. Although AGYW constitute approximately 15% of the country's population, they accounted for 23% of new HIV infections and 69% of new HIV infections in 2023. Furthermore, only 86% of HIV-positive AGYW were initiated on antiretroviral treatment in 2023;[24] 16% of AGYW are unaware of their HIV status, and only 73% of those on treatment are virally suppressed.[25] Consequently, there has only been a marginal decline in the high HIV incidence rate among AGYW, from 1.7% to 1.6%.[26]

Limited oversight, commodity stock-outs and shortages, as well as other operational challenges, are key contributing factors to the above issues:

Sub-optimal supervision and oversight of vulnerable population interventions: Despite the establishment of a National TB/HIV Coordinating Committee (NCC) to spearhead the TB/HIV co-infection response, the committee has been ineffective in fulfilling its mandate. Only three out of the nine required quarterly NCC sessions were held. Furthermore, action points raised during these sessions lacked implementation timelines and were not followed up on in subsequent meetings. The Technical Working Group (TWG), which oversees and spearheads AGYW interventions, only held four out of nine required meetings between 2022 and May 2024. National programs are responsible for supportive supervision and monitoring, but only provided limited supportive supervision during the period under review. The OIG noted a lack of supervision at health facilities and low absorption (7%) of grant funds allocated for supervision.

*Commodities shortages and stock-outs***:** Stock-outs and shortage of key TB diagnostic tools[27] and key EID diagnostic tools[28] were observed centrally at the Central Medical Stores, and there were reported stock-outs of TB and EID diagnostics at all sites visited by the OIG. In addition, 40% of the sites visited by the OIG reported stock-outs of PrEP for 30-90 days.

Operational challenges: Interruptions in the provision of AGYW outreach activities occurred, notably between October 2021 and July 2022, and between August and October 2023. These disruptions were due to delays in onboarding and contract renewal for the mobile clinic subcontractor. Gaps in the mentor mothers program also affected the AGYW program. Mentor Mothers are deployed in only 61% of hospitals providing Antenatal Care and PMTCT services. In addition, there is a lack of focus on HEIs and children within the mentor mothers' Terms of Reference and reports. Maternity clinics rely on manual (paper-based) systems for EID data collection and reporting, due to the Client Management Information System not being installed. Furthermore, the OIG noted significant delays (up to 4 months) and mix-ups in communicating EID results. For example, as of June 2024, for 52% of samples collected in January 2024, no results had been provided, and instances of sample results being sent to incorrect health facilities were observed.

[23] 2021 IBBS
[24] 2023 Annual HIV Program Report
[25] SHIMS 3 (accessed 26 June 24)
[26] HIV incidence: Adult population (1.13% vs 0.62%), AGYW (1.67% vs. 1.63%) SHIMS 3 vs SHIMS 2 - (accessed 26 June 24)
[27] GeneXpert cartridges were stocked out 71% of the time and was at risk of stock out 12% of the time. TB LAM kits stocked out 76% and at risk of stock out 18% of the time
[28] Dry Blood Sample (DBS) kits were stocked out 53% of the time and was at risk of stock out 18% of the time. M-pima kits stocked out 65% and at risk of stock-out 24% at the time.

Agreed Management Action 1:
The Secretariat will work with Principal Recipients, the Ministry of Health, CSOs and key partners to: a. Via the *AGYW package of services* review, identify operational and service gaps, including opportunities to enhance national AGYW program coordination and strengthening referral and linkage pathways for high risk AGYW to prevention services and care. The review will further guide implementers to provide i. targeted and tailored services for AGYW engaged in transactional sex, ii. strengthen GBV prevention, the provision of post violence care and improve critical services access (including mobile clinics), iii. assess adequacy of current human resource and strengthen program supervision and coordination among sub-recipients and key partners. b. Operationalize mobile clinics offering health services to priority populations, including linkages of the populations reached in the community into health facilities. c. Deliver a coordinated national PrEP scale-up plan covering all key partners to accelerate introduction of new options and improve PrEP coverage and uptake. This will include demand creation, entry-points for targeted beneficiaries, stock & programmatic accountability, and linkage strategies.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2025

4.2 Implementation of RSSH and C19RM interventions needs to improve, to ensure timely availability of quality health and supply chain data

The Global Fund and partners have allocated resources to strengthen health systems in Eswatini, including constructing the Central Medical Store and setting up data systems. However, delays in the roll-out of data systems have led to issues with timely availability of quality programmatic and logistics data.

To support health system strengthening, the Global Fund (since 2015) and partners have made significant investments in data systems. In Grant Cycles 5 and 6, the Global Fund allocated 94% of its resilient and sustainable systems for health (RSSH) investments towards strengthening data systems. Through PEPFAR support, a Strategic Information Department (SID) roadmap was developed to improve health information system leadership and governance. However, significant delays in these investments' roll-out have led to continued reliance on multiple non-interoperable and manual data systems. This affects the timely availability of quality data and consistent availability of health commodities at service delivery points.

Significant delays in roll-out of health and logistics management information systems affect timely availability of quality programmatic and logistics data

Following the inception of the Client Management Information System (CMIS) in 2012, with a target to fully roll out by October 2013, only 73% (239 out of 327) of health facilities had CMIS installed as of May 2024. Furthermore, the roll out is only partial in these facilities, with not all departments having CMIS installed. There are also design gaps within CMIS, such as the absence or non-functionality of in-patient, malaria, and TB modules. Additionally, CMIS lacks system validation controls to ensure data accuracy, and does not have data aggregation dashboards.

Consequently, CMIS continues to be supplemented with multiple fragmented and non-interoperable electronic and manual data systems. This has contributed to gaps in data quality, delayed reporting, and an inability to disaggregate data effectively. For example, different stakeholders reported varying performance achievement rates for key population programs.[29] Additionally, no data are available to assess the achievement rate of the Global Fund grant objective of reducing HIV incidence among persons aged 15-24 by 85% by 2023. Furthermore, Principal Recipients are not meeting the Global Fund's disaggregation reporting requirements.

The electronic Logistics Management Information System (eLMIS) roll out was initiated in 2020, with plans to design and pilot in three health facilities by June 2021, followed by scaling up to an additional 22 health facilities during GC6. However, as of May 2024, the eLMIS had only been deployed in three health facilities, and was not functional at any of those.

As a result, the country continues to rely on a manual (paper-based) logistics management system. Orders from health facilities are manually entered into the commodity tracking system, which is not interoperable with the Warehouse Management System, leading to potential errors and compromising the timely availability of logistics data. This contributed to suboptimal stock holding and supply planning, as HIV and TB commodity stocks at the Central Medical Stores (CMS) rarely

[29] A Global Fund review noted discripancies in data reported on ART initiation rates for FSW & MSM where an implemtener reported rates of between 93-96% whereas the national data was 51% & 56% for FSW and MSM respectively

remained within the minimum and maximum threshold[30] between January 2023 and May 2024. Monthly stock status reports were not consistently available or accurate at the CMS.[31]

On average, 42%, 46%, and 31% of orders placed by health facilities were not fulfilled by the Central Medical Stores across the three diseases in 2021, 2022, and 2023 respectively. In addition, the OIG observed instances of partial fulfilment of orders from health facilities, despite adequate availability of ordered items at the CMS. Out of 34 products issued to facilities in May 2024, 56% (19) were partially filled, despite adequate or overstocked inventory at the CMS, without reasons provided for the partial fulfilment. In the absence of integrated supply chain data systems which enable end-to-end visibility across the supply chain, accountability and traceability of commodities are compromised. A review by the Global Fund for the period January to November 2023 identified variances in commodities both at central and health facility level. Additionally, commodities valued at US$2.6 million had expired, and US$1.6 million worth of commodities were at risk of expiring.[32]

Some root causes contributing to the issues above are:

Gaps in governance and oversight are impacting accountability, ownership, and coordination: There is no national-level technical working group for Health Management Information Systems (HMIS), and roles and responsibilities among the four units of the SID at the Ministry of Health are not clearly defined. The position of Chief of SID was vacant between 2008 and 2023, hindering the implementation of a comprehensive data management framework, and delaying addressing the issues identified above. In addition, SID has not provided input into CMIS and eLMIS designs, or leveraged existing health IT solutions in the country.

Discussions on CMIS roll-out delays were last held at the Country Coordinating Mechanism (CCM) in 2021. Although a Steering Committee was established at the inception of the eLMIS project, it has only met once, in May 2024, upon the project's reinitiation. There has been a limited governance structure during the lifecycle of the eLMIS contract, with roles and responsibilities not clearly defined, resulting in inadequate oversight of contract performance. Furthermore, the National Supply Chain Technical Working Group (TWG) and its constituent sub-committees have not met as required, with only one out of nine sessions being held.

Inadequate national policies, guidelines and procedures undermine the ability to address data system issues: There is no national digital strategy or blueprint to guide the design and implementation of data systems, including integrating and interoperating various data systems. Furthermore, there are no CMIS data quality guidelines or data management procedures. There is also no national monitoring and evaluation Data Quality Assurance plan to assess and validate data quality. The National Health Sector Supply Chain Strategy (2018-2022) is out of date, and there areth no plans to update it.

Suboptimal project management is impacting timely delivery: While the impact of COVID 19 contributed to the delay, key activities crucial for the effective roll-out of the CMIS, such as developing annual and medium-term budgets for development, operation, maintenance, supervision, and training, have not been carried out. Inadequate scope definition and suboptimal contract design at the inception of the eLMIS project have led to payments not being linked to milestones or deliverables. Despite significant investments in data systems roll out, there was a lack of

[30] HIV commodities (35 ARV & OIs) average of 19% (7) were adequately stocked; 9% (3) at risk of stock-out; 17% (6) were stocked out; and 55% (19) were overstocked. TB commodities (30 TB pharmaceuticals): 6 (20%) were adequately stocked; 17% (5) at risk of stock out; 30% (9) were stocked out; and 33% (10) were overstocked.
[31] In the 29 months since January 2022, only 28% (8) ARV & OIs stock reports, 33% (9) of TB stock status reports, and 70% (19) of laboratory products reports were available. Existence of duplicate stock status reports for the same reporting period; two different stock status reports: for TB in March 2021; Labs in April 2022; and antiretroviral treatment (paediatric) in February 2023
[32] Commodities worth US$ 2.6 million expired between 1 January 2022 and 30 April 2023 with an additional commodities worth US$ 1.6 million at the risk of expiry between 1 May 2023 and 31 December 2023. Global Fund Review of Health Product Expiries Report (June 2023)

performance indicators or work plan tracking measures at the Global Fund Secretariat for specific roll-out milestones, which are crucial for routine monitoring and for the timely identification and resolution of issues.

Agreed Management Action 2:
The Secretariat will work with the PR and Ministry of Health to accelerate the full roll-out of data systems, i.e. CMIS and eLMIS. This will include: a. Development of an implementation plan for the installation of equipment for CMIS access at prioritized health facilities. b. Development of costed eLMIS rollout workplan and confirmation of completed roll-out of the eLMIS.
OWNER: Head of Grant Management Division
DUE DATE: 31 December 2025

4.3 Improvement in oversight and coordination is needed to ensure effective and efficient use of grant resources

Structures and properly designed controls exist to ensure adequate grant oversight and safeguard resources. However, lapses in oversight, coordination, and controls result in suboptimal implementation of activities.

The design of internal control systems around procurement and finance for both Principal Recipients is robust. One Principal Recipient maintains an audit action plan to track the implementation of audit recommendations raised by assurance providers, and undertakes quarterly financial and programmatic review of sub-recipient performance. The other Principal Recipient uses a system for raising procurement requisitions, approvals, and tracking. Additionally, a qualified and independent tender evaluation committee evaluates procurement tenders.

The Global Fund Secretariat, through the Strengthening Country Link Project (CO-LINK), assessed both Principal Recipients to strengthen their finance and grant management functions. There is robust review and validation of adolescent girls and young women (AGYW) school fee subsidy payments. The Principal Recipients use an Enterprise Resource Planning (ERP) system to record, maintain and report grant financial information. Additionally, the Country Coordinating Mechanism (CCM) is developing a dashboard to enhance grant performance monitoring.

Despite the progress made, the OIG identified gaps in oversight, coordination, and the implementation of procurement and financial management controls. These challenges may adversely impact programmatic gains and compromise grant resources.

Sub-optimal coordination among key stakeholders, including government and donor partners, results in duplication of efforts

The CCM membership includes representatives from funding partners, the Ministry of Health, and other stakeholders. Despite holding quarterly CCM meetings, the OIG identified gaps in coordination between funding partners and the Ministry of Health, which hinder the ability to ensure coordinated efforts and efficiently address grant-related bottlenecks. This lack of coordination leads to missed opportunities for synergy and contributes to duplication of efforts. As of December 2023, the OIG noted unutilized budget allocations of approximately US$0.7million for the procurement of condoms and US$0.9 million for the procurement of maintenance equipment for CMIS connectivity, due to PEPFAR and the World Bank funding the same interventions. Despite being procured through Global Fund funding, government funds were used to procure TB drugs.[33] Additionally, antiretroviral medicine[34] was overstocked at 59 months of stock, with a further 29 months of stock procured using government funds. The audit also noted varying delivery of services for AGYW funded by different partners, limiting the effectiveness of AGYW interventions across regions. For instance, interruptions in AGYW outreach activities in Global Fund-supported *tinkundla* due to PrEP shortages, were not experienced in PEPFAR-supported *tinkhundla*.

There is a lack of a national procurement plan and monitoring framework. The various stakeholders do not coordinate effectively to establish procurement plans, initiation dates, procurement methods, review timelines, or planned delivery dates. In addition, forecasting and quantification outputs are not mapped to available funding sources, to streamline coordination and visibility across funding sources. Effective planning and coordination are critical, given the involvement of multiple

[33] Bedaquiline & Injectable Amikacin
[34] Tenofovir, Lamivudine, and Efavirenz (TLE), which is being phased out due to regimen transition to Tenofovir, Lamivudine, and Dolutegravir (TLD)

stakeholders (including the Government, PEPFAR, and the Global Fund) in procuring the same health commodities, each with different funding plans (annual vs three years).

Sub-optimal governance and oversight impacts the effective implementation of grant activities

The OIG noted lapses in the oversight function of the Country Coordinating Mechanism (CCM) and Principal Recipient during the GC6 period to March 2024. Only 55% (5 out of 9) of planned quarterly meetings with the Principal Recipients were conducted by the CCM Oversight Committee. Between 2022 and 2023, the CCM Oversight Committee conducted only 25% (one out of four) of planned semi-annual site visits. There is also no evidence that epidemiology reports and other reports from assurance providers were discussed and reviewed by the CCM.

The CCM and Principal Recipients lack a mechanism for collaboratively discussing and resolving issues. For example, the Principal Recipient reported issues such as a 29-month delay in procuring mobile van clinics and commodity stock-outs to the CCM. However, there is no evidence that the CCM escalated these issues to the Global Fund or the Ministry of Health. Additionally, the OIG noted that there are no documented action plans or timelines for resolving issues identified and discussed at CCM Oversight Committee meetings.

The CCM and Principal Recipient did not adequately monitor the realization of government co-financing commitments, contributing to a failure to identify and mitigate program impacts in a timely manner. There were delays in government disbursements for antiretroviral medicine procurements. For instance, in the financial year 2022/2023, 95% (US$7.2 million) of the total disbursements were released three months before the end of the fiscal year. Additionally, only 50% (US$7.6 million) of the government's annual commitment for antiretroviral medicines was disbursed for the financial year 2022/2023. Delayed payments to a TB medicines supplier for government-funded procurements resulted in retendering, further delaying the procurement process. As a result, commodity shortages and stock-outs impacted service delivery, such as TB sputum testing, and EID, as highlighted in Finding 4.1.

The audit also noted slow progress in the implementation of COVID-19 Response Mechanism (C19RM) interventions, which hinders the strengthening of health systems. Health system strengthening interventions funded through C19RM have been delayed, with the absorption of C19RM grants at only 28% as of December 2023. Delayed activities include the set-up of Pressure Swing Adsorption (PSA) oxygen plants, a waste management plant, and the procurement of x-ray machines. Additionally, the genome sequencing machine procured and set up through C19RM funding had not started operations at the time of the audit.

Root causes which contributed to the governance, oversight and coordination issues include:

Delays and gaps in reporting and communication: The Principal Recipients did not share the required reports with the CCM in a timely and regular manner.[35] Additionally, there were delays averaging 26 days in the submission of programmatic reports by the national programs to the Principal Recipient.

Inadequate monitoring of projects: There was no plan or mechanism to monitor and track C19RM projects. Despite the Memorandum of Understanding (MoU) requiring national programs to share an annual work plan with the Principal Recipient for the development of a procurement plan, they are not doing so.

Outdated Procurement Guidelines: The procurement and tender manual used by the Principal Recipient is outdated (i.e. 2013) and not aligned with the Eswatini Public Procurement Regulatory

[35] CANGO and NERCHA shared the required reports with the CCM 80% and 40% of the time, respectively

Authority (SPPRA) regulations of 2020. For example, the SPPRA regulations include two additional criteria for limited tender procurement that are not included in the Principal Recipient's manual. This misalignment can lead to delays in approving key procurements.

Agreed Management Action 3:
The Secretariat will work with the CCM to strengthen coordination, monitoring and oversight mechanisms, including the updating of relevant manuals and revised planning and administrative framework to support the core CCM and CCM Oversight Committee functions.
OWNER: Head of Grant Management Division
DUE DATE: 31 October 2025

Annex A. Audit rating classification and methodology.

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

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

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

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

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

Annex B. Risk appetite and risk ratings

In 2023, the Global Fund issued a new Operational Policy Note (OPN), setting recommended risk appetite levels for 13 key risks affecting Global Fund grants, formed by aggregating 35 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. Individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Current Risk Level for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

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

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

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

Overall, the updated Secretariat risk levels assessment aligns with the OIG audit rating, except for procurement, and monitoring and evaluation. Design gaps and significant delays in rolling out the CMIS, along with inadequate supervision of national programs, led to the OIG rating of "High" for monitoring and evaluation. The Secretariat's procurement risk rating of "High" was mainly driven by the critical issues in procurement processes for Government-funded health commodities as well as issues with non-compliance with the procurement policy for non-health procurement. The OIG rated procurement as "Moderate" because while some non-compliance with procurement policies was found, these issues were not significant enough to warrant a "High" rating. In addition, some of the health commodities funded by the Government are procured via Wambo.