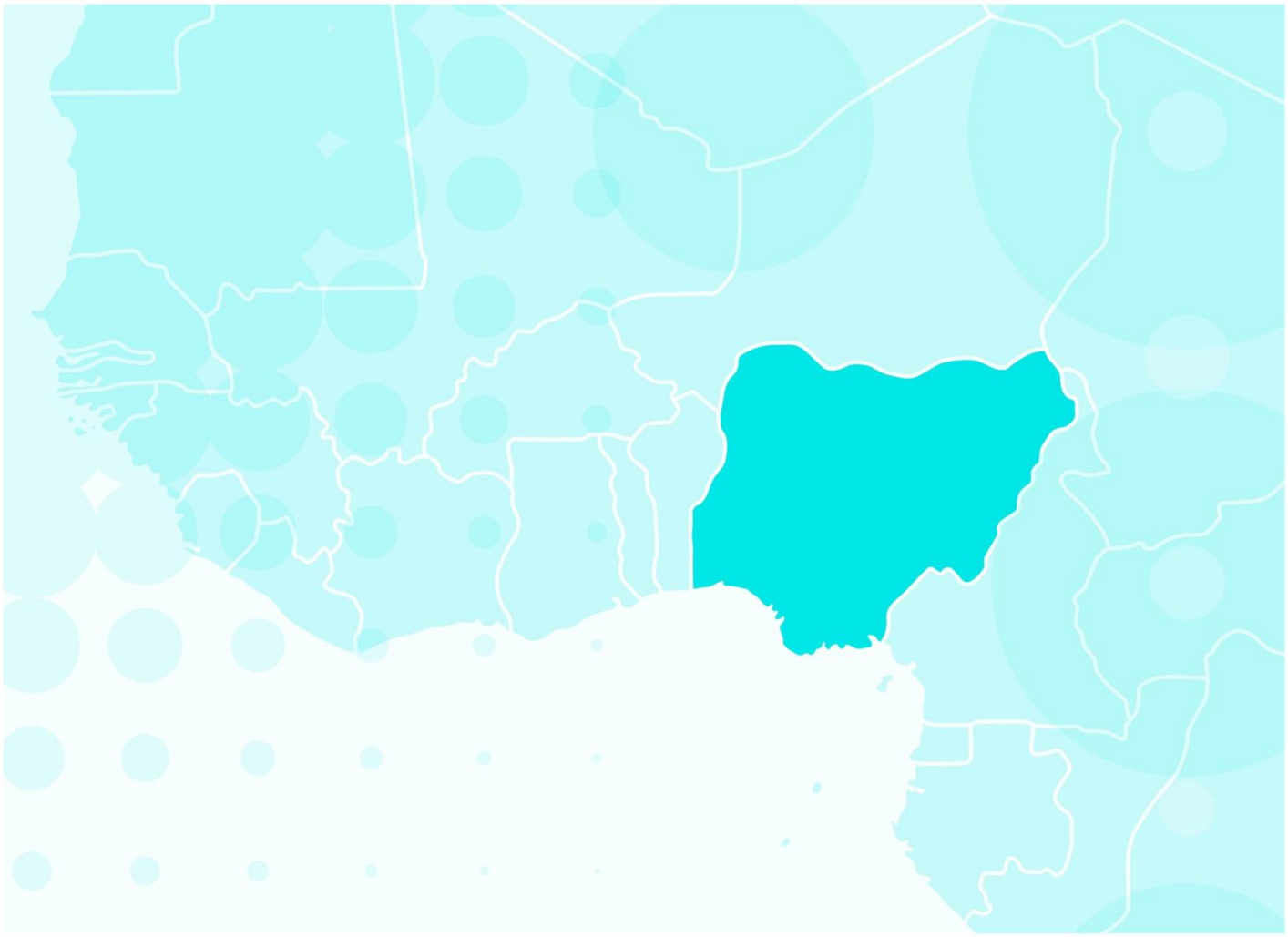

Audit Report

Global Fund Grants to the

Federal Republic of Nigeria

GF-OIG-25-006
6 June 2025
Geneva, Switzerland

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Office of the Inspector General

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1. Executive Summary

1.1 Opinion

Nigeria has one of the highest burdens of HIV, TB, and malaria in the world. In 2023, it accounted for the highest global burden with 26% of malaria cases and 31% of malaria deaths.[1] Nigeria ranks third globally in HIV burden, with an estimated 2 million people living with HIV according to UNAIDS. The country has the sixth highest TB burden globally, accounting for 4.6% of total estimated cases.[2]

Significant progress has been made in malaria control, with declines in mortality rates and children under-five prevalence. However, reported malaria cases rose by 22% between 2020 and 2023 in the general population,[3] attributable to factors including population growth, Covid-19, and climate events. Other key contributors include enhanced health management information system reporting, and a 42% increase in parasitological testing, driven by improved diagnostic capacity. The rise is exacerbated by suboptimal coverage and use of some key malaria control interventions and tools, as well as insufficient engagement with the private sector and communities in malaria control efforts.

Nigeria has made significant progress in combating the HIV epidemic, with notable declines in HIV prevalence, new infections, and AIDS-related mortality. However, progress for key and vulnerable populations remains limited, due to gaps in the design, quality, and implementation of targeted interventions. Implementation challenges, limited scale, and insufficient normative guidance undermine effective HIV prevention and control efforts among key and vulnerable populations. Consequently, these populations continue to disproportionately drive the HIV epidemic in the country. Additionally, insufficient government co-financing leaves some at-risk populations without adequate coverage, and affects implementation of key interventions.

Implementation delays in completing key resilient and sustainable systems for health (RSSH) and pandemic preparedness and response (PPR) interventions have undermined progress, especially for data and laboratory systems. Significant data quality issues persist despite material investments, and slow implementation of laboratory interventions impede health system strengthening efforts. The implementation and mitigating actions to address risk and ensure achievement of grant objectives **need significant improvement**.

In-country supply chain mechanisms have improved the availability and traceability of Global Fund-supported commodities. Procedures for inter-donor swapping, loaning, and inter-State redistribution have been established for malaria health products, helping to reduce potential stock-outs. However, insufficient oversight of storage and distribution, along with significant delays in implementing supply chain integration plans, undermine the effectiveness and sustainability of the country's supply chain systems. The Principal Recipients lack adequate oversight for the storage and distribution of HIV commodities under grant cycle 7, due to the absence of a signed tripartite agreement among donor partners, the government, and a Service Level Agreement with the fourth-party logistics provider.

The National Tuberculosis and Leprosy Control Program's (NTBLCP) oversight of storage and distribution of commodities faces deficiencies, including the lack of a formalized mechanism for monitoring these processes. As of October 2024, only 14% of the activities in the National Health Supply Chain Strategic Plan (2021-2025) had been completed. As a result, the Global Fund and

[1] WHO World Malaria Report 2024
[2] WHO Global Tuberculosis Report 2024
[3] Reported malaria cases rose from 21.6 million in 2020 to 26.4 million in 2023 (Source: WHO World Malaria Report 2024 (Annex 4 - H. Reported malaria cases by method of confirmation, 2015-2023))

other donor-funded programs continue to rely on parallel supply chain arrangements, which could benefit from integration. Supply chain processes and systems **need significant improvement**.

The Global Fund has implemented measures to mitigate high fiduciary risks. While the established financial assurance mechanisms identify and report on financial risks and issues, the OIG noted some lapses in the effective execution of financial controls and assurance activities, leading to the recurrence of issues which undermine the safeguarding of grant resources. Financial oversight and assurance to safeguard grant resources is **partially effective**.

1.2 Key Achievements and Good Practices

Significant progress made in the fight against the three diseases

Nigeria has made substantial progress in responding to the HIV epidemic, with a decline in prevalence, new infections, and AIDS-related deaths since 2020. About 85% of people living with HIV know their status, 85% are on treatment, and 82% achieve viral load suppression.[4]

TB treatment coverage increased from 30% in 2020 to 74% in 2023, with TB case notifications rising by 167% between 2021 and 2023. Nigeria has achieved high treatment success rates for both drug-sensitive TB (93%) and drug-resistant TB (84%). Since 2020, approximately one million people have been treated for TB, and 423,000 people have received TB preventive therapy.[5] Malaria mortality decreased by 12% between 2015 and 2023, and malaria prevalence among children under five declined from 27% in 2015 to 22% in 2021. Seasonal Malaria Chemoprevention is routinely undertaken in the eligible states, with the Principal Recipient reporting that 99%[6] of at-risk children received three or four courses as of December 2023.

Reinforced health systems and infrastructure

The Global Fund has invested US$157 million across grant cycle 6 (GC6) and grant cycle 7 (GC7) to strengthen health systems and infrastructure, with an additional US$79 million from C19RM redirected towards pandemic preparedness and response (PPR). This funding supported the establishment of PSA oxygen plants,[7] enhanced surveillance systems, laboratory accreditations, and upgrades to state and federal warehouses. Global Fund financing in GC6 enabled the procurement of 63 PSA oxygen plants, upgrades to the National External Quality Assurance Laboratory, laboratory for genome sequencing, the improvement of 12 public health labs and 10 Nigerian Postal Services facilities,[8] and upgrades to 21 state warehouses and one Federal Medical Store. Governance and coordination were improved through the creation of an RSSH Steering Committee, comprising 16 members from six government agencies, including national coordinators of HIV, TB, and malaria programs, and chaired by the Permanent Secretary at the Ministry of Health.

Systems and coordination of the supply chain processes have been strengthened

Enhancements to IT systems and improved collaboration between Principal Recipients and Fourth-party logistics (4PL) providers have significantly strengthened supply chain efficiency and effectiveness. This includes the development and roll-out of policies, strategic plans, standard operating procedures (SOPs), and tools to guide and improve the supply chain system. A national SOP for managing malaria health products has been established, defining procedures for inter-donor swapping, loaning, and inter-State redistribution at both National and State levels. These measures

[4] UNAIDS Factsheets 2023 – accessed on 2 October 2024
[5] Ibid
[6] Validated results from NGA-M-NMEP PU/DR (July – December 2023)
[7] PSA oxygen plants refer to systems that generate oxygen using Pressure Swing Adsorption (PSA) technology.
[8] The Nigerian Postal Service (NIPOST), with its nationwide presence, logistical capabilities and plays a significant role in supporting healthcare delivery, especially in lab sample transportation

have effectively alleviated potential stock-outs and commodity gaps. All 21 states signed MOUs for 15% co-financing towards state warehouse refurbishments, with 91% fulfilling their contributions. Additionally, Drug Revolving Funds or Drug Management Agencies have been established in 62% of states. These co-financing contributions enhance sustainable financing and resourcing for supply chain processes.

1.3 Key Issues and Risks

Suboptimal coverage of key malaria control interventions undermines progress

Malaria cases in the general population continue to rise, driven by factors such as increased parasitological testing, enhanced DHIS2 reporting, population growth, and climate change. The suboptimal coverage of key malaria control interventions due to funding constraints, low use of insecticide-treated nets (ITNs), and insufficient private sector and community engagement is undermining progress. The Global Fund supports comprehensive malaria interventions in 13 states, but its support is limited to public health facilities, with antimalarial commodities provided to 59% of these facilities.[9] Low ITN use has reduced the effectiveness of vector control interventions. This is partly due to insufficient access, with only 59% of households[10] owning at least one ITN.[11]

Implementation challenges in programs to prevent the transmission of HIV from mother to child (PMTCT), and limited HIV prevention interventions for key and vulnerable populations

Despite significant reductions in HIV prevalence, new infections, and AIDS-related deaths since 2020, critical gaps remain in PMTCT programs and in interventions for key and vulnerable populations. Delays and operational challenges to scale the PMTCT program contributed to low coverage and high vertical transmission rates (23% in 2023).[12] Although key populations represent only 3.4% of the population, they account for 11% of new HIV infections, rising to 32% when including their partners.[13] While important progress has been made compared to the 2019 baseline,[14] gaps remain in the uptake of antiretroviral treatment among key populations.

Implementation challenges involving key populations stem from gaps in normative guidance, limited funding, and low absorption, all of which undermine effective service delivery and coverage. Additionally, human rights issues, such as punitive laws and discrimination, along with limitations in monitoring and data systems, further limit progress. A large proportion of at-risk adolescent girls and young women (AGYW) are not reached by prevention packages, despite accounting for over 17%[15] of new HIV infections in Nigeria in 2023. Performance on GC6 and GC7 (as of June 2024) targets for AGYW reach with HIV prevention packages was less than 5%.

Grant implementation and coordination challenges limit impact of RSSH and PPR investments, particularly in laboratory and data systems

Despite significant RSSH and PPR investments, procurement delays, inadequate coordination among health sector entities, and limited domestic health financing have hindered progress and the timely realization of benefits. Some key projects experienced delays ranging from 144 to 327 days. Data quality issues persist, with 43% of the RSSH budget for GC5 and GC6 allocated to investment in Health Management Information Systems (HMIS). Approximately 7% of the GC6 RSSH budget

[9] This relates to 7,070 out of 12,004 public health facilities in the 13 Global Fund supported states. Some public health facilities were excluded because they were not reporting consumption data in the LMIS and/or DHIS platforms
[10] ITN ownership in the 13 Global Fund supported states is 68%, which is 9% higher than the national average
[11] NDHS2023-24 (Section 3.14 and figure 8)
[12] UNAIDS Factsheets 2023 – accessed on 2 October 2024
[13] Modes of Transmission Study Report – UNAIDS, 2022
[14] For instance, HIV prevention service coverage among MSM and FSW in 2019 was less than 20%. Coverage increased to close to 50% by 2023 for both key population groups
[15] UNAIDS data

was allocated to support investments to advance electronic reporting and interoperability, but progress remains slow, with limited interoperability between DHIS2 and other health data systems. Additionally, delays in laboratory interventions have slowed diagnostic efforts. Root causes include suboptimal sub-recipient management, significant procurement delays, and limited domestic health financing. As of November 2024, 11 months into GC7 implementation, the government had yet to sign the GC7 co-financing commitment letter that was due by June 2024.

Oversight gaps and significant delays in integrating supply chain interventions

While improvements were made to the availability and traceability of health commodities, gaps in oversight and significant delays in integrating supply chain interventions hinder progress and sustainability. The GC7 implementation arrangements lack adequate oversight over storage and distribution of HIV commodities, unlike GC6.[16] Suboptimal controls over stock adjustments were noted, as well as limited enforcement of the shelf-life policy, which has contributed to significant losses due to expiry of funded commodities.

NTBLCP's management of storage and distribution of commodities has critical deficiencies, including the lack of proof of delivery reconciliations for TB drugs, the absence of a comprehensive performance measurement systems for warehousing, and the lack of a contract for the storage of TB laboratory and cold chain commodities at a third-party warehouse. Significant delays in implementing supply chain integration interventions have also limited efficiencies and sustainability, with only 14% of activities in the National Health Supply Chain Strategic Plan (2021-25) being completed as of October 2024. Consequently, the Global Fund and other donor-funded programs continue to rely on parallel supply chain arrangements for storage and distribution.

Gaps in oversight and internal controls result in issues recurring, despite enhanced financial assurance and risk mitigation measures

The Global Fund has implemented measures to mitigate high fiduciary risks, including a robust finance assurance framework with internal audit functions at all Principal Recipients. A Fiscal Agent provides fiduciary oversight of grants implemented by specific implementers, with the support of external auditors and the Local Fund Agent. Despite this framework, gaps in financial controls and assurance activities have led to recurring issues that undermine the efficient use of grant resources.

The OIG noted instances where procurements amounting to US$1.7 million were not competitively sourced, and sampled transactions amounting to US$3.3 million were approved despite material inconsistencies in supporting documents. The root causes of these issues include inadequate enforcement of internal controls, non-adherence to procurement guidelines, and insufficient rotation of the Fiscal Agent's financial experts embedded within implementer offices. These lapses increase both fiduciary and value-for-money risks.

[16] In GC6, the Global Fund maintained a contractual relationship with the Fourth-Party Logistics (4PL) provider. However, in GC7, the implementation arrangement has changed, where the 4PL will store and distribute Global Fund commodities under the PEPFAR program. The 4PL has a contractual agreement with PEPFAR but none directly with the Global Fund, despite handling its commodities

1.4 Objectives, Ratings and Scope

The audit's overall objective was to provide reasonable assurance to the Global Fund Board on the adequacy and effectiveness of Global Fund Grants to the Federal Republic of Nigeria. Specifically, the audit assessed the governance, risk management, and controls for effective implementation of:

Objectives	Rating	Scope
Implementation and mitigating actions to address risk and ensure achievement of grant objectives, with a focus on:[17] • HIV interventions for key and vulnerable populations • Malaria interventions • RSSH and PPR investments	**Needs significant improvement**	**Audit period** January 2022 to June 2024 **Grants and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund supported programs. **Scope exclusion:** None
Supply chain processes and systems to ensure: • timely availability and accountability of commodities • sustainable arrangements	**Needs significant improvement**	
Financial oversight and assurance to safeguard grant resources.	**Partially effective**	

OIG auditors visited 15 health facilities in three states (Osun, Delta, Kwara). These three states represent 6% of the people living with HIV receiving antiretroviral treatment, 9% of TB case notifications, and 5% of malaria cases in 2023. The OIG auditors also undertook physical verifications of RSSH investments and infrastructure in two states (Lagos and Abuja).

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

[17] The TB programmatic area was assessed as low risk. The audit focused on the RSSH (i.e. lab equipment and products), supply chain, and finance components of the TB program

2. Background and Context

2.1 Country Context

Nigeria is Africa's most populous nation, with a population of 229 million, 42% of whom are aged 14 and below.[18] The country is administratively divided into 36 autonomous states and the Federal Capital Territory of Abuja. States are further divided into 774 Local Government Areas, six geopolitical zones, and 8,806 electoral wards.

Nigeria is classified as a lower-middle-income country, with an estimated poverty rate of 39% (2023).[19] The country has been experiencing economic challenges, evidenced by rising inflation rates[20] and currency depreciation.[21] While the budgetary allocation to the Ministry of Health has been increasing in absolute terms, the proportion of the Ministry of Health budget to the national budget is low, averaging 4.2% since 2021,[22] well below the 15% target set by the 2001 Abuja Declaration. Out-of-pocket expenditure continues to be the primary source of healthcare financing, accounting for over 76% of healthcare expenditure[23] in 2021, among the highest in the world.

Country data[24]	
Population	229.2 million (2024)
GDP per capita	US$1,621 (2023)
Corruption Perception Index	145/180 (2023)
UNDP Human Development Index	161/193 (2022)
Government spending on health (% of GDP)	4% (2021)

2.2 Global Fund Grants in Nigeria

The Global Fund has signed grant agreements worth over US$4.9 billion and disbursed over US$3.9 billion to fight the three diseases. For Grant Cycle 6 (GC6), the Global Fund signed total grants of US$1.3 billion. The allocation for the current implementation cycle (Grant Cycle 7 - GC7), which began in 2024, is over US$933 million, of which 23% has been disbursed.[25] In addition, C19RM investments covering 2024 – 2025 amount to US$305 million.

In GC7, seven Principal Recipients manage eight grants:

- HIV grants are managed by the National AIDS, Viral Hepatitis and STIs Control Programme (NASCP) and the National Agency for the Control of AIDS (NACA); [26]
- The TB grant is managed by the National Tuberculosis and Leprosy Control Program (NTBLCP);

[18] UNFPA World Population Dashboard - Nigeria (Accessed on 4 Dec 2024)
[19] World Bank Nigeria Overview (Accessed on 4 Dec 2024)
[20] Inflation increased by 74% average 2022 (18.8%) & Average Jan-Sept 2024 (32.8%) (Central Bank of Nigeria Inflation data)
[21] Nigerian Naira has lost 243% of its value average 2022 (₦423.3/US$ 1) & Average Jan-Oct 2024 (₦1,453.4/US$ 1) (Central Bank of Nigeria Exchange rates data) (Accessed 4 Dec 2024)
[22] Budget Office of the Federation 2021 to 2024 Appropriation Acts data (Accessed on 4 Dec 2024)
[23] WHO Global Health Expenditure Database – Nigeria profile (Accessed 4 Dec 2024)
[24] UNFPA World Population Dashboard - Nigeria, World Bank Nigeria Country profile, UNDP 2022 Human Development Index – Nigeria Country profile, Transparency International Corruption Perception Index; WHO Global Health Expenditure Database – Nigeria profile (all accessed 4 Dec 2024)
[25] Full details on grants can be found at the Global Fund's Data Explorer (Accessed 4 Dec 2024)
[26] Unlike in GC6, Family Health International (FHI360) is no longer a Principal Recipient

- The combined HIV/TB grant is managed by the Institute of Human Virology Nigeria (IHVN);
- Malaria grants are managed by the National Malaria Elimination Programme of the Federal Ministry of Health of the Federal Republic of Nigeria (NMEP) and Catholic Relief Services - United States Conference of Catholic Bishops (CRS);
- Resilient and Sustainable Systems for Health (RSSH) grants are managed by NACA, NTBLCP and the Lagos State Ministry of Health.

2.3 The Three Diseases

HIV / AIDS (2023)

Nigeria has the **3rd highest global HIV burden**.

In 2023, an estimated **2 million people were living with HIV in Nigeria,** of whom 85% knew their status, 85% were on treatment and 82% were virally suppressed.

Marginal **reduction in prevalence,** from **1.6%** in 2020 to **1.4%** in 2023.

Annual **new infections decreased** by **26%** between 2020 and 2023.

AIDS-related deaths reduced by **33%** between 2020 and 2023.

23% rate of **mother-to-child transmission** in 2023.

Source: 2023 Nigeria UNAIDS Country Factsheet; NASCP Program Data

TUBERCULOSIS (2023)

Nigeria is among the **WHO 30 high-burden countries** for **TB, TB/HIV & Multi-Drug Resistant (MDR) TB**.

Highest TB burden in Africa & **6th highest globally,** accounting for **4.6%** of the global TB burden in 2023.

Estimated incidence of **219** cases of **Drug Susceptible TB**, **4.1** of **MDR-TB** and **11 TB/HIV** per 100K population in 2023.

Drug Susceptible TB treatment coverage increased from **30%** in 2020 to **74%** in 2023.

Only **38%** of estimated MDR/RR-TB cases notified in 2023

TB treatment success rate of 93% (DS TB) and **84% (DR TB)** in 2023

Source: WHO Global TB Report 2024; 2023 WHO TB profile for Nigeria

MALARIA (2023)

Nigeria has the **highest global malaria burden** and is among the **WHO/RBM High Burden to High Impact Approach (HBHI)** countries

Nigeria accounted for **26% of the Global malaria burden** and **31% of Global malaria deaths** in 2023.

Malaria mortality rate decreased by **12%** from **92** (2015) to **81** (2023) malaria deaths per 100,000 population

Mortality for children under 5 years old declined by 17% from **132** (2018) to **110** (2023)

Source: 2024 WHO Global Malaria Report; NMEP Program data

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

GC6 Grant performance and grant ratings are shown below[27],[28]:

Component	Grant	Principal Recipient	Grant Period	Total Signed Amount (USD)	Budget as at Dec 23 (USD)	Expend as at Dec 23 (USD)	Absorb as at Dec 23	June 2021	Dec 2021*	June 2022	Dec 2022	June 2023	Dec 2023
TB	NGA-T-NTBLCP	National Tuberculosis & Leprosy Control Programme	1 Jan 21 - 31 Dec 23	198,250,120	153,880,586	104,034,105	68%	B2	C	C	C	C	C
									4	3	2	3	4
	NGA-T-IHVN	Institute of Human Virology Nigeria	1 Jan 21 - 31 Dec 23	50,936,271	53,248,569	47,173,340	89%	B1	C	C	C	C	C
									1	2	1	2	2
	NGA-T-LSMOH	Lagos State Ministry of Health	1 Jan 21 - 31 Dec 23	12,343,066	12,794,316	10,116,586	79%	B1	C	C	C	C	C
									4	5	2	3	3
HIV	NGA-H-FHI360	Family Health International (FHI360)	1 Jan 21 - 31 Dec 23	290,868,575	292,478,305	258,308,901	88%	B2	D	C	B	B	B
									1	4	3	3	2
	NGA-H-NACA	National Agency for the Control of AIDS	1 Jan 21 - 31 Dec 23	37,857,779	37,963,133	33,593,115	88%	B1	C	C	C	D	D
									3	3	3	3	2
Malaria	NGA-M-CRS	Catholic Relief Services	1 Jan 21 - 31 Dec 23	319,166,375	323,935,333	270,081,895	83%	A2	B	B	B	B	B
									3	2	2	1	3
	NGA-M-NMEP	National Malaria Elimination Programme	1 Jan 21 - 31-Dec-23	79,266,661	79,705,814	75,741,061	95%	B1	C	C	C	C	C
									1	2	1	2	2
RSSH	NGA-S-NACA	National Agency for the Control of AIDS	1 April 21 - 31 Dec 23	300,410,069	175,019,510	168,366,501	96%	N/A	C	C	C	C	C
									5	5	5	5	1
Total				1,289,098,916	1,129,025,566	967,415,504	86%						

[27] Effective February 2022, Global Fund Revised PU/DR and Performance Ratings with programmatic performance assessed via alphabetic ratings while financial performance assessed via numerical ratings. (Accessed 3 Dec 2024)
[28] The difference between the total signed amount (US$ 1,289 Million) and the Total Budget as of Dec 23 (1,116 million) is due to the C19RM grants signed during GC6 whose implementation continues in GC7 i.e. US$ 44.7M (NTBLCP) & US$ 125.4M (NACA)

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 Nigeria 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; RSSH & Pandemic Preparedness	HIV: program quality	**Moderate**	**Moderate**	4.2
	Malaria: program quality	**Moderate**	**High**	4.1
	RSSH & Pandemic Preparedness	**Moderate**	**High**	4.4
Supply chain management	In-country supply chain	**High**	**High**	4.3
Financial oversight and assurance	Grant-related fraud and fiduciary risks	**Moderate**	**Moderate**	4.5
	Health Financing	**High**	**High**	4.1, 4.2, 4.4

4. Findings

4.1 Reduction in mortality rates and prevalence in young children, but suboptimal coverage of malaria control interventions limits impact

Significant progress has been made in malaria control, with notable declines in prevalence and mortality rates for children under five years old. However, inadequate coverage of key malaria control interventions, low use of insecticide-treated nets (ITN), and insufficient engagement with the private sector and communities are hindering programmatic impact.

According to WHO estimates, malaria-related deaths per 100,000 population decreased by 12%, from 92 in 2015 to 81 in 2023. Malaria prevalence in children under five years old reduced nationally from 27% in 2015 to 22% in 2021.[29] Governance and coordinating structures, such as the Advisory for Malaria Elimination in Nigeria (AMEN) and the Malaria Partners Forum, are helping malaria efforts. The creation and subsequent routinization of data deep dives by the National Malaria Elimination Program (NMEP) have enhanced WHO's subnational data analysis, enabling a country-specific supplement for the World Malaria Report, which allows for more precise and actionable insights, enhancing efforts to control and eventually eliminate malaria. Additionally, efforts to triangulate malaria service and consumption data have helped reduce variance over time.

Despite these significant investment in malaria vector control and prevention efforts, malaria cases in the general population continue to rise, driven by various environmental and social factors. Key contributors include a 42% increase in parasitological testing between 2020 and 2023 due to: improved diagnostic capacity; enhanced health management information system (DHIS2) reporting, which now disaggregates malaria cases for pregnant women and leads to higher reported numbers; population growth; and climate events. The increase is exacerbated by inadequate coverage and usage of key malaria control interventions, as well as insufficient engagement with the private sector and communities.

Suboptimal coverage of key malaria control interventions and low use of insecticide treated nets (ITNs) among at-risk populations

The Global Fund funding supports comprehensive malaria interventions, including vector control, chemoprevention, diagnostics, treatment, and systems strengthening in 13 states. However, its support is limited to public health facilities, and does not cover all facilities within these states. The Global Fund provides antimalarial commodities to 59% (7,070 out of 12,004) of public health facilities in these states.[30] Five of the 14 public health facilities visited by the OIG did not receive Global Fund support for malaria despite being high-burden facilities, due to funding constraints.

Low use of ITNs reduces the effectiveness of vector control interventions. Between 2021 and 2023, over 80 million ITNs were distributed nationally to at-risk populations through mass campaigns and targeted continuous distribution. However, at the national level, only 59%[31] of households own at least one ITN. In the 13 Global Fund-supported states, ITN ownership (68%) and usage rates are higher than the national average, but remain insufficient. In these states, the percentage of children under five who slept under an ITN the previous night decreased from 59% in 2018 to 49% in 2023,[32] and from 78% to 64% in households with at least one ITN. Among pregnant women, the percentage

[29] Nigeria Malaria Indicator Survey 2021
[30] Some public health facilities were excluded because they were not reporting consumption data in the LMIS and/or DHIS platforms
[31] Source: Nigeria Demographic Health Survey (2022 – 2023)
[32] Ibid

who slept under an ITN decreased from 65% in 2018 to 55% in 2023, and from 84% to 72% in households with at least one ITN.[33]

Insufficient engagement with the private sector and community in malaria control response mainly due to limited funding

The private sector plays a critical role in malaria case management, accounting for 50%[34] of DHIS2-registered health facilities in 2022. According to the 2021 Malaria Indicator Survey, 56%[35] of children under five with a fever are treated in private facilities. To address this, the National Malaria Elimination Program (NMEP) piloted a private sector project in five states during GC6 to strengthen case management and reporting. Integrated community case management of malaria was implemented in two states, and will expand to six more under GC7 through the Community Health Influencers, Promoters, and Services program. To minimise the coverage gap, the Global Fund has allocated US$5.8 million in GC7 to scale up private sector case management interventions.

Limited coverage, low use of LLINs, and insufficient private sector and community engagement have contributed to Nigeria having the world's highest malaria burden: in 2023, the country accounted for 26% of global malaria cases and 31% of deaths. Reported malaria cases rose by 22% from 21.6 million in 2020 to 26.4 million in 2023.[36] In 2023, the 13 Global Fund-supported states, that have historically had the highest malaria burden, accounted for 60% of reported cases. The country is off-track to achieve its target of 170 cases per 1,000 population by 2025. WHO estimates a 4% rise in malaria incidence per 1,000 population at risk between 2015 and 2022, from 294 to 305. Reported malaria cases among pregnant women increased sevenfold, from 207,285 in 2020, to 1,404,161 in 2023. In the 13 Global Fund-supported states, such cases increased fivefold, from 159,943 in 2020 to 761,668 in 2023.[37]

The low coverage and use of key vector control interventions, as well as limited private sector and community engagement, are driven by two key factors:

Limited funding and government co-financing challenges: Due to national prioritization decisions, changes were made to the planned mixed-malaria interventions to fit available resources, reducing their overall impact. For example, in Global Fund-supported states, mass ITN distributions in large urban areas were conducted in only 9% (2 of 23) of the targeted local government areas (LGAs) due to funding constraints. Insufficient government funding led to shortages of ITNs for routine distribution and Sulphadoxine-Pyrimethamine (SP) for intermittent preventive treatment of malaria during pregnancy (IPTp).[38] IPTp1 coverage reached 52% nationwide between 2021 and 2023, but IPTp3 remained low, ranging from 32% to 46%. All 15 health facilities visited by the OIG reported SP stock-outs, and 47% experienced routine ITN stock-outs, with average stock-outs of 120 days during the audit period. Some progress has been made in GC7 to enhance the availability and uptake of IPTp, with WHO prequalifying a local manufacturer of SP in 2024, allowing for local procurement using grant funds.

Low fund absorption for community systems strengthening and Behavioural Change Communication (BCC) activities: Of the additional US$0.2 million allocated in GC6 for post-ITN campaign BCC activities, only 16% had been spent by December 2023. Late arrivals[39] of ITNs, coupled with delays

[33] Ibid
[34] Representing over 16,400 hospitals and clinics, 3768 registered Community Pharmacies, and over 200,000 Proprietary Patent Medicine Vendors (PPMVs)
[35] Private sector (30.8%), NGO private sector (0.1%), other private sector (25%). Source: Malaria Indicator Survey 2021
[36] WHO World Malaria Report 2024 (Annex 4 - H. Reported malaria cases by method of confirmation, 2015-2023)
[37] Source: DHIS2 data extracts (Malaria cases and deaths in Nigeria 2015 – 2023)
[38] IPTp is a preventive regimen with sulfadoxine-pyrimethamine (SP). The number after IPTp is the number of doses. It is recommended by WHO for all pregnant women in their first or second pregnancy in malaria-endemic areas. (Source: https://www.who.int/tools/elena/interventions/iptp-pregnancy – accessed on 18 December 2024)
[39] In Osun final deliveries of ITNs arrived at the end of May 2023 instead of the second week of April 2023. In Kwara some deliveries of ITNs (Dual AI) that were supposed to arrive at the end of June 2023 arrived at the end of August 2023.

during the handover between Principal Recipients, led to changes to the ITN campaign timeline in three states,[40] causing delays. In GC6, only 37% of allocated funds for community systems strengthening activities was spent.

Agreed Management Action 1
The Secretariat will work with the Federal Ministry of Health, its relevant agencies, and in-country partners to tailor and cost the National Strategic Plan (2026 and beyond) to support a targeted, prioritized and evidence based national response.
OWNER: Head, Grant Management Division
DUE DATE: 31 October 2026

[40] Adamawa, Osun, and Kwara

4.2 Reduced HIV prevalence, new infections and mortality, but PMTCT implementation challenges and limited coverage of key and vulnerable population interventions hindered further progress

Since 2020, Nigeria has reduced HIV prevalence, new infections, and AIDS-related mortality. However, progress for key and vulnerable populations remains limited, due to gaps in the design, quality, and implementation of targeted interventions.

Nigeria has made significant progress in combating the HIV epidemic, with notable declines in HIV prevalence, new infections, and AIDS-related mortality. HIV prevalence decreased from 1.6% in 2020 to 1.4% in 2023.[41] New HIV infections dropped by 26%, from 99,000 in 2020 to 73,000 in 2023, and HIV-related deaths decreased by 33%, from 81,000 in 2020 to 54,000 in 2023.[42] However, there has been limited progress for key and vulnerable populations, due to low coverage and implementation challenges of HIV prevention interventions.

Limited progress on prevention of mother to child transmission (PMTCT) outcomes due to challenges in implementing the national PMTCT scale-up plan

Following the last OIG audit, Nigeria launched a National PMTCT scale-up plan in August 2022 to expand services nationwide and empower states to take ownership of implementation. However, several challenges hindered its impact. The conceptualization and development of the PMTCT scale-up plan was significantly delayed. After finalization, implementation was delayed by over eight months, reducing its timeline from over a year to just seven months. This contributed to only 38% of the budget for PMTCT related activities being utilized by December 2023.

The PMTCT scale-up plan has been extended under the National Treatment and PMTCT Program Plan (2023 to 2026). In GC7, the Global Fund is supporting implementation in comprehensive health facilities in four states, as well as in non-comprehensive and unconventional sites[43] across all 36+1 states.[44] However, there has been a slow start to implementation. As of November 2024, the Principal Recipient responsible for the non-comprehensive sites had not finalized Memoranda of Understanding (MoUs) with all states, delaying Maturity Index Assessments[45] planned to start in December 2024. The Principal Recipient tasked with activating over 10,000 unconventional service delivery points by end of GC7 (December 2026) had activated just 1,171 sites by November 2024.

The challenges and delays in implementing the PMTCT scale-up plan have limited progress in expanding coverage and reducing vertical transmission rates. Vertical transmission remains high, at 23% in 2023, exceeding the regional average.[46] PMTCT testing coverage (34%) and antiretroviral treatment coverage for HIV-positive pregnant women (22%) remain low as of November 2024. Early Infant Diagnosis (EID) remains low, with only 18% of infants tested.[47] OIG site visits to 15 health facilities revealed turnaround times of up to four weeks for EID and viral load samples. In addition, the HIV testing and treatment cascade for children is underperforming, with coverage rates of 30% for testing, 29% for treatment, and 25% for viral suppression as of 2023.[48]

[41] Spectrum estimate data from the National HIV/AIDS, Viral Hepatitis and STIs Control Programme (NASCP)
[42] Ibid
[43] Non-comprehensive sites are healthcare facilities or service delivery points that provide limited services of healthcare interventions. Unconventional sites are non-traditional settings used to deliver health services, often aimed at increasing accessibility for underserved or hard-to-reach populations; these include outreach tents or mobile clinics, workplace clinics, religious or social gathering venues
[44] 36 states and the Federal Capital Territory, Abuja
[45] Maturity Index Assessment refers to an evaluation tool or framework used to assess the readiness, capability, and performance of states, organizations, or entities involved in the implementation of a program or project
[46] Nigeria HIV epi analysis (Accessed 4 Dec 2024)
[47] National Data Reporting System (NDARS) – accessed November 2024
[48] National HIV/AIDS, Viral Hepatitis and STIs Control Programme (NASCP) data

The main drivers for the delayed implementation are:

Design challenges in PMTCT implementation impact their integration and effectiveness: In GC7, one of the approaches used by the Principal Recipient is to utilize the TB community outreach model to identify and test presumed pregnant women during community outreach activities. Delivery of PMTCT services through an integrated approach was one of the recommendations from the Global Fund Technical Review Panel for GC7. While leveraging existing TB community outreach structures offers efficiencies,[49] the specific approach of screening presumed pregnant women in the community through TB community outreach workers lacks supporting evidence of efficacy, and is not well integrated with state government structures and the RMNCAH[50] program. Weak integration between HIV, PMTCT, and Maternal and Child Health programs has also hindered the effectiveness of PMTCT interventions. The Global Fund Secretariat's mitigation action to build capacity within the coordinating unit to ensure integration across programs/components is yet to be completed.[51] Additionally, PMTCT coordination mechanisms at the federal, state, and local government area levels are not yet fully established. This vertical approach risks limiting broader program integration and the sustainability of PMTCT services.

Challenges in engaging states as sub-recipients in both GC6 and GC7, and insufficient government funding to scale up PMTCT activities: The activation of 'situation rooms'[52] at national and state levels, a key risk mitigation action for PMTCT, was delayed. Although 25 states had activated situation rooms, there were no written and endorsed Terms of Reference (ToR) for these situation rooms at either the national or state level. OIG site visits revealed operational gaps in PMTCT services at health facilities: specifically, none of the 14 health facilities visited offering antenatal /PMTCT services had established Standard Operating Procedures (SOPs) for community referrals, potentially affecting care coordination and quality for pregnant women. Furthermore, only 46% (88 out of 191) of HIV-positive mothers in these facilities were screened for high-risk pregnancies during January to June 2024.

Data reporting issues: While reporting coverage from comprehensive sites was 85% as of June 2024, only 44% of non-comprehensive and unconventional sites submitted data. PMTCT data from the Principal Recipient implementing services at unconventional delivery points is not captured in the national system (NDARS), creating gaps in national reporting and monitoring. A recommendation from the previous OIG audit to improve the PMTCT and EID data systems is yet to be fully implemented.

Limited scale and insufficient normative guidance are affecting HIV prevention and control efforts among key and vulnerable populations

Nigeria's National HIV Strategic Plan (2023-2027) prioritizes HIV prevention for key and vulnerable populations, yet national coverage remains suboptimal, ranging from 2% to 45%.[53] The 2024 Key Population Program Review highlighted a decrease in condom use between 2020 and 2024 across a number of groups: 91% to 84% among female sex workers (FSWs); 83% to 56% among men who have sex with men (MSM); 80% to 69% among people who inject drugs (PWIDs); and 79% to 52% among transgender individuals (TGs). The Review also found that the uptake of antiretroviral

[49] This includes using community level structures and systems (as Traditional Birth Attendants/TBAs and TB community outreach programs), optimizing lab service (such as GeneXpert machines for EID), using alternative service delivery points (such as immunization and nutrition centres) to expand services
[50] RMNCAH: Reproductive, Maternal, Newborn, Child, and Adolescent Health program.
[51] The original due date was June 2024, but it has now been extended to June 2025
[52] A "situation room" is a data-driven operational hub where stakeholders, such as government health officials, implementing partners, and donor agencies, meet or coordinate to monitor, analyse, and make decisions about the HIV response in real time. These are often designed to enhance program performance, improve service delivery, and address emerging challenges efficiently
[53] National key population coverage at the end of 2023 was estimated at 45% of FSW, 39% for MSM, 2% for TG, 28% for PWID, 15% for people in closed settings and 3% for at risk AGYW

treatment among key populations remains low, with only 18% of FSWs, 25% of MSM, 16% of PWIDs, and 25% of TGs who tested positive for HIV are currently on antiretroviral treatment. Performance on GC6 and GC7 (as of June 2024) targets for adolescent girls and young women (AGYW) reach with HIV prevention packages was less than 5%.

Consequently, key and vulnerable populations continue to disproportionately drive the HIV epidemic in Nigeria. Although key populations represent just over 3% of the population, they account for 11% of new HIV infections, rising to 32% when including their partners.[54] UNAIDS data shows AGYW accounted for 17% of new HIV infections in Nigeria in 2023. The 2020 Integrated Biological-Behavioral Surveillance Survey revealed an increase in HIV prevalence among MSM, from 17% in 2010 to 25% in 2020, and among PWIDs, from 4% to 11%. While HIV prevalence among FSWs decreased from 27% to 17% among brothel-based sex workers, and from 21% to 15% among non-brothel-based sex workers, it remains significantly higher than in the general population.

Issues contributing to implementation challenges affecting key and vulnerable populations include:

Gaps in the normative guidance for key population (KP) services: KP service delivery packages developed in 2021 have not been updated to reflect evolving risk behaviours, including guidance on using social media platforms for service delivery, and developing robust monitoring and evaluation guidelines. Additionally, despite plans to significantly scale up pre-exposure prophylaxis (PrEP), no national feasibility study has been conducted to assess acceptance, preferences, and challenges, which is essential for an evidence-based approach. While health facilities provide antiretroviral treatment services to key populations, there is no national strategy for developing and transitioning to a sustainable, KP-friendly service model. Only 13% (2 out of 15) of health facilities visited by the OIG had staff members trained on the KP service delivery package.

Limited funding and low absorption: While KP-friendly services are implemented through One-Stop-Shop (OSS)/Prevention services delivery points, coverage remains low, due to funding constraints. OSS sites are available across Nigeria, but 49% (18 out of 36+1) of the states have just one OSS site per state. OSS sites are entirely donor-funded, with no sustainable funding strategy in place, jeopardizing the long-term availability of these services. By the end of GC6, only 52% of the HIV prevention budget was utilized: delays in onboarding sub-recipients contributed to the low absorption, delaying program implementation, resulting in unmet grant targets for key populations.

Human rights challenges: punitive laws, stigma, and discrimination continue to impact access to care. The 2024 Key Population Program review found that, in the 12 months preceding the study, 37% of FSWs, 26% of MSM, 42% of PWIDs, and 19% of TGs experienced harassment by police or other law enforcement agencies. The delayed onboarding of the National Human Rights Commission has further impeded efforts to address these critical challenges.

Limitations in key population monitoring and data systems: Gaps in monitoring and reporting KP program data hinder the ability to monitor and evaluate the effectiveness of HIV prevention and treatment interventions. While the HIV National Strategic Plan includes KP size estimates, it does not outline specific annual targets to achieve 95% coverage by the end of the plan period. Although Nigeria has conducted several rounds of KP size estimation studies, most recently in 2023 across 20 states, there are no updated national size estimates that incorporate recent mapping studies and triangulated programmatic data.

OSS sites currently rely on manual tools to track and report KP service data. In 2023, the National Agency for the Control of AIDS (NACA) developed a key population-specific *Nigerian National Response Information Management System (eNNRIMS)* database. However, it is not interoperable

[54] Modes of Transmission Study Report – UNAIDS, 2022

with the National Data Reporting System (NDARS) database, creating siloed data and hindering comprehensive analysis and reporting.

Agreed Management Action 2
The Secretariat will work with the Federal Ministry of Health, its relevant agencies and the in-country partnership to review the progress of implementing PMTCT and paediatric ART services in GC7 and develop a costed and tailored plan to accelerate service scale up subject to availability of financing.
OWNER: Head, Grant Management Division
DUE DATE: 31 October 2026

4.3 Implementation delays and limited coordination impede the effective use of RSSH and PPR investments

Significant investments in resilient and sustainable systems for health (RSSH) and pandemic preparedness and response (PPR) have helped to reinforce health systems and infrastructure. But several challenges have undermined progress, including procurement delays, inadequate coordination among different health sector entities, and limited domestic health financing.

Across GC6 and GC7, the Global Fund has invested US$157 million in RSSH, focusing on laboratories, supply chains, Community Strengthening Systems (CSS), and Health Management Information Systems (HMIS). Complementing these RSSH grants in GC7, the Global Fund refocused US$79 million of C19RM investments towards pandemic preparedness and response. These efforts have strengthened health systems and infrastructure, and improved governance and coordination through the establishment of an RSSH Steering Committee.

Despite these significant investments, the program did not achieve its RSSH targets.[55] There were significant delays (ranging from 144 to 327 days in GC6) in completing some key projects, as detailed below. Implementation challenges contributed to delays in realizing the intended benefits from investments, especially for data and laboratory systems.

Implementation delays are contributing to significant data quality issues

Health Management Information Systems (HMIS) investments accounted for 43% (US$67 million) of RSSH budget in GC5 and GC6, mainly relating to quarterly program reviews/supervisions, surveys/studies, and printing of tools/guidelines. Approximately 7% of the GC6 RSSH budget was allocated to support investments to advance electronic reporting and interoperability, but progress has been slow. There is limited interoperability between DHIS2 and other health data systems such as warehouse, logistics management, and administrative data sources. Additionally, DHIS2 does not fully capture HIV/TB and PMTCT, and community-level malaria indicator data.

Despite significant investments, the National TB and Leprosy Program (NTBLCP) reverted to manual records and registers to capture TB patient and treatment information, discontinuing use of the eTB Manager[56] due to persistent technical challenges and frequent breakdowns, which had led to a heavy reliance on an external developer for troubleshooting. At the time of the audit, NTBLCP had begun developing a new system, including rolling out a community screening module. However, both Principal Recipients for the TB grants continue to develop and implement parallel TB patient screening tools. One tool captures TB screening by private healthcare providers, and another by community health workers, and the tool for private healthcare providers is not interoperable with the national HMIS (DHIS2). The lack of an integrated data capture source for TB screening across public, private sector, and community interventions limits visibility, data ownership, and sustainability.

Although the Global Fund has supported periodic data quality audits (DQAs), there is inadequate follow-up on data quality improvement. In GC6, three of the seven Principal Recipients lacked DQA trackers for effective monitoring and follow-up on action plans. Additionally, four of the Principal Recipients showed sub-optimal tracking of recommendations, with no evidence of follow-up on issues raised in the DQA reports. The TB program did not conduct 50% of its planned DQAs in GC6.

The challenges noted above have contributed to data accuracy and completeness issues across the three diseases. For example, a proactive HIV data cleaning exercise by the Government and

[55] 8% and 34% vs target for NACA
[56] e-TB Manager is a TB Management Information System

partners identified an overstatement of patients on antiretroviral treatment, resulting in a 16% reduction in the reported number of patients, from 1.9 million to 1.6 million, as of June 2024.

Slow implementation of laboratory interventions affects diagnostic efforts

The Global Fund has invested US$76 million in laboratory interventions in GC6 and GC7, including C19RM interventions. However, slow implementation continues to hinder improvements in diagnostic capacity. For example, the genome sequencing laboratory's completion was delayed by 326 days, due to sub-standard renovation works at the Central Public Health Laboratory (CPHL). Additionally, the procurement of 333 Truenat testing machines for TB, initiated in April 2023, was significantly delayed, and had not been delivered by the time of the audit.[57] Upgrades to 12 public health laboratories, and the installation and operationalization of 32 PSA plants, were delayed by an average of 327 days and 144 days, respectively. While the upgrade of the National External Quality Assurance Laboratory (NEQAL) was completed in March 2024, it was not fully functional at the time of the audit. At the time of the OIG audit, PCR (polymerase chain reaction) machines procured in GC6 for the NEQAL had not been delivered. The slow implementation of laboratory interventions has limited access to quality services, including TB diagnostic services. While other TB diagnostic platforms have been used to compensate for the delays, this has potentially contributed to the low performance of childhood TB case notifications, which accounted for only 7% of notified cases in 2022, and suboptimal performance in drug-resistant TB case finding.

Contributing factors for the delayed implementation of key RSSH and PPR interventions include:

Suboptimal sub-recipient (SR) management and coordination: In GC6, it took an average of 335 days for the Principal Recipient to enter agreements with SRs implementing RSSH activities. In GC7, after prolonged negotiations and disagreement on project costs, the initial SR for the health insurance pilot withdrew in September 2024. Consequently, a new SR, the National Health Insurance Authority (NHIA), was selected over nine months into GC7. The Principal Recipient had not signed the SR agreement with the NHIA at the time of the audit. Although agreements with the Department of Health Planning, Research and Statistics (DHPRS) and National Primary Health Care Department Agency (NPHCDA) have been in place since December 2023, activities have not been implemented due to low readiness. 12,000 electronic tablets procured in September 2024 to help in data collection and collation have not yet been distributed due to pending software specifications and distribution lists from DHPRS. Due to lengthy negotiations and administrative delays, the contractor (UNICEF) that is supposed to provide technical assistance to six SRs, signed an agreement 10 months (October 2024) into GC7. As a result, technical assistance to the SRs had not been implemented at the time of the audit, meaning that the in-country absorption rates of C19RM and RSSH grants were just 16% and 11% in GC6 and GC7 (as of June 2024), respectively.

Significant procurement delays: An OIG sample of eight laboratories found that it took on average over 300 days to complete the procurement process for contractors. Additionally, it took 687 days to approve the order for a PCR machine in the Global Fund's online procurement platform, wambo.org, and approximately 975 days to place orders for PCR machine reagents. These delays were caused by protracted negotiations over the signing of the reagent rental agreement between the manufacturer, supplier, and the grant implementers.[58]

Insufficient domestic health financing: Nigeria’s Government has faced significant challenges in meeting its co-financing commitments for health programs, particularly for HIV, TB, and malaria. During GC6, the Government did not fulfil 36% of its co-financing obligations, with substantial

[57] The delay in the Truenat procurement was due to the complexity of procuring and installing equipment across 300+ sites in 34 states, which required significant time to finalize specifications, delivery, and installation details, compounded by multiple revisions (five times between April 2023 and February 2024) of the initial requisition.
[58] The initial order for the PCR machine and reagents was initiated in December 2021, with the PCR machine order approved in October 2023, the reagent rental agreement signed in August 2024, and the reagent order placed and approved in November 2024

shortfalls in funding for TB (US$47 million), malaria (US$69 million), and HIV (US$15.6 million). These shortfalls were primarily due to macroeconomic challenges, such as inflation and exchange rate devaluation, as well as poor planning, and delays in fund disbursement. Despite some progress, such as Lagos State achieving over 60% of its commitment and 21 states signing MOUs for co-financing warehouse refurbishments, challenges remain in state-level health financing visibility. There were no co-financing agreements for the HIV program with any states, and the TB program lacked MOUs with 23 states. At the time of the audit, 11 months into GC7 implementation, the Government has yet to sign the GC7 co-financing commitment letter, due by June 2024.

Management Action

No agreed management action was considered for this finding, as the finding and root causes are linked to broader RSSH/PPR implementation challenges which are being addressed by ongoing Secretariat initiatives being applied across various countries.

4.4 Enhanced supply chain systems and coordination, but limited oversight and integration undermine progress and sustainability

Progress has been made in the availability and traceability of health commodities at all levels. While improvements were noted in the oversight of supply chain systems and processes, some gaps remain, along with persistent delays in the implementation of supply chain integration interventions.

The Nigeria portfolio is highly commoditized, with 61% (US$1.4 billion) of the Global Fund's total grants for GC6 and GC7 allocated to the procurement of health commodities and related supply chain costs. Fourth-party logistics (4PL) providers manage Global Fund-supported HIV and malaria commodities. These providers oversee the entire in-country supply chain, including warehousing, transportation, inventory management, and order fulfilment through multiple third-party logistics (3PL) providers. The National TB and Leprosy Control Programme (NTBLCP) manages the procurement, warehousing, and distribution of TB commodities (drugs and laboratory reagents), and has integrated last mile delivery of TB and selected HIV commodities, such as harm reduction and PMTCT commodities.

The in-country supply chain mechanism has improved the availability and traceability of Global Fund-supported commodities. In addition, the Global Fund has funded and supported transformative initiatives to enhance supply chain efficiency and sustainability.

Improved availability and traceability of health commodities, but stronger oversight of storage and distribution needed, to mitigate loss and wastage risks

Following the 2022 OIG audit, IT systems for Nigeria's supply chain were enhanced, to improve management. The OIG found that the national warehouse in Abuja, used for HIV and malaria grants, has good storage practices. These facilities ensure commodities maintain their quality without degradation. Performance of HIV and malaria 4PL providers is measured through KPIs. Policies, strategic plans, SOPs, and tools have been developed to guide and improve the supply chain system. A National SOP for managing malaria health products has been established, defining procedures for inter-donor swapping, loaning, and redistribution at both national and state levels. These measures have effectively alleviated potential stock-outs and commodity gaps in the country.

However, further improvement is needed to enhance controls across the supply chain at all levels, to mitigate the risk of loss and wastage of health commodities, and ensure timely availability of commodities.

GC7 implementation arrangements lack adequate oversight for the storage and distribution of HIV commodities: Under the proposed HIV alignment agreement between the Government, PEPFAR, and the Global Fund, PEPFAR will fund warehousing and distribution costs for HIV commodities in the national pool mechanism.[59] In GC7, 95% (US$165 million) of HIV commodities procured by the Global Fund will be managed through this mechanism. Unlike in GC6, the Global Fund has limited oversight and assurance over warehousing and distribution performance. The tripartite HIV alignment agreement, however, is yet to be signed, over a year into the GC7 grants. Additionally, the draft arrangement does not specify oversight or reporting requirements for the 4PL. There are also no Service Level Agreements (SLAs) between the Principal Recipients, the National Product Supply Chain Management Program (NPSCMP), and the 4PL, further limiting monitoring and oversight by in-country grant implementers.

[59] All agreed HIV commodities (i.e. ARVs, rapid test kits, condoms & lubricants, etc.) procured by the three parties (Government of Nigeria, PEPFAR & Global Fund) are collated & managed (warehoused & distributed) collectively

This could undermine the efficiency, accountability, and sustainability of the supply chain arrangement in Nigeria. Without oversight or reporting requirements for the 4PL provider, there is reduced visibility into warehousing and distribution performance, increasing the risk of inefficiencies, errors, or potential misuse of resources. The absence of SLAs restricts the ability of in-country grant implementers to monitor and ensure adherence to performance standards. Additionally, the Global Fund may face difficulties ensuring compliance with its policies and operational standards in the absence of direct oversight mechanisms.

Deficiencies in the oversight of storage and distribution of TB and selected HIV commodities by the National TB and Leprosy Program's (NTBLCP): In GC7, NTBLCP is responsible for warehousing and distribution of TB and HIV commodities (harm reduction and PMTCT) worth US$95 million. There is no evidence of Proof of Delivery (POD) reconciliations at the Logistics Management Coordination Units (LMCU) level for TB drugs, unlike those for malaria and HIV. This risks mismanagement and diversion of commodities. Additionally, NTBLCP lacks a comprehensive performance measurement system for warehousing, such as KPIs for stock levels, product loss, order fulfilment, warehouse compliance, and on-time last mile delivery order submissions for TB commodities. These deficiencies undermine tracking and reporting of supply chain performance, contributing to operational inefficiencies. For example, stocks of TB GeneXpert cartridges were below the recommended minimum stock level of six months during eight of ten quarters between January 2022 to June 2024, contributing to stock-outs at the health facility level.[60]

Limited staffing is a contributing factor. NTBLCP does not have state logistics advisors, unlike the 4PLs managing malaria and HIV commodities. This impacts effective management and coordination of supply chain activities at state level. There are also no service level agreements with state warehouses. NTBLCP's data management capabilities are limited, with some key warehousing data points missing, such as stock adjustments and shelf life at receipt, which undermine effective decision-making and accountability.

Limited enforcement of the shelf-life policy has contributed to losses due to expired products: The OIG observed gaps in inventory management and enforcement of the shelf-life policy, particularly for genomic sequencing laboratory commodities (consumables and reagents). Between January 2022 and August 2024, 49% of these commodities, worth US$3.1 million, had less than the recommended 75% remaining shelf life, with some having already expired upon receipt. This contributed to expiries of genomic sequencing laboratory commodities worth US$1.8 million. Contributing factors included inefficient procurement processes, with the Principal Recipient accepting pipeline orders with short remaining shelf life. For example, in August 2024, 30% of items received had an average remaining shelf life of 2.7 months out of a total average shelf life of 4.7 years. Inconsistent shelf-life policies among 4PL providers also played a role, with one 4PL enforcing a 75% remaining shelf-life policy and the other considering 3-6 months as short-dated. Delays in completing the genome sequencing laboratory also contributed to expiries (*see finding 4.3 for details*).

Sub-optimal controls over warehouse stock adjustments: The audit noted gaps in the 4PL providers' oversight of sub-contracted 3PL providers' inventory management practices. Based on a sample of four malaria tracer commodities, unapproved adjustments worth US$0.8 million were made at the Abuja Premier Medical Warehouse between January 2022 and April 2024. While these adjustments were subsequently fully reconciled during the audit, they were passed by 3PL warehouse personnel without the requisite 4PL provider approval, indicating a lapse in control and oversight. Although the 4PL provider's SOPs require reporting on inventory adjustments with accompanying justifications, this has not been enforced.

[60] Five out of 15 facilities visited had stock out of GeneXpert cartridges averaging 43 days

Delayed transition of TB laboratory supply chain resulted in contracting gaps over warehousing arrangements: During GC7, the warehousing and distribution of TB laboratory and cold chain commodities were transitioned from the Institute of Human Virology Nigeria (IHVN) to NTBLCP. However, there is no contract between NTBLCP and the third-party warehouse, after the previous contract with IHVN lapsed in June 2024. This puts US$0.5 million worth of commodities at risk, with a third-party continuing to provide storage without a contract. Additionally, operationalization of the refurbished cold chain storage facility at the Federal Central Medical Stores, funded under the C19RM grants, was delayed. Due to NTBLCP's delay in finding alternative cold chain storage solutions after transitioning from IHVN in July 2024, additional warehousing costs continue to accrue at the time of the audit.

Significant delays in the implementation of supply chain integration interventions limit efficiencies and sustainability

Over the past nine years, efforts have been made to address supply chain challenges by integrating vertical supply chains for HIV, TB, Malaria, and Reproductive Health to ensure cost-efficiency, effectiveness, and sustainability. Since 2015, the Global Fund has invested over US$39 million in supply chain integration interventions, and the country has developed several plans[61] to guide this integration. Some progress has been made in strengthening Nigeria's supply chain through initiatives led by the National Product Supply Chain Management Program (NPSCMP). These include the development and roll-out of policies, strategic plans, and standard operating procedures (SOPs) to improve the supply chain system, as well as the establishment of the Drug Revolving Fund (DRF) and Drug Management Agencies (DMAs) in 23 states as of October 2024.

However, the implementation of supply chain integration activities in the National Health Supply Chain Strategic Plan (2021-25) is not on track, with only 14% of activities completed as of October 2024. Similarly, the implementation of sub-set supply chain integration plans is delayed, with progress ranging between 14% and 29% as of October 2024. Consequently, the Global Fund and other donor-funded programs continue to rely on parallel supply chain arrangements and 4PL providers for storage and distribution.

The root causes of Nigeria’s limited progress on supply chain integration include:

Limited governance, capacity, oversight, and coordination: The establishment of a supply chain agency, an objective under the 2015 Nigeria Supply Chain Integration Project and the 2022 Last Mile Distribution Transition plan, has yet to be achieved. This agency was intended to streamline governance, coordination, and oversight of supply chain activities, but its delay is hindering integration efforts. The NPSCMP, mandated to coordinate all health sector supply chain activities, has limited capacity to effectively fulfil its mandate. NPSCMP does not effectively monitor the implementation of various plans and lacks mechanisms to track financial commitments from the Government and partners. Additionally, Global Fund-supported technical assistance for NPSCMP via the Supply Chain Operations Unit (SCOU) has been delayed.

Delayed completion of key activities: A three-month delay in recruiting and onboarding the SCOU for technical assistance at NPSCMP contributed to the non-implementation of 17%[62] of the activities in the 2023 Implementation Plan. Similarly, the delayed operationalization of refurbished state warehouses resulted in the non-implementation of 44%[63] of activities in the 2023 Implementation Plan.

[61] National Health Supply Chain Strategic and Implementation Plan (NHSCP) 2021- 25, Transition plan for instituting & managing the National integrated and optimized Last Mile Delivery (LMD) system (Feb 2022); Pre-transition Plan (2024)
[62] Relates to activities supporting states in setting up 3PL procurement systems and managing 3PL SLAs, capacitating NPSCMP to oversee state distribution processes through audits, demand planning, and knowledge transfer.
[63] Relates to activities including State-led last mile delivery piloting, state level engagement of 4PL providers and integration of all disease programs into bimonthly distribution

Limited funding and oversight: The implementation of the integration plans faces significant hurdles due to funding constraints and inadequate tracking mechanisms. Heavy reliance on donors at both national and sub-national levels limits financial sustainability. There is limited visibility on stakeholders' funding commitments and the status of their fulfilment. Some plans are costed without accompanying funding plans, while others lack both cost estimates and funding framework, undermining their effectiveness. Insufficient co-financing, primarily due to macroeconomic challenges such as inflation and exchange rate devaluation, contributed to delays in renovating 21 state warehouses.

Agreed Management Action 3

The Secretariat will work with the Federal Ministry of Health, Principal Recipients and in-country partnership to:

a) Revise the National Supply Chain Strategy to ensure alignment with national priorities and reflect the evolving in-country context for the period 2026-2030.

b) Advance the operationalization of the Federal and States warehouses to strengthen overall warehousing capacity.

OWNER: Head, Grant Management Division

DUE DATE: Part A – 30 June 2026; Part B – 31 October 2026

Agreed Management Action 4

The Secretariat will work with the Federal Ministry of Health, Principal Recipients and in-country partnership to strengthen the oversight and performance monitoring framework to:

a) Develop a costed commodity oversight plan capturing key activities to be performed to strengthen accountability, warehousing and distribution of HIV commodities procured by the Global Fund.

b) Develop performance measurement framework for warehousing and distribution for commodities handled by NTBLCP, including key performance indicators (KPIs) for stock levels, product loss, order fulfilment, warehouse compliance, and on-time last mile delivery order submissions.

OWNER: Head, Grant Management Division

DUE DATE: 30 June 2026

4.5 Enhanced financial assurance and risk mitigation measures, but gaps in oversight and internal controls result in persistent issues

Measures instituted by the Global Fund have helped to mitigate against overall fiduciary risk in the portfolio. However, gaps in the effective execution of financial controls and assurance activities are impacting the efficient use of grant resources, and contributing to the recurrence of issues.

The Global Fund has implemented measures to mitigate high fiduciary risks. These include a robust finance assurance framework that encompasses internal audit functions at all Principal Recipients, the appointment of a Fiscal Agent to provide fiduciary oversight of grants led by specific implementers, as well as the involvement of external auditors and the Local Fund Agent. Disbursements to the national disease programs are made in Nigerian Naira to safeguard against foreign exchange fluctuation risks. The Global Fund has supported the development and update of financial management policies and procedures, along with the roll-out of a financial accounting and reporting system to process transactions by the national disease programs.

While financial assurance mechanisms routinely identify and report on financial risks and issues, the audit noted lapses in the effective execution of financial controls and assurance activities, leading to recurring issues impacting the efficient utilization of grant resources.

Lapses in the enforcement of controls and assurance increase financial and value-for-money risks

Global Fund grant implementers are required to have adequate financial management systems to ensure the effective and efficient use of financial resources for their intended purposes. However, the audit noted sub-optimal enforcement of internal controls, as described below:

Non-adherence to in-country procurement guidelines: The OIG identified continued delays[64] in procurement processes among some Principal Recipients, based on the procurement samples reviewed. Additionally, procurement procedures were not routinely adhered by all Principal Recipients. For example, the audit noted instances for procurements amounting to US$1.7 million where price quotations were not sourced from all pre-qualified service providers with Service Level Agreements/Long-Term Agreements, as required.

Principal Recipients do not effectively manage contracts signed with service providers, including conducting performance assessments. Instances were noted where advance payments were made to suppliers without the requisite guarantees. Similarly, service providers were repeatedly awarded contracts despite delays in the performance of previous contracts. While goods and services were delivered, the non-adherence to procurement procedures reduced competition and could limit value for money.

Although the Fiscal Agent (FA) is required to be involved in the procurement process for all local procurements, and to review all payment vouchers above set thresholds, Principal Recipients did not involve the FA in some cases[65], contributing to procurement lapses. The OIG noted that the involvement of the FA is not stipulated in all implementers' financial policies and procedures. Delays

[64] Average number of days from requisition date to date of issuance of Purchase Order/ contract signing – NACA (253 days); NMEP – (121 days) FHI360 – (170 days). Similar issue reported in the 2022 OIG audit report (OIG report number GF-OIG-22-003)
[65] Between January 2022 & June 2024, there were procurements worth US$ 580K (₦ 631M) undertaken by 3 PRs without the FA's involvement as required.

of over 13 months in the implementation of the Common Vendor Database[66] also hindered the remediation of some of the procurement issues identified above.

Gaps in sub-recipient oversight undermine safeguarding of grant resources: While all Principal Recipients have policies to guide periodic financial monitoring of SRs' financial activities, the audit identified gaps in SR oversight. PRs do not have risk-based monitoring plans. Given the high number of SRs engaged, adequate prioritization of monitoring activities without risk-based monitoring plans may not be feasible. The audit also noted instances where planned financial monitoring visits were either delayed or not conducted.[67]

Improvement required in Fiscal Agent reviews to improve enforcement of internal controls

The Fiscal Agent's has contributed signficantly in safeguarding Global Fund resources in Nigeria. The FA has undertaken fraud training and performs fraud surveys at selected PRs. Aditionally, the FA has developed tailored tools and checklists that hamornize the various procurement and finance reviews and checks across the different implementers. However, the audit noted that the reviews performed by the FA are not consistently effective. As highlighted above, there were instances of non-adherence to procurement guidelines, despite the FA involvement in the procurement process.[68] Additionally, there were gaps in the adequacy of FA reviews during the payment processes, and the FA did not participate in verifying goods received by implementers before payments were made. This is due to a control design limitation, as the FA's work orders do not require their involvement in verifying the goods received. Similar gaps were identified in the OIG's 2018 and 2022 audits.[69]

Consequently, there were sampled transactions amounting to US$3.3 million[70] where the FA had granted payment clearance despite the absence of, or material inconsistencies in, supporting documents. Additionally, there were sampled transactions amounting to US$0.5 million[71] where there was no evidence of the FA's prerequsite review prior to processing transactions in the accounting system.

While these instances are not highly material in the context of the Nigeria grants, the lapses in enforcing internal controls and gaps in the quality of the FA services have contributed to the recurrence of issues including procurement challenges, fixed assets management issues, and repeated errors/exceptions. Contributing factors for these issues include:

Insufficient rotation of the FA's financial experts: The FA embeds its financial experts within implementer organizations, however they are not routinely rotated.[72] The design of some key performance indicators to assess the FA's performance may potentially discourage the FA from reporting control issues that reflect poorly on their performance. This increases risks of self-review, advocacy, and familiarity, which may limit the FA's effectiveness.

Limitations in the design and execution of capacity building activities: In GC6, capacity building activities were designed without baseline capacity assessments, and lacked metrics for monitoring and evaluating their effectiveness. Additionally, there were delays or non-implementation of activities[73] outlined in the capacity building plans. The third-party service provider intended to

[66] The Common Vendor Database is an initiative of establishing a centralised database of vendors shortlisted via a pre-determined and harmonized pre-qualification process
[67] Between January 2022 to June 2024, only 16% and 3% of required monitoring visits were undertaken by NTBLCP & NACA respectively
[68] 12% (23 out of 189) of procurements sampled by OIG identified compliance and control gaps despite having reviewed by the FA
[69] OIG audit reports on grants in Nigeria, 2018 & 2022 (OIG report number GF-OIG-18-005; OIG report number GF-OIG-22-003)
[70] The identified exceptions relate to a sample of transactions at four PRs: NMEP - US$2,455,082; NTBLCP - US$579,393; IHVN - US$182,888; and NACA - US$46,116
[71] The identified exceptions involve five transactions under NTBLCP totalling US$438,855 and one transaction under NACA amounting to US$25,963
[72] NACA had the same finance expert from July 2020 to Sept 2024 (>4 years), NTBLCP had same finance expert from Sept 2021 to date (>3 years), NMEP had same finance expert from May 2022 to date (2.5 years). The changes in 2020 & 2021 are due to staff attrition
[73] Capacity building trainings not undertaken - NACA (60%), NMEP (78%), LSMoH (100%). All Short-Term Experts scheduled for NTBLCP, NMEP, LSMoH and NACA were not undertaken

undertake capacity building activities in GC7 has yet to be recruited by the Global Fund Secretariat at the time of the audit, 11 months after the start of the GC7 grants.

Agreed Management Action 5
The Secretariat will work with the Principal Recipients and the Fiscal Agent to develop a Common Vendor Database to enhance efficiency and accountability for local procurement of non-health products services.
OWNER: Head, Grant Management Division
DUE DATE: 31 October 2026

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 2018, the Global Fund operationalized a Risk Appetite Framework, 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.

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

OIG's assessed residual risks are compared against the Secretariat's assessed risk levels at an aggregated level for those of the 13 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 Nigeria: comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment is aligned with the OIG audit rating except for malaria program quality and RSSH & Pandemic Preparedness. Below is a summary of the considerations for the OIG's assessed residual risk ratings:

Malaria program quality risk is "High" due to limited coverage of key malaria control interventions and insufficient engagement with the private sector and communities, which contributed to 22% of new malaria cases between 2020 and 2023. The private sector accounts for 50% of registered health facilities on the DHIS2 in 2022. Funding and government co-financing challenges led to changes in planned interventions. For example, mass ITN distributions in urban areas were conducted in only 9% of targeted LGAs due to funding constraints. Insufficient government funding also caused shortages of ITNs and Sulphadoxine-Pyrimethamine (SP) for intermittent preventive therapy in pregnancy (IPTp). This resulted in significant stockouts, with 47% of health facilities experiencing routine ITN stockouts, averaging 120 days during the audit period. Consequently, IPTp1 coverage reached 52% nationwide between 2021 and 2023, but IPTp3 remained low, ranging from 36% to 43%. Refer to finding 4.1 for details.

RSSH & Pandemic Preparedness risk is "High" due to challenges in grant implementation and coordination, which limit the effective use of investments for sustainability. Despite significant investments, procurement delays, poor coordination among health sector entities, and limited domestic health financing have hindered timely benefits. Specifically, the slow implementation of laboratory interventions, such as the delayed completion of the genome sequencing laboratory and procurement of 333 Truenat machines, has impeded diagnostic efforts. This has limited access to quality services, including TB diagnostics, potentially contributing to the low performance of childhood TB case notifications, which accounted for only 7% of notified cases in 2022. Refer to finding 4.3 for details. Other contributing factors for the suboptimal performance of the RSSH interventions including government counterpart funding issues were assessed under the Health Financing risk.