



OFFICE OF INSPECTOR GENERAL
U.S. Agency for International Development

Assessment and Oversight Gaps Hindered OFDA's Decision Making About Medical Funding During the Ebola Response

AUDIT REPORT 9-000-18-002-P
JANUARY 24, 2018

1300 Pennsylvania Avenue NW • Washington, DC 20523
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MEMORANDUM

DATE: January 24, 2018

TO: USAID/DCHA/OFDA, Acting Director, Carol Chan

FROM: IG/A/GSAD, Director, Van Nguyen /s/

SUBJECT: Assessment and Oversight Gaps Hindered OFDA's Decision Making About Medical Funding During the Ebola Response (9-000-18-002-P)

This memorandum transmits the final report on our audit of Ebola treatment units, community care centers, and medical commodities. Our audit objectives were to determine if USAID's Office of U.S. Foreign Disaster Assistance (1) effectively assessed needs for Ebola treatment units, community care centers, and medical commodities to respond to the Ebola outbreak in Guinea, Liberia, and Sierra Leone, and (2) adequately oversaw the treatment units, centers, and medical commodities it funded. In finalizing the report, we considered your comments on the draft and included them in their entirety, excluding attachments, in appendix D.

The report contains eight recommendations to help OFDA better assess needs for emergency responses and to better monitor the efficiency and effectiveness of relief activities. After reviewing information you provided in response to the draft report, we consider six resolved but open pending completion of planned activities (recommendations 1, 3, 5, 6, 7, and 8) and two unresolved (recommendations 2 and 4).

For the resolved recommendations, please provide evidence of final action to the Audit Performance and Compliance Division. For recommendations 2 and 4, please work with us to resolve them.

We appreciate the assistance you and your staff extended to us during this audit.

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INTRODUCTION

On August 8, 2014, the World Health Organization (WHO) announced that the Ebola virus outbreak in West Africa had become a public health emergency of international concern, with Guinea, Liberia, and Sierra Leone the three most affected countries. After the U.S. Centers for Disease Control and Prevention (CDC) estimated that the number of cases could rise to 1.4 million by January 20, 2015, without intervention, President Obama announced the U.S. Government strategy and Congress appropriated funding for the response.

Of the \$1.3 billion the Department of State and USAID requested to control the outbreak, most was for building and managing medical facilities—\$756 million was designated for Ebola treatment units (ETUs) and community care centers (CCCs). Another \$297 million was for medical commodities and training, and the remaining \$247 million was for other activities.¹

The Office of Inspector General (OIG) conducted this audit to determine (1) whether USAID's Office of Foreign Disaster Assistance (OFDA) effectively assessed needs for ETUs, CCCs, and medical commodities to respond to the Ebola outbreak in Guinea, Liberia, and Sierra Leone and (2) whether USAID/OFDA adequately oversaw the ETUs, CCCs, and medical commodities it funded.

To conduct our work, we interviewed OFDA and other USAID personnel, implementers, host-country government officials, United Nations (U.N.) agencies, and other stakeholders involved in Ebola response efforts in West Africa; conducted site visits to a selection of ETUs, CCCs, warehouses, and health facilities in Guinea, Liberia, and Sierra Leone; and reviewed award documents, policies and procedures, and Ebola case data and projections. Appendix A presents our scope and methodology.

SUMMARY

USAID/OFDA neither effectively determined initial needs nor sufficiently reassessed those needs as the outbreak evolved, leading to decisions based on insufficient information and to inefficient expenditures. OFDA conducted a high-level initial assessment that identified a general need for protective equipment, structures, personnel, and supplies for patient isolation and treatment, and other assistance but lacked detail—such as the number and size of ETUs and CCCs, where to build them, and when they needed to be operational. OFDA's Field Operations Guide provides technical guidance on conducting damage and needs assessments, but staff did not follow it because they felt it was outdated and they did not think it applied to an emergency as

¹ Budget amounts come from the Emergency Request Justification, Department of State, Foreign Operations, and Related Programs, Fiscal Year 2015.

complex as Ebola. Insufficient assessments contributed to the delayed opening of ETUs and CCCs and resulted in an excess of medical commodities. By the time most ETUs and CCCs were operational, the majority of confirmed Ebola cases had already occurred.

In addition, OFDA did not adequately oversee the ETUs, CCCs, or commodities it funded, and it lacked the information it needed to track activities and determine the funding's effectiveness. OFDA's Field Operations Guide states: "Monitoring systems should be put in place to enable relief officials to determine whether a situation is improving or deteriorating . . . and must include ways to measure the efficiency and effectiveness of relief activities." However, OFDA generally does not view this level of monitoring as part of its responsibilities, and there was some confusion over whose responsibility it was. Inadequate staffing levels, turnover on the Disaster Assistance Response Teams (DART) in each country and on the Washington-based Response Management Team (RMT), and too few agreement officer's representatives (AOR) overseeing awards also hindered OFDA's ability to monitor activities.

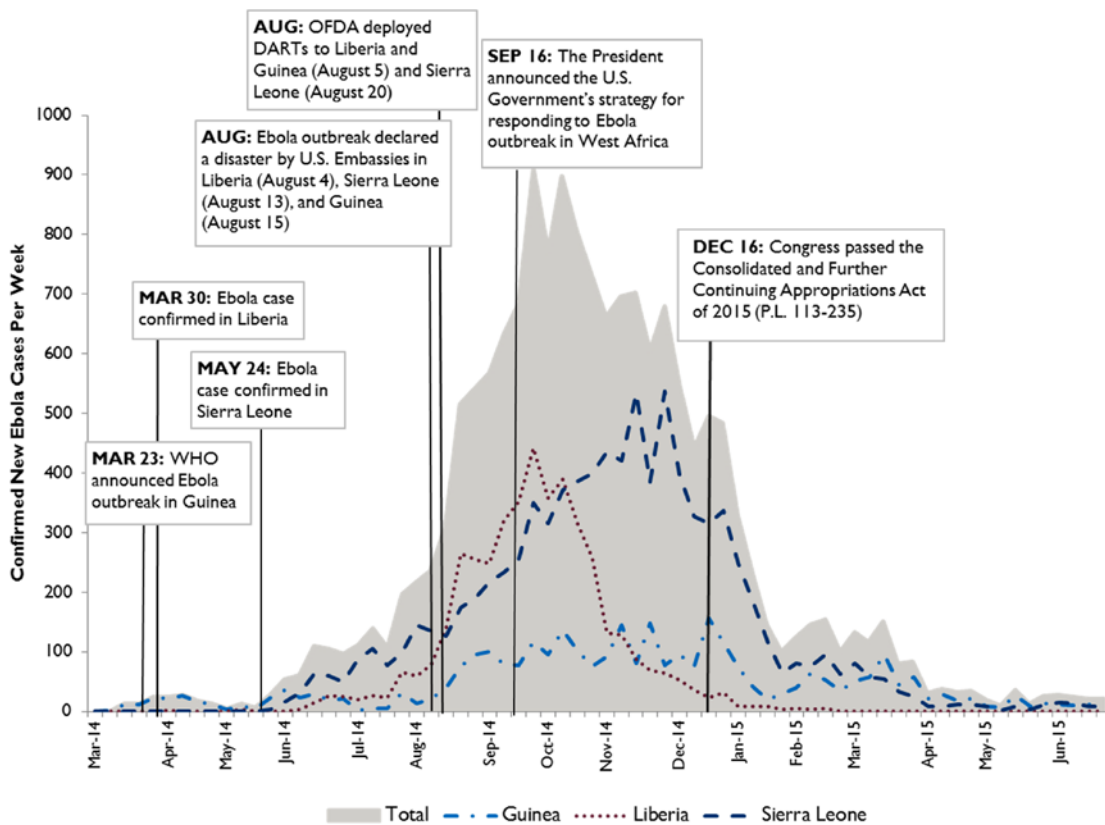
We are making eight recommendations to help OFDA better assess needs at the outset of an emergency and continually throughout, and to better monitor the efficiency and effectiveness of relief activities.

BACKGROUND

The U.S. Government's response to the West Africa Ebola outbreak involved multiple departments and agencies, including USAID, CDC, the Department of State, the Department of Defense, and the Department of Health and Human Services. USAID was designated as the lead Federal agency to manage and coordinate the U.S. response effort overseas through OFDA, which typically leads the U.S. Government's response to overseas disasters such as earthquakes, floods, drought, and conflict. CDC, with its technical expertise, led the medical and public health component of the response.

As the Ebola outbreak accelerated, several models were prepared predicting the number of cases that could result from the outbreak without effective control measures. A model funded by the National Institutes of Health predicted up to 6,800 new cases in Guinea, Liberia, and Sierra Leone during the last half of September 2014, while WHO's model predicted 20,630 cumulative cases by early November 2014. CDC predicted that in a worst-case scenario, if there were no additional actions taken or changes in community behavior, the outbreak could result in as many as 1.4 million cases in Liberia and Sierra Leone by late January 2015. This prediction garnered great attention in the United States, and fear of Ebola as an international security concern became a major driver of response efforts. Figure 1 shows key events in the U.S. Government response as the outbreak unfolded.

Figure 1. Timeline of the Ebola Outbreak and Key Events in the U.S. Government Response



Source: OIG analysis of the number of new confirmed cases per week in Guinea, Liberia, and Sierra Leone from March 2014 through June 2015, published on WHO's website.

In the emergency congressional budget request for the Department of State and USAID, the focus was on the construction and management of ETUs and CCCs. OFDA initially budgeted \$747 million for this activity, but ultimately obligated \$346 million and disbursed \$318 million.

ETUs, like the one shown on the next page, were to safely isolate and treat suspected and confirmed Ebola patients; generally, CCCs were used to safely manage patients while ETUs were being constructed and to quickly isolate and provide basic care for patients when ETUs were full or unavailable.



Ebola treatment unit awaits patients in Lunsar, Sierra Leone. Photo: OIG (July 6, 2015)

OFDA also funded the purchase of medical commodities—protective equipment, medical supplies, medical equipment, pharmaceuticals, and other supplies, some of which are shown in figure 2—to protect workers and care for patients. OFDA funded these procurements through organizations involved in managing ETUs and CCCs and through U.N. agencies that fed the countries’ central supplies. Implementers budgeted some \$96 million for this activity using OFDA funds.²

Figure 2. Full Protective Equipment Used in Treating Ebola Patients



Source: Médecins Sans Frontières.

² Since OFDA was not tracking this information, we calculated it after reviewing implementers’ award documents. This is our best estimate of the amount budgeted for medical commodities with OFDA funds from August 2014 through June 2015. The amount expended is unknown.

The other activities OFDA funded included contact tracing, health worker support services, burial teams, social mobilization, and community outreach.³ While these activities were complementary and deemed critical by members of the international community, the budgetary focus of USAID and the Department of State to control the outbreak was on ETUs, CCCs, and medical commodities.

Two things in particular affected OFDA's role in responding to the outbreak:

- U.S. Government personnel understood the United States would lead response efforts in Liberia, the United Kingdom in Sierra Leone, and France in Guinea, but OFDA officials said this understanding did not materialize. OFDA focused on Liberia initially but ramped up efforts in Guinea and Sierra Leone once it became clear that more support was needed. This put even more pressure on OFDA when its human resources were already stretched thin. The U.S. Government was ultimately the largest international financial contributor to Ebola response efforts in West Africa.⁴
- The traditional U.N. coordination system that is usually set up to respond to large-scale humanitarian emergencies was not set up for this outbreak. Instead, the U.N. Mission for Ebola Emergency Response (UNMEER) was established to coordinate the efforts of U.N. agencies, donor countries, and international nongovernmental organizations (NGO) to avoid gaps in the response. However, it was slow to get started and did not provide adequate coordination.⁵ OFDA stepped in to help coordinate response efforts.

In March 2016, WHO's Director-General announced that the West Africa Ebola outbreak was no longer a public health emergency of international concern. The outbreak was the largest recorded to date, with more than 28,600 cases and more than 11,310 deaths,⁶ and was the first to spread through both urban and rural areas of multiple countries. Ultimately, the combined efforts of donors, host-country governments, international organizations, NGOs, and the U.S. Government—coordinated by OFDA—saved lives and contributed to controlling the outbreak. Murals on the walls of ETUs, like the one shown on the next page, celebrate those who survived.

³ Contact tracing is the process of identifying all the people who have had contact with someone who tested positive for Ebola and ensuring they are aware that they have been exposed. Social mobilization and community outreach activities aim to disrupt transmission of the virus by informing people of the risks of certain behaviors and promoting alternative, safe behaviors.

⁴ As of June 30, 2015, according to USAID and CDC's West Africa Ebola Outbreak Fact Sheet #37 for Fiscal Year 2015.

⁵ WHO's "Report of the Ebola Interim Assessment Panel" (not dated) and OFDA's "Ebola After Action Review Final Report," September 2015.

⁶ Includes confirmed, probable, and suspected cases in Guinea, Liberia, and Sierra Leone according to WHO's Ebola Situation Report, June 10, 2016.



Handprints of Ebola survivors paint the wall of an ETU in Gbarnga, Liberia. Photo: OIG (June 22, 2015)

OFDA’S INITIAL AND ONGOING NEEDS ASSESSMENTS WERE INSUFFICIENT TO SUPPORT INFORMED DECISIONS ABOUT ETUS, CCCS, AND MEDICAL COMMODITIES

OFDA’s Field Operations Guide provides technical guidance on conducting damage and needs assessments to ensure a disaster response is timely, appropriate, and cost-effective.⁷ The guide states that “the information collected in the initial assessment(s) is the basis for determining the type and amount of relief needed during the immediate response phase of the disaster.” The guide also states:

An assessment should not be seen as an end in itself, but rather as one part of a continuing process of reevaluating the needs and capacities of affected populations as well as the effectiveness and appropriateness of responses to the disaster situation. This is particularly true in long-term, complex humanitarian emergencies.

However, OFDA’s initial and ongoing assessments were insufficient to support decisions about ETUs, CCCs, and medical commodities for timely and appropriate assistance.

OFDA’S INITIAL NEEDS ASSESSMENT DID NOT LEAD TO TIMELY AND APPROPRIATE ASSISTANCE

OFDA conducted a high-level initial assessment—documenting the magnitude of the disaster and identifying a general need for protective equipment, patient isolation and treatment, coordination, and other assistance—but it lacked details outlining how OFDA determined how many ETUs and CCCs to build, where to build them, what size they should be, when they needed to be operational, what went into their design, and

⁷ Version 4.0, dated September 2005.

how much they cost.⁸ No documentation showed how OFDA determined the medical supplies and equipment needed for the ETUs, CCCs, and other healthcare facilities, such as which type of protective equipment OFDA endorsed, or which guidance OFDA encouraged implementers to follow in quantifying their medical commodity needs. Similarly, we were unable to locate documentation to support the basis for other assumptions, including which case projection informed response efforts.

OFDA staff did not follow the Field Operations Guide because they felt it was outdated and not applicable to such a complex emergency. Staff said the guide's basic concepts are focused on natural disasters. A senior official said it is no longer representative of how OFDA operates for the following reasons:

- The industry has changed and needs assessments have become more formal, technical, and data intensive than when the guide was written; OFDA does not have the expertise or staff to do a detailed assessment.
- OFDA has not had enough staff to update the guide without detracting from ongoing responses.
- OFDA does not always have access to the places where assessments need to be done, partly because of security restrictions.

The senior official said it would take years to revise the guide and get it approved. Other OFDA officials said new guidance is being developed, but no interim guidance has yet been published.

Instead of conducting a detailed needs assessment, OFDA officials said their current practice is to “triangulate” information from host-country governments, implementers, and other sources—meaning they validate the data by cross-checking two or more sources. However, OFDA does not have guidance explaining triangulation and did not have documentation showing how this process was conducted or that the information gathered was validated. For instance, USAID officials said they relied on the host-country governments to specify ETU and CCC needs and on implementers to determine medical commodity needs, but there was no apparent cross-verification or other check to determine whether the purchases were necessary.

Not having a detailed needs assessment contributed to a slow rollout of ETUs and CCCs in Liberia. According to a lessons learned document incorporating feedback from the DART, the U.S. Department of Defense, and the Armed Forces of Liberia,⁹ only one

⁸ Exact costs to build and manage an ETU and a CCC are uncertain. Based on budgeted estimates from an implementer, the cost of building an ETU could range from \$64,000 to \$104,000. A separate document developed by OFDA suggests the average cost of building a 100-bed ETU through the Department of Defense could be as much as \$1.5 million. OFDA estimated the cost of managing a 100-bed ETU for one month at \$1 to \$2.5 million. OFDA did not know the costs for building and managing a CCC.

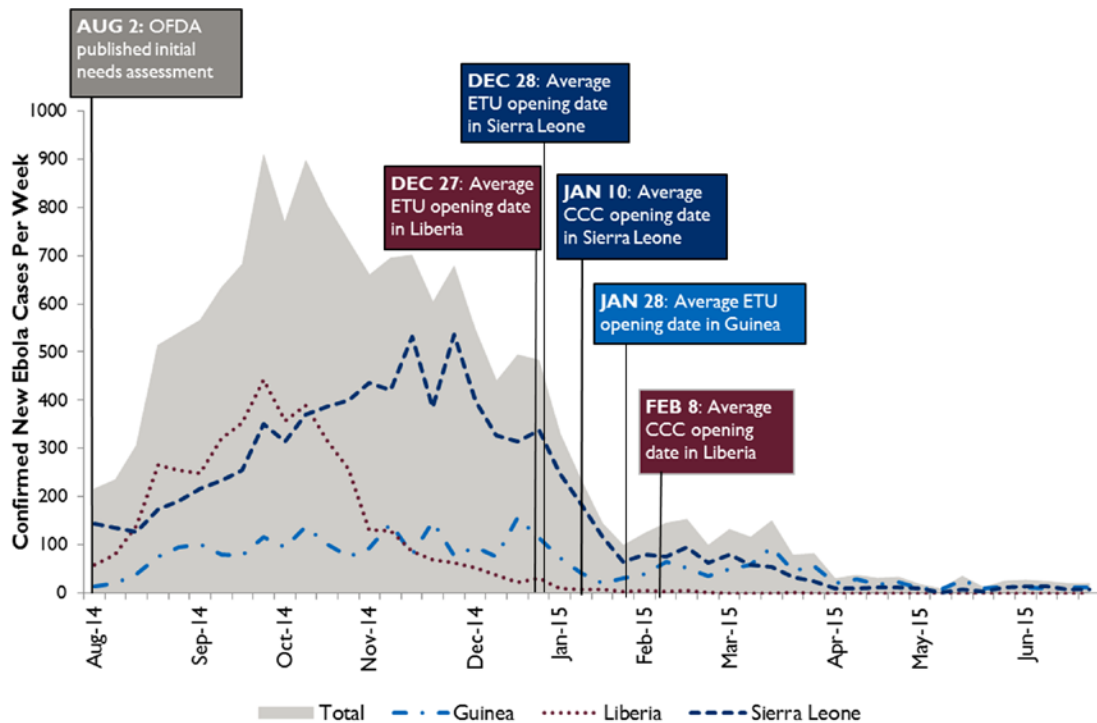
⁹ “ETU Lessons Learned – DART Liberia,” December 20, 2014, developed by USAID and the Department of Defense.

ETU model designed by Médecins Sans Frontières (Doctors Without Borders, or MSF) existed before the Ebola outbreak in West Africa. Response actors adapted that model to the projected scale of the outbreak, but their unfamiliarity with the design of an ETU and with the local resources available to build one delayed implementation. Selecting the sites for ETUs was also challenging because it required community and leadership buy-in and consideration of other factors, such as access to water and the conditions of roads for transporting supplies.

With ETUs taking 1 to 3 months to become operational, West African governments and the international community saw CCCs as the most practical way to prevent further transmission and safely manage patients while ETUs were being built. Yet CCCs represented an untested approach to controlling an outbreak. CCCs would be small, lightly staffed, community-operated facilities made from local materials. They would be easier to set up than ETUs and would provide basic care, safely dispose of waste, and manage burials. CCCs were to outnumber ETUs and be in more remote places. When more ETUs opened, CCCs would still be used to provide initial isolation and treatment as needed.

However, the rollout of OFDA-funded CCCs was delayed because technical experts and host-country governments could not agree on the approach. The general concern was that if not designed and managed properly, CCCs could contribute to spreading the virus instead of controlling it. Since laboratories initially were not equipped to confirm suspect cases, people with other illnesses presenting Ebola-like symptoms (such as malaria or typhoid) might be admitted to a CCC, where they would be unnecessarily exposed to Ebola. Another concern was that CCCs might not be able to ensure proper staffing, training, and supervision to safely manage patients. By the time most OFDA-funded ETUs and CCCs were operational, the majority of confirmed Ebola cases had already occurred (figure 3).

Figure 3. ETU and CCC Openings in Relation to the Progression of the Outbreak



Note: Opening dates were based on available information (provided by OFDA and its implementers) for 22 of the 24 ETUs in Guinea, Liberia, and Sierra Leone and for 17 of the 25 CCCs in Liberia and Sierra Leone. Dates were not provided for the other two ETUs. Of the other eight CCCs, two never opened, and data were insufficient for six. Average opening dates were then compared with the cumulative number of confirmed Ebola cases that had occurred in each country at those times.

Source: OIG analysis of the number of new confirmed cases per week in Guinea, Liberia, and Sierra Leone from August 2014 through June 2015, published on WHO’s website.

On average, OFDA-funded ETUs opened after 77, 99, and 85 percent of confirmed Ebola cases had occurred in Guinea, Liberia, and Sierra Leone, respectively. CCCs on average opened even later, after almost 100 and 90 percent of confirmed cases had occurred in Liberia and Sierra Leone, respectively. Appendix B details when OFDA-funded ETUs and CCCs came online in relation to the progression of the outbreak in each country.

While the early ETUs had significant impact in safely managing Ebola patients, the impact of ETUs and CCCs opening later was much less, especially in Liberia, where OFDA funded the largest number of ETUs and CCCs. Of the six ETUs sampled in Liberia, the first two opened on average 3 months before the others and admitted 30 times as many suspect patients. Of the 11 CCCs sampled, 2 never opened, 4 never saw any patients, and the remaining 5 together admitted some 10 patients, none testing positive.

Though most Ebola cases had occurred before many of the ETUs and CCCs opened, responders had a valid concern at the time that case numbers could increase again because of the porous country borders and active cases in the region. However, the lack of adequate ongoing needs assessments and monitoring to track new cases kept OFDA leaders from recognizing the decline in real time and adjusting response efforts accordingly.

Appendix C lists all the ETUs and CCCs in our sample and the number of patients admitted and testing positive for Ebola at each.

OFDA'S ONGOING NEEDS ASSESSMENTS WERE INADEQUATE, RESULTING IN \$4.6 MILLION IN EXCESS INVENTORY

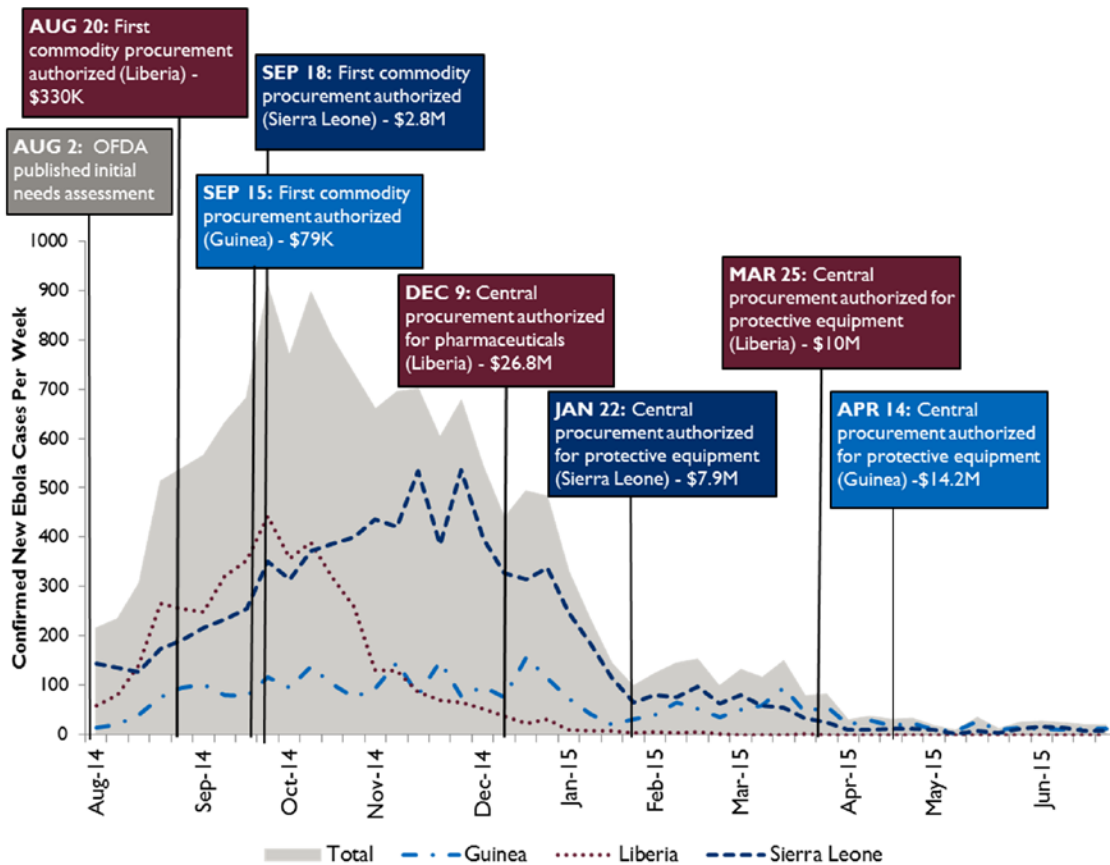
While limited evidence points to some adjustments made by implementers during the Ebola response, we were unable to attribute any of these actions to formal reassessment efforts by OFDA. For example, as the outbreak declined and the number and size of ETUs and CCCs in Liberia decreased, implementers in our sample spaced or canceled commodity orders, reducing the amount purchased by one-third.¹⁰ However, we were unable to locate documentation to demonstrate that OFDA directed implementers to make these adjustments based on informed reassessments. The insufficient reassessment process contributed to inappropriately timed central commodity procurements and overloaded storage capacity across the region.

Central Procurements

Even though new cases had dropped precipitously by December 2014, OFDA continued funding large central commodity procurements of protective equipment, pharmaceuticals, and other supplies as late as April 2015, as shown in figure 4. These procurements fed into the countries' main supply systems for Ebola commodities.

¹⁰ Excluding U.N. agencies, for which we were not able to get detailed information.

Figure 4. OFDA’s Authorization of Commodity Procurements in Relation to the Progression of the Outbreak



Note: Dates for OFDA’s authorization of commodity procurements are based on when awards were issued.

Source: OIG analysis of the number of new confirmed cases per week in Guinea, Liberia, and Sierra Leone from August 2014 through June 2015, published on WHO’s website.

Collectively, \$32.1 million in protective equipment purchases were authorized for the three countries, though not until 94 percent of confirmed cases had already occurred, on average.¹¹ One of those procurements was for 6 months of protective equipment to be used at Liberia’s more than 650 health facilities, although only one confirmed Ebola case had occurred there the month before. A protective equipment procurement for Guinea worth about \$14 million was authorized in April 2015, but 3 months later only one small portion of the purchase had arrived in-country. According to a U.N. employee, of the 22 million pairs of gloves, 4.3 million face masks, 250,000 face shields,

¹¹ Central procurements for protective equipment were authorized on January 22, 2015, for Sierra Leone; April 14, 2015, for Guinea; and March 25, 2015, for Liberia. By then, 92, 93, and almost 100 percent of confirmed cases had occurred in each country.

and more than 3 million gowns ordered, only 45,000 face shields had arrived. An OFDA employee reported that the rest of the order arrived over the next 7 months. However, from mid-July, when the U.N. employee reported these figures, through March 2016, when the public health emergency of international concern was lifted, only 57 new cases of Ebola were confirmed in Guinea.¹²

As for pharmaceuticals and other supplies, OFDA funded one central procurement in Liberia. The procurement, worth \$27 million, was authorized in December 2014, when 97 percent of confirmed cases in Liberia had already occurred. According to a modification to the award 12 months later, “approximately 70 percent of the drugs procured have not been utilized and [the U.N. agency] has asked the suppliers to slow down the delivery rate so that the remaining orders do not flood the country.”

Storage Capacity

OFDA did not sufficiently assess the impact that large inventory purchases would have on the region’s limited storage capacity and on each country’s ability to absorb excess items. OFDA’s December 2014 assessment of Liberia’s supply chain and forward logistics noted that storage facilities in Monrovia were near 100 percent capacity and that the forward logistics bases risked reaching their maximum storage limit. Nonetheless, OFDA authorized a large protective equipment procurement for 650 health facilities in March 2015.

In fact, a senior program officer under the Liberian Ministry of Health and Social Welfare shared an analysis that determined, as of early June 2015, that if conditions remained constant,¹³ the supply of certain items in-country would suffice for up to 22 years, as shown in table 1.

Table 1. Excess of Selected Medical Commodities in Liberia

Item	Quantity Remaining	Years’ Worth
Rubber boots	207,000 pairs	2.4
Surgical face masks	3.8 million	3.8
Goggles	480,000	4.1
Examination gloves	14.5 million 100-count boxes	21.9

Note: Quantities do not include items ordered that had not yet arrived in-country.
Source: Liberia Ministry of Health and Social Welfare, document dated June 6, 2015.

¹² According to WHO weekly situation reports from July 13, 2015, through April 3, 2016.

¹³ Supplying ETUs (20-beds), 13 CCCs, and 657 other health facilities.

ODFA did not do sufficient reassessments in part because it lacked policy on what is required. OFDA's Field Operations Guide does not include instructions on how to perform and document reassessments or use information from them. Such guidance is also missing from the Agency's policy directives on international disaster assistance and from the supplemental guidance cable for disaster planning and response that was in effect at the time.

Under the 13 sampled awards, \$15.9 million was budgeted for medical commodities, of which implementers reported \$10.6 million was spent. Even though planned procurements were reduced by \$5.3 million, implementers reported they still ended up with \$4.6 million in excess inventory.¹⁴

The excess inventory led to storage problems that we observed in each country. In Sierra Leone, a World Food Programme employee who handled logistics said storage capacity at the main hub had increased fourfold to accommodate the excess protective equipment. Because of insufficient storage space in Guinea, OFDA staff reported that WHO at one point stored OFDA-funded medical commodities more than a thousand miles away in the Canary Islands, Spain. In Liberia, storage problems were even greater (the photo on the next page shows a crowded warehouse there). Even after one implementer in Liberia reportedly distributed over 100 metric tons of leftover supplies, it still had supplies that it did not know what to do with. Nearly a year after the award ended, another implementer said it was still storing inventory because the hospitals, county health teams, and NGOs set to receive it did not have space.

¹⁴ Although we sampled a total of 17 awards for this audit, this analysis includes only the 13 for which we were able to get information on commodity expenditures and leftover inventory. The other four awards were to U.N. agencies, from which information was limited. The 13 awards referenced here represent 25 percent of the 53 awards under which commodity purchases were authorized from the beginning of the response through June 30, 2015. The \$15.9 million budgeted for commodities under those 13 awards represents 16 percent of the total amount budgeted for commodities—approximately \$96 million.



Face shields and other medical commodities at a forward logistics base in Gbarnga, Liberia, await redistribution. Photo: OIG (June 24, 2015)

OFDA asked implementers to submit disposition plans outlining what they intended to do with leftover commodities. We received documentation showing that OFDA approved implementers' plans, but we do not know if these plans were actually implemented or what remains of leftover inventory.

OFDA'S INADEQUATE OVERSIGHT REDUCED THE INFORMATION NEEDED TO TRACK ACTIVITIES AND DETERMINE FUNDING EFFECTIVENESS

OFDA's Field Operations Guide states that "monitoring systems should be put in place to enable relief officials to determine whether a situation is improving or deteriorating . . . and must include ways to measure the efficiency and effectiveness of relief activities." Despite this guidance, we found weaknesses in how OFDA tracked relevant data. We also noted concerns with the insufficient and inconsistent deployment of staff to monitor the Ebola response.

INSUFFICIENT DATA IMPEDED MEASUREMENT OF RELIEF EFFORT'S EFFECTIVENESS

Data quality was a concern throughout the response. In the beginning, there were not enough laboratories to confirm suspect cases, and case management systems contained inaccurate, untimely, inaccessible, and hard-to-interpret information. Even after the case management systems improved, DART and OFDA staff did not have total confidence that the data accurately reflected what was happening on the ground; a senior OFDA official said the data still lagged by 2 to 3 weeks.

Despite the absence of reliable data and contrary to its internal guidance, OFDA did not have an effective system to monitor the effectiveness of interventions through its implementers. OFDA's Field Operations Guide defines monitoring as the "ongoing systematic collection, analysis, and use of data that occurs during the course of a project." But OFDA did not sufficiently collect or analyze data on the ETUs, CCCs, and medical commodities it funded to ensure they were meeting objectives and achieving intended results.

ETUs and CCCs

OFDA did not routinely track ETU or CCC operational data on the facilities or even know basic information, as these examples make clear:

- OFDA did not track the CCCs it funded. When asked for a complete record, OFDA listed only those in Liberia. We learned of five CCCs in Sierra Leone but could not determine if OFDA supported any in Guinea.
- OFDA did not sufficiently track when its ETUs and CCCs opened and closed. Its records showed no opening or closing dates for nine facilities, and only an opening or a closing date for seven.¹⁵
- OFDA did not sufficiently track the number of patients admitted or confirmed positive for Ebola at its ETUs and CCCs. For 12 CCCs, OFDA did not record these data. Where OFDA did record some patient data, they were inconsistent across countries and could not reasonably be compared to determine bed availability or to highlight rates useful for distributing commodities.

Those providing assistance differed as to the usefulness of tracking this data. A Liberia DART member said the DART could have done more to collect information from implementers. A senior OFDA official believed ETU-specific information was too granular and that tracking it would not change OFDA's overall response. She said staff were hesitant to ask implementers for more information when they were operating in emergency mode, but we found all of the implementers managing the 9 ETUs and 16 CCCs in our sample were tracking this information anyway.

Medical Commodities

OFDA also did not adequately oversee the medical commodities it funded, as these examples demonstrate:

- OFDA did not track the total amount budgeted and disbursed for commodities. In fact, OFDA could not easily identify the awards under which commodities were being purchased.

¹⁵ These numbers were out of a total of 24 ETUs and 20 CCCs. This total does not include the five CCCs in Sierra Leone that OFDA was not tracking.

- Staff were not aware of the amount of OFDA-funded inventory in each country at any given time, resulting in inefficiencies. For example, one implementer in Sierra Leone budgeted enough protective equipment for a 100-bed ETU at full occupancy for 6 months, but found that the highest occupancy was around 35 percent. Had OFDA been tracking implementers' inventory levels, it might have halted additional procurements and explored ways to redistribute what was already in-country.
- OFDA did not review implementers' planned commodity procurements to determine whether quantities were reasonable. Some implementers did not even submit itemized lists of the commodities they planned to buy, as required per OFDA's proposal guidelines. According to one reviewer, time did not always allow for questions, as there was a push to "get the money out."
- OFDA did not verify that implementers actually purchased the pharmaceuticals they were approved to buy. Because pharmaceuticals are restricted items, OFDA must formally approve their purchase, and implementers are instructed to maintain all pharmaceutical invoices for review. Yet OFDA did not request any invoices and does not have a system that would enable this verification.
- DART members did not review implementers' inventory or inventory management systems at most storage sites. Doing these reviews could have mitigated the insufficient, incomplete, or incorrect records and inadequate storage conditions we found at 17 of the 20 locations we gathered information on, including ETUs, other health facilities, U.N.-managed warehouses, and implementer warehouses.

OFDA's lack of monitoring was due in part to confusion over who was responsible for managing data. Typically during an emergency response, implementers feed information into a central reporting system managed by the United Nations. However, the traditional U.N. humanitarian coordination system was not set up, and information was not collected and disseminated as usual. A DART member and senior OFDA official saw data management as a function of the United Nations or the appropriate ministry of health, while two DART and RMT members believed CDC was in charge of collecting certain data.

Confusion aside, OFDA generally does not view this level of monitoring as part of its responsibilities. Officials said OFDA manages disaster responses at a macro, not a micro, level. They said the office "did not track the number of CCCs [it funded] because [its] core unit of measurement was at a higher level, aimed at impacting the case load and coping capacity of [Ebola-affected] countries." They saw detailed budget tracking as "neither helpful nor realistic" and shared their belief that implementers, not OFDA, were responsible for inventory management under assistance awards.

Further, staff did not track OFDA-funded inventory because they thought a more meaningful metric was the amount of inventory in-country from all donors, which could help identify gaps and shortages. While host-country governments and international responders tried to collect this information, they left out inventory—for example, counts did not include what was stored at more than 650 health facilities in Liberia—and depended on local institutions' capacity to track inventory.

While monitoring during an emergency response cannot compare with monitoring during USAID's development activities, OFDA still has a responsibility to ensure proper stewardship of taxpayer dollars. The lack of monitoring affected OFDA's ability to make adjustments to ensure the efficient use of funds. OFDA used resources to equip ETUs and CCCs that did not significantly contribute to controlling the outbreak. Additionally, not doing monitoring heightened the risk that resources would be used for other than their intended purposes. For example, a senior DART member said that some protective equipment in Liberia was used as rain gear by motorcycle drivers.

INADEQUATE STAFFING LEVELS AND HIGH TURNOVER FURTHER HINDERED OFDA'S ABILITY TO MONITOR ACTIVITIES

OFDA's monitoring of medical commodities, ETUs, and CCCs suffered because of insufficient staff in headquarters and the field, and frequent staff turnover. OFDA's Africa Division director reported that, before the Ebola outbreak, the division was understaffed—21 and 32 percent below authorized levels in the field and in Washington, respectively. OFDA was also managing three other humanitarian disasters and DARTs around the same time, further limiting the number of staff available.

Staff were in short supply for several reasons. According to a senior OFDA official, she had difficulty filling open positions: half of the authorized personal services contract (PSC) positions in fiscal year 2015 were unfilled.¹⁶ She said the surge roster of PSCs who are on retainer to staff up for emergencies was diminished given the health risks involved. Officials said other factors outside their control that affected the office's ability to staff at higher levels included delays in getting security clearances for new hires and limitations to the Agency's operating expense account.

OFDA's staffing challenges contributed to a high degree of turnover on the DARTs and RMT. From August 2014 to July 2015, 163 people served on the DARTs, and 153 people on the RMT, with average rotations lasting 7 to 9 weeks and some individuals serving multiple times. This resulted in a general turnover of about six or seven times per position over the course of the year.

Some positions were not filled. One DART leader indicated that he felt constantly overwhelmed by not having enough staff and that it distracted him from other aspects of the response. He said his deputy planning coordinators had three times the normal case load, and at one point two program officers were managing 15 implementers each, which he said was not feasible. He requested two field officers to help monitor, but reported getting only one for 2 of the 7 months he was in West Africa. Field officers, he said, are the "eyes and ears in the field." They gather vital information on needs and performance, which is used to guide programming decisions. He said they had no way of knowing if the right medical equipment and pharmaceuticals were reaching their intended beneficiaries because they were "operating blindly" with too few people to follow the money.

¹⁶ OFDA depends heavily on contract personnel, who made up over 80 percent of its workforce in 2016.

Coordination within and between DART teams suffered not only because of the turnover, but also because of an inconsistent handover process—the handover of notes by outgoing to incoming members and the sharing of context to get incoming staff up to speed. OFDA’s policies and guidance documents cover what is expected of RMT members when transitioning, but not of DART members. Consequently, DART members were not aware of key decisions that had been made over the course of the Ebola response. Because of the frequent DART turnover, inconsistent handovers, and weak information management, institutional memory was limited, and incoming members had steep learning curves. A DART leader said the turnover made it difficult to carefully review proposals and manage awards.

The turnover affected relationships with implementers. Some reported receiving different guidance from rotating DART members. For example, staff for one implementer said they adjusted the approach to their work 22 times over an 8-month period because of changes in opinion or preference of DART members.

OFDA had too few AORs to properly oversee the awards and provide necessary technical direction. AORs help agreement officers oversee USAID awards and monitor implementers’ progress toward objectives. Ten AORs provided oversight of 109 awards, one overseeing 36 while another oversaw 22. A senior OFDA official attributed this shortage to difficulties getting staff into the Agency’s certification courses and the time commitment required for staff (more than 120 hours required to complete the course and the prerequisites). The official reported that because so many of their AORs were pulled onto the Ebola response, the Africa division was left with only one AOR to manage 290 non-Ebola awards.

Some of these issues were noted in another OIG audit report,¹⁷ as well as in after-action reviews from OFDA’s previous emergency responses. The audit report recommended “standard operating procedures for rotating [DART] members to transfer program information . . . [including] documenting site visits and all other efforts to verify program activity.” OFDA noted that it is addressing this recommendation; however, the issues noted here point out additional weaknesses in the handover process that need correction. Previous after-action reviews noted problems with DART member turnover, inadequate handover, and weak information management. The persistence of these issues shows they have not been sufficiently addressed. OFDA acknowledged its staffing issues and is developing a multiple response strategy to “determine [the] number of qualified staff required to staff multiple, concurrent DARTs and RMTs” and to determine how to fill these positions with the most qualified people. However, OFDA has developed at least six strategy papers over the last 10 years to address its staffing needs, and none of them have compelled decision makers to take sufficient action.

¹⁷ “Audit of Selected Ebola-Response Activities Managed by USAID’s Office of U.S. Foreign Disaster Assistance in Liberia,” 7-669-16-002-P, December 4, 2015.

CONCLUSION

In the chaos of a disease epidemic, when the primary response objective is to save lives, implementing checks and balances can be difficult. Nonetheless, having some level of awareness ahead of time and controls built into the system could help increase the effectiveness and efficiency of operations, safeguard resources, and ensure program objectives are met. Better needs assessments, data and tracking efforts, and staff utilization could have resulted in more timely and efficient decisions about resource allocation and the use of funds, including those related to the construction of medical facilities and the procurement of materials. Our work highlights opportunities for OFDA to strengthen its response to future emergencies, including updating policies, procedures, and practices for needs assessments, inventory management, response effectiveness monitoring, award oversight, staffing and employee turnover, and lessons learned.

RECOMMENDATIONS

We recommend that OFDA take the following actions:

1. Update policies and procedures to clearly define how staff should conduct initial and ongoing assessments and how the assessments should inform the development and modification of OFDA's strategic approach to disasters—especially the longer-term, complex emergencies that are becoming more common.
2. Require staff to document needs assessments, reassessments, the data used to inform these assessments, and any underlying assumptions.
3. Determine the extent to which the USAID-funded Ebola inventory has been redistributed in accordance with implementers' disposition plans, the excess inventory that remains, and whether U.S. Government funds are being used to store excess inventory.
4. Update policies and procedures on monitoring response effectiveness, specifying the parties responsible, the frequency, and the method for collecting, analyzing, documenting, and reporting the information necessary to oversee response activities.
5. Establish handover policies and procedures for members of Disaster Assistance Response Teams to provide consistency, continuity of operations, and institutional memory.
6. Implement a strategy to provide proper monitoring and management of awards by agreement officer's representatives, especially when a disaster requires immediate oversight on a large scale.

7. Implement a strategy to institutionalize OFDA's lessons learned from previous emergency responses and after-action reviews.
8. Include sections in the multiple response strategy on filling open positions, ensuring a sufficient surge roster, and attracting qualified individuals to work on response efforts.

OIG RESPONSE TO AGENCY COMMENTS

We provided our draft report to USAID/OFDA on November 14, 2017, and on January 3, 2018, received its response, which is included as appendix D.

The report included eight recommendations. We acknowledge management decisions on all eight. We consider six of them resolved but open pending completion of planned activities (recommendations 1, 3, 5, 6, 7, and 8), and two unresolved (recommendations 2 and 4) for the reasons below.

We disagree with the management decisions on recommendations 2 and 4. For recommendation 2, while partner-provided information can provide more complete situational awareness, OFDA personnel should be responsible for conducting and documenting initial and recurring assessments throughout an emergency response. To resolve recommendation 2, OFDA should develop policies and procedures that require staff to document needs assessments, reassessments, the data used to inform these assessments, and any underlying assumptions.

For recommendation 4, while OFDA said it identified the need to update its policies and procedures for monitoring the effectiveness of response actions, OFDA's approach seems to place the responsibility on the implementer and does not clarify its own involvement in the process. OFDA plans to address this recommendation by updating its Guidelines for Proposals and requiring applicants/implementers to include a monitoring plan defining indicators, among other things, but OFDA does not clarify what is expected or required of its staff in compiling, analyzing, and using this information for decision making. To resolve recommendation 4, OFDA should specify in its policies and procedures the roles and responsibilities of its staff in overseeing response activities.

We cannot close recommendation 5 without further information. To see what handover policies OFDA has developed for DART members, we need the final version of the Response Management System, which is still in draft form. As discussed with OFDA by email, the target completion date for this recommendation is January 31, 2018.

APPENDIX A. SCOPE AND METHODOLOGY

We conducted our work from February 2015 to November 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our objectives were to determine if USAID/OFDA (1) effectively assessed needs for ETUs, CCCs, and medical commodities to respond to the Ebola outbreak in Guinea, Liberia, and Sierra Leone and (2) adequately oversaw the ETUs, CCCs, and medical commodities it funded.

The audit covered OFDA's assessment and oversight of medical commodities, ETUs, and CCCs in Guinea, Liberia, and Sierra Leone from August 2014, when the DARTs were deployed, through June 2015, when the outbreak had largely been controlled. Activities or other information preceding or following this period were also considered when deemed relevant to answering the audit objectives. During this period, USAID/OFDA issued 83 awards.¹⁸ We judgmentally selected 17 awards for our sample based on the size of budgeted commodity procurements and, in part, on whether the awards' program descriptions included the management of ETUs or CCCs.¹⁹ The implementers included Catholic Relief Services, the French Red Cross, Heart to Heart International, the International Medical Corps, the International Rescue Committee, Project Concern International, Partners in Health, Samaritan's Purse, the United Nations Children's Fund (UNICEF), and WHO, with some implementers responsible for more than one award. Our sample represents 73 percent of the total amount OFDA budgeted for medical commodities, 38 percent of the ETUs OFDA funded, and 64 percent of the known CCCs as shown in table 2. Since we judgmentally selected our sample, the results are limited to the tested awards and cannot be projected to all of OFDA's funded ETU, CCC, and medical commodity activities.

¹⁸ Based on information available through OFDA's repository system for award management, Abacus. In some instances, we considered awards issued after June 2015. For example, when reviewing the number of AORs overseeing awards, we considered 109 awards issued between August 2014 and mid-August 2016.

¹⁹ The 17 selected awards were made up of 4 in Guinea, 10 in Liberia, and 3 in Sierra Leone.

Table 2. Audit Sample in Relation to All OFDA-Funded ETUs, CCCs, and Medical Commodities

Category	Total	Sample	Sample as a % of Total
Medical Commodities	\$96 million ^a	\$70 million	73
Guinea	\$25 million	\$18 million	72
Liberia	\$51 million	\$47 million	92
Sierra Leone	\$20 million	\$5 million	25
ETUs	24	9	38
Guinea	3	1	33
Liberia	16	6	38
Sierra Leone	5	2	40
CCCs	25 ^b	16	64
Guinea	--	--	--
Liberia	20	11	55
Sierra Leone	5	5	100

^a The total amounts listed for commodities are estimates based on our review of award documents available on Abacus, since budgets were not itemized in comparable detail. The estimates represent the amount budgeted for commodities, excluding shipping and handling costs where possible, from when the disaster was declared in August 2014 through June 2015. The total amount spent on commodities with OFDA funds is unknown.

^b The CCC total is unknown. This figure represents the 20 CCCs that OFDA tracked in Liberia and the 5 CCCs we discovered in Sierra Leone. We are unsure if there were other OFDA-funded CCCs in Sierra Leone or any in Guinea.

Source: The ETU total was based on information provided by OFDA, dated June 1, 2015. The CCC total was based on a combination of information provided by OFDA and by implementers. The medical commodity total was based on award documents available through Abacus.

To gain an understanding of how OFDA assessed needs for ETUs, CCCs, and medical commodities, as well as how it oversaw the ETUs, CCCs, and medical commodities it funded, we conducted interviews with DART and RMT members, other OFDA and USAID personnel, implementers, host-country government officials, U.N. agencies, and other stakeholders involved in the Ebola response. The breakdown of stakeholders interviewed is shown in table 3.

Table 3. Stakeholders Interviewed

Stakeholder	Number
DART members ^a	13
RMT members ^b	6
DART & RMT members ^c	9
OFDA personnel who did not serve on the DART or RMT	7
USAID personnel who did not serve on the DART or RMT	14
U.N. officials and staff from WHO, UNICEF, World Food Programme, and UNMEER	45
NGO implementer staff ^d	55
Host-country government officials and staff members	18
Local health facility staff members	8
Ebola survivors	3
Other U.S. Government personnel	2
Other international donor officials	3
Total	183

^a Served just on the DART.

^b Served just on the RMT.

^c Served on both the DART and RMT.

^d Representing 13 NGOs.

We conducted site visits to Guinea, Liberia, and Sierra Leone from June 17 to July 16, 2015, visiting six ETUs, one CCC, six warehouses, and four health facilities. We also reviewed documents submitted by OFDA and its implementers; general Ebola guidance from WHO, MSF, CDC, and host-country governments; OFDA's policies and procedures; and Ebola case data and projections. We reviewed commodity procurement and inventory information from implementers, but information from U.N. agencies was limited. We were still able to obtain sufficient and appropriate evidence to support our conclusions.

In answering the audit objectives, we primarily relied on evidence from interviews, document reviews, research, analysis, and site visits. When analyzing when key events occurred in relation to the progression of illnesses over the course of the outbreak (referred to as the epidemic curve), we relied on Ebola case data available through

WHO's website, published on May 11, 2016.²⁰ The epidemic curve shown in our graphs uses data on the confirmed number of Ebola cases from the patient databases for the early part of the response and then from WHO's weekly situation reports once those became available. While we did not test the reliability of the data, it represents WHO's best estimates to define the progression of the outbreak.

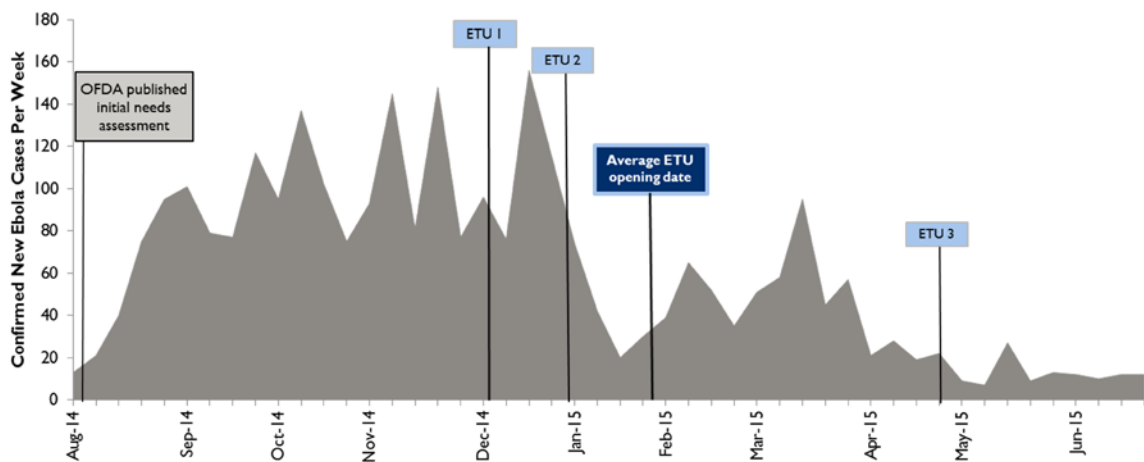
For conclusions relating to medical commodities, we relied on budgeting, disbursement, and inventory information from implementers because of inconsistencies in how commodity data were tracked and reported. For conclusions relating to ETU and CCC operations, we relied on Microsoft Excel files and other tables provided by OFDA and implementers in our sample. Our review of OFDA's spreadsheets led us to question the validity of some because they were incomplete and inconsistent with what implementers reported. When inconsistencies were noted, we relied on the information reported by implementers when available since OFDA was not closely tracking this information. Nonetheless, since we were able to corroborate these data with other evidence, we believe the opinions, conclusions, and recommendations in the report are valid.

²⁰ WHO Ebola data and statistics, <http://apps.who.int/gho/data/node.Ebola-sitrep>, accessed May 23, 2016.

APPENDIX B. TIMELINE OF ETU AND CCC OPENINGS

The following graphs show when OFDA-funded ETUs and CCCs opened in Guinea, Liberia, and Sierra Leone in relation to the epidemic curve from August 2014, when the DARTs were deployed, through June 2015, when the outbreak had largely been controlled. Note that when discrepancies were noted between what OFDA and its implementers reported, we relied on the information provided by implementers. Additionally, only ETUs and CCCs for which data were available are included in figures 5, 6, and 7.

Figure 5. Timeline of ETU Openings in Guinea



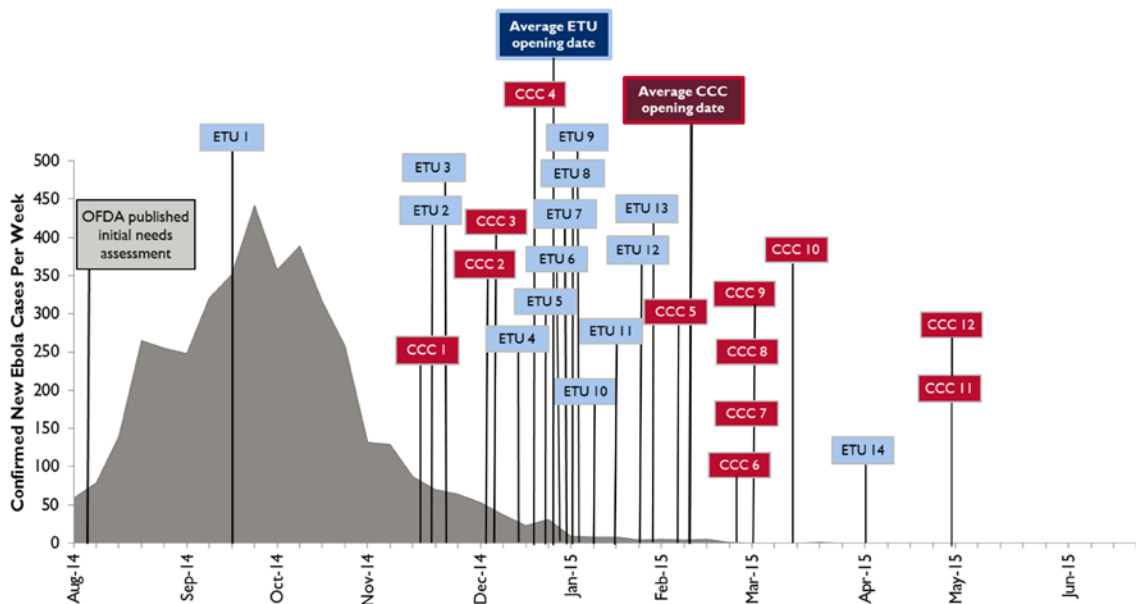
Source: OIG analysis of the number of new confirmed cases per week in Guinea from August 2014 through June 2015, published on WHO's website.

Sites and opening dates for ETUs in Guinea based on available data from implementers or OFDA:

- ETU 1: N'zérékoré, December 2, 2014
- ETU 2: Coyah (Wonkifong), December 31, 2014
- ETU 3: Forécariah, April 23, 2015

Average ETU Opening Date: January 28, 2015

Figure 6. Timeline of ETU and CCC Openings in Liberia



Source: OIG analysis of the number of new confirmed cases per week in Liberia from August 2014 through June 2015, published on WHO's website.

Sites and opening dates for 14 of 16 ETUs in Liberia for which data was available from implementers or OFDA:

- ETU 1: Gbarnga, September 15, 2014
- ETU 2: Tubmanburg, November 18, 2014
- ETU 3: Kakata, November 22, 2014
- ETU 4: Zwedru, December 13, 2014
- ETU 5: Buchanan, December 22, 2014
- ETU 6: Sinje, December 29, 2014
- ETU 7: Gbediah Town, December 31, 2014
- ETU 8: Ganta, January 1, 2015*
- ETU 9: Bopolu, January 3, 2015
- ETU 10: Tappita, January 7, 2015
- ETU 11: Voinjama, January 14, 2015
- ETU 12: Zorzor, January 22, 2015
- ETU 13: Barclayville, January 28, 2015
- ETU 14: Harper, April 1, 2015

Average ETU Opening Date: December 27, 2014

Sites and opening dates for 12 of 18 CCCs in Liberia for which data was available from implementers or OFDA (not including 2 CCCs that never opened):

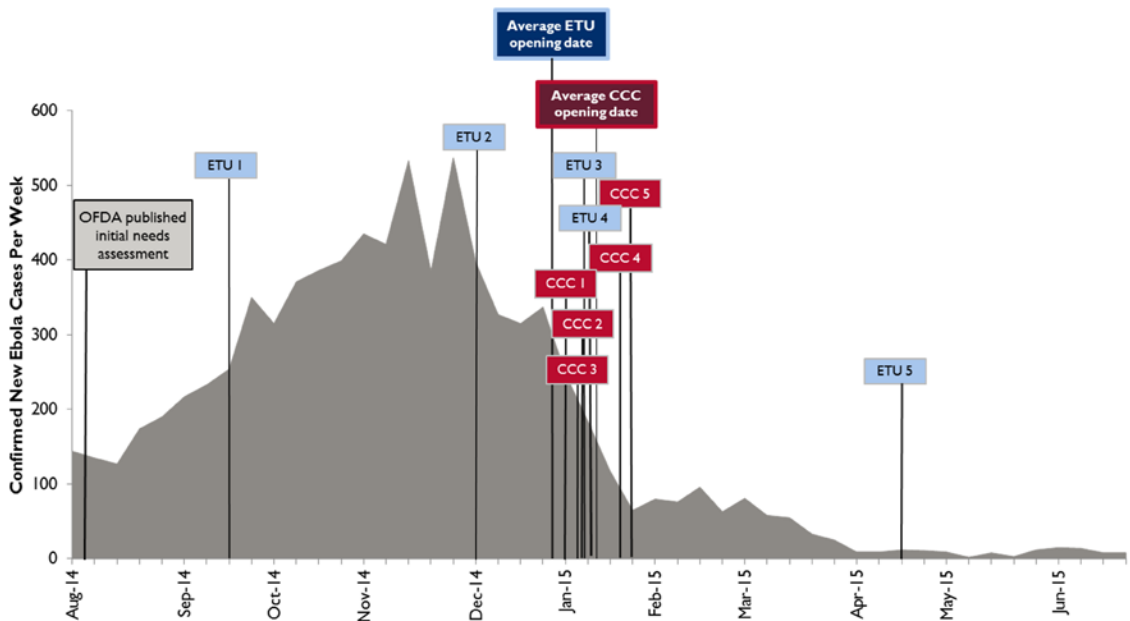
- CCC 1: Dolo Town Health Center, November 17, 2014

- CCC 2: Fish Town, December 2, 2014
- CCC 3: Worhn Clinic, December 5, 2014
- CCC 4: Zorzor, December 19, 2014
- CCC 5: Karguekpo, February 6, 2015
- CCC 6: Gbarzon Health Center, February 27, 2015
- CCC 7: St. Francis Hospital, March 1, 2015*
- CCC 8: Haindii Clinic, March 1, 2015*
- CCC 9: Pleebo, March 1, 2015*
- CCC 10: Morlaquila, March 13, 2015
- CCC 11: Karnplay, May 1, 2015*
- CCC 12: Saclepea, May 1, 2015*

Average CCC Opening Date: February 8, 2015

*Exact date was not specified by implementer, so we used the first date of the month provided.

Figure 7. Timeline of ETU and CCC Openings in Sierra Leone



Source: OIG analysis of the number of new confirmed cases per week in Sierra Leone from August 2014 through June 2015, published on WHO's website.

Sites and opening dates for ETUs in Sierra Leone based on available data from implementers or OFDA:

ETU 1: Rural Kenema Field Hospital, September 15, 2014

ETU 2: Lunsar, December 1, 2014

ETU 3: Koidu, January 8, 2015
ETU 4: Kontorloh, January 9, 2015
ETU 5: Kambia Town, April 15, 2015

Average ETU Opening Date: December 28, 2014

Sites and opening dates for CCCs in Sierra Leone based on data provided by the implementer:

CCC 1: Condama, January 2, 2015
CCC 2: Fiama, January 6, 2015
CCC 3: Sandor, January 6, 2015
CCC 4: Gbane, January 18, 2015
CCC 5: Kambia Holding Unit, January 22, 2015

Average CCC Opening Date: January 10, 2015

APPENDIX C. GENERAL PATIENT DATA FOR SAMPLED ETUS AND CCCS

Table 4. Patient Data for Sampled ETUs

Country	Site Name	County/District	Patients Admitted	Patients Who Tested Positive for Ebola
Guinea				
	Forécariah	Forécariah	293	55
Liberia				
	Gbarnga	Bong	549	161
	Zwedru	Grand Gedeh	15	0
	Kakata	Margibi	286	5
	Harper	Maryland	14	0
	Ganta	Nimba	18	0
	Tappita	Nimba	9	0
Sierra Leone				
	Kambia Town	Kambia	220	35
	Lunsar	Port Loko	505	151

Source: Implementers managing the ETUs.

Table 5. Patient Data for Sampled CCCs

Country	Site Name	County/District	Patients Admitted	Patients Who Tested Positive for Ebola
Liberia				
	Haindii Clinic	Bong	1	0
	Morlaquila	Gbarpolu	0	0
	Kpayeakwelleh Clinic	Gbarpolu	0	0
	Gbarzon Health Center	Grand Gedeh	0	0
	Zorzor	Lofa	2	0
	Pleebo	Maryland	0	0
	Karnplay	Nimba	1	0
	Saclepea	Nimba	6	0
	St. Francis Hospital	River Cess	0	0
	Gbeapo Health Center	River Gee	0	0
	Fish Town	River Gee	1	0
Sierra Leone				
	Kambia Holding Unit	Kambia	99	41
	Condama	Kono	56	0
	Fiama	Kono	13	0
	Gbane	Kono	82	0
	Sandor	Kono	7	0

Source: Implementers managing the CCCs.

APPENDIX D. AGENCY COMMENTS



January 3, 2018

MEMORANDUM

TO: IG/A/GSAD, Director, Van Nguyen

FROM: DCHA/OFDA Acting Director, Carol Chan

SUBJECT: DRAFT AUDIT REPORT “ASSESSMENT AND OVERSIGHT GAPS HINDERED OFDA’S DECISION MAKING ABOUT MEDICAL FUNDING DURING THE EBOLA RESPONSE (9-000-18-00X-P)”

The Bureau for Democracy, Conflict, and Humanitarian Assistance, Office of U.S. Foreign Disaster Assistance (OFDA) appreciates the opportunity to provide a formal response to OIG’s findings and conclusions.

The West Africa Ebola response marked a turning point in the history of international humanitarian response and OFDA. The Ebola epidemic created a humanitarian emergency that was layered on top of a public health emergency that crossed borders through multiple countries. The scale and complexity of this emergency were catastrophic and unprecedented. OFDA and the broader international humanitarian system dealt with this sadly historic event by adapting the available systems and resources to address the emergency, while simultaneously drawing on public health experts to develop the technical guidance based on real-time analysis of the rapidly evolving outbreak. This was an “all hands on deck” situation, and OFDA, along with the USG interagency and international partners, quickly understood that the problems faced were unlike any that had been encountered before. As the lead public health emergency agency, the Centers for Disease Control and Prevention (CDC) provides forecasts that are expert predictions for the direction of an outbreak, and OFDA was directed to base its planning on the models CDC presented, which pointed to catastrophic loss of life and other humanitarian outcomes. Response approaches—such as the construction of Ebola Treatment Units (ETUs) and Community Care Centers (CCCs) at a large scale—were designed with the best information available at the time of the start of the outbreak and as

a part of an approach made with host governments, other U.S. Government (USG) agencies, and international actors to halt the spread of the disease.

While OFDA concurs with all of the draft audit report's recommendations, it is important that the final report acknowledges the scale and unique nature of the emergency and response environment described above. Given the potentially catastrophic and unknown nature of the emergency, OFDA worked to "bend the curve," or reverse the upward trend of the disease outbreak. In doing so, OFDA charted new territory in its relationships with other parts of the USG and the international community. OFDA worked as instructed by the National Security Council with CDC to understand trends and projections for the response.

OFDA works in partnership with host governments and international humanitarian actors. As laid out in United Nations General Assembly Resolution 46/182, which establishes the Guiding Principles for Humanitarian Action, it is the primary responsibility of a government to address a disaster within its borders; donors, non-governmental organizations (NGOs), and public international organizations (PIOs) support their response. Host governments play the lead role in response decisions, and OFDA cannot—and should not—make decisions in place of sovereign governments when partnering with them to respond. Host governments are the lead in responding in their own countries, and the timelines for decisions are the responsibility of those sovereign nations.

In the West Africa Ebola response, OFDA's role as a humanitarian leader and expert was to advise its host government partners on everything from the location and use of ETUs to the methods for community mobilization and outreach. OFDA programmed its resources in support of the response lead by host governments, with their input and collaboration. In addition, other donors and private actors provided funding and responded alongside the USG. The vital work of ensuring that duplicative services were avoided was a key part of the response. All these factors together meant that decisions about the response did not rest with OFDA alone, and as such, lessons learned from the response must take into account the time and resources necessary to work with the many actors across the response. OFDA worked to ensure the best use of resources in this very complicated environment.

In the end, Ebola did not make it to the United States and was stopped from spreading any further in other parts of the world. Above all else, lives were saved. OFDA welcomes this opportunity to learn from the experience and improve the efficiency of its response should a situation like this ever occur again.

OFDA Response to Individual OIG Recommendations:

1. Update policies and procedures to clearly define how staff should conduct initial and ongoing assessments and how the assessments should inform the development and modification of OFDA’s strategic approach to disasters—especially the longer-term, complex emergencies that are becoming more common.

OFDA Response: OFDA concurs with this recommendation. OFDA will update and enhance procedures on conducting field assessments and using assessment results to inform strategic planning and field programming. This will include revising guidance and best practices for conducting assessments and updating the format of assessment guidance to better promote its use and application. Information will also be made available through a smartphone app to facilitate access to information and tools. In addition, OFDA will roll out updated training on assessments for staff.

In addition, as a result of lessons learned from this response and others, OFDA has developed guidance on planning that provides all staff with a framework that includes integrating information from assessments into planning at a variety of levels. This guidance was finalized and distributed to all OFDA staff in January 2017. (See Tab 1 a and 1b)

Target Date for Completion: January 30, 2019

2. Require staff to document needs assessments, reassessments, the data used to inform these assessments, and any underlying assumptions.

OFDA Response: OFDA concurs that further documentation and systematic use of needs assessments throughout responses will improve response capacity. OFDA will incorporate a feature for partners to upload assessment documents into its web-based reporting portal, thereby recording assessments and further increasing the ease of access to these documents by staff.

Target Date for Closure: June 30, 2018

3. Determine the extent to which the USAID-funded Ebola inventory has been redistributed in accordance with implementers’ disposition plans, the excess inventory that remains, and whether U.S. Government funds are being used to store excess inventory.

OFDA Response: OFDA concurs with this recommendation. OFDA will conduct a review to determine the extent to which USAID-funded Ebola inventory has been redistributed in accordance with implementers' disposition plans, the excess inventory remains, and whether USG funds are being used to store excess inventory.

Target Date for Closure: September 30, 2018

4. Update policies and procedures on monitoring response effectiveness, specifying the parties responsible, the frequency, and the method for collecting, analyzing, documenting, and reporting the information necessary to oversee response activities.

OFDA Response: OFDA concurs with this recommendation to the extent that it is within USAID's manageable interests. During humanitarian responses, OFDA works as a leader to advocate for improved response effectiveness within the international community across the breadth of a response. OFDA identifies areas for improvement and works with host governments and the UN-led humanitarian response system to advocate for overall increased response effectiveness.

Through this audit and other after action reviews, OFDA has identified the need to update its policies and procedures for monitoring the effectiveness of the response actions it manages. As such, OFDA is in the process of updating its Guidelines for Proposals, which includes substantial revisions to the requirements for monitoring and evaluation plans. The revised monitoring guidance requires applicants to include a Monitoring Plan, which includes a Monitoring Table in their proposal. The Monitoring Table states the data collection plan for program monitoring. In addition, the revised Guidelines include Performance Indicator Reference Sheets, which clearly define every required indicator and include suggested methods and analysis. The revisions to the monitoring and evaluation portion of the Guidelines will improve the quality of data that is collected during responses and will allow OFDA to better monitor response effectiveness.

Target Date for Closure: June 30, 2018

5. Establish handover policies and procedures for members of Disaster Assistance Response Teams to provide consistency, continuity of operations, and institutional memory.

OFDA Response: OFDA concurs with this recommendation. As result of after action reviews of the Ebola response, standard operating procedures that enable effective handover for rotating Disaster Assistance Response Team (DART) members are now included OFDA's Response Management System, which governs the work of the DART and Response Management Team (RMT). (Tab 2: RMS chapter on Handover and Demobilization)

Target Date for Closure: OFDA seeks closure of this recommendation upon final issuance of the audit report, based on actions already taken.

6. Implement a strategy to provide proper monitoring and management of awards by agreement officer's representatives, especially when a disaster requires immediate oversight on a large scale.

OFDA Response: OFDA agrees with this recommendation. In order to ensure Agreement Officer's Representatives (AORs) have all the tools needed to monitor and manage awards, OFDA will develop and roll out a new monitoring and evaluation training required for all AORs. OFDA will also develop an online award management toolkit for AORs, and expand the training requirements for OFDA AORs on OFDA's award-making and management business processes. In addition, OFDA will work with USAID management to address staffing constraints that limit the number of AORs available.

Target Date for Closure: January 30, 2019

7. Implement a strategy to institutionalize OFDA's lessons learned from previous emergency responses and after-action reviews.

OFDA Response: OFDA concurs with this recommendation. OFDA has a long established After Action Review and lessons learned process after responses. OFDA concurs that there are additional steps that will improve the use of information gathered through these systems.

OFDA will implement a system to support response teams with historical response data, including guidance on implementing past lessons learned. OFDA is conducting an analysis of response-specific learning trends over time related to specific types of disasters, e.g. public health emergencies or earthquakes with an urban search and rescue deployment. Once the full analysis is completed, this aggregated information will be made readily available as response teams activate or change leadership through OFDA's RMS websites. OFDA will examine options to make AAR data available to staff members through a database. Additionally, OFDA will work with the Operations Center staff to establish a standard practice to deliver disaster-specific aggregated lessons learned and implementation guidance directly to the leadership of newly activated response teams.

Target Date for Closure: January 30, 2019

8. Include sections in the multiple response strategy on filling open positions, ensuring a sufficient surge roster, and attracting qualified individuals to work on response efforts.

OFDA Response: OFDA concurs that staffing levels must be increased to meet the current demands on the office for humanitarian responses. The multiple response strategy (MRS) is a tool for OFDA to identify what staffing levels are needed to meet demands on the office. OFDA has worked through the MRS to identify needed staffing levels and is now taking action where

possible to achieve those levels and create improved staffing surge mechanism. It should be noted that OFDA has implemented these steps to the extent possible within a constrained environment, including an agency-level hiring freeze. Limitations related to staffing are frequently outside of OFDA's sphere of control.

OFDA has also taken the following actions to address this issue:

- Initiated the OnRamp program to prepare trained and technically capable staff from across USAID to earn disaster-related qualifications and later deploy on DARTs, when needed. (See Tab 3: OnRamp briefer)
- Decreased the amount of time required for newly recruited Personal Service Contractor (PSC) staff to receive security clearances. This has had a significant impact on staffing, as some clearances can take up to or more than a year, during which time a newly recruited PSC will often find another job. In order to decrease the onboarding timeline for PSCs, OFDA has recruited a Case Controller/Security Specialist and an Adjudicator to facilitate clearances for OFDA staff only. The Adjudicator is responsible for tracking the status of all active investigations. The Adjudicator is able to quickly pinpoint issues within the Office of Security (SEC) Personal Security Division that might be delaying an investigation and identify a solution to recommend to SEC, while keeping OFDA advised of status. The OFDA clearance process is 25 percent faster since the establishment of this position.

In addition, OFDA now also supports a Case Controller/Security Specialist. The Specialist's work has decreased the amount of time between the date a security investigation is submitted to SEC for processing and the start date of the investigation by two to five business days.

In addition to OnRamp and improvements in the security clearance process, OFDA is developing and launching the Personnel, Experience, Training, Equipment, and Readiness (PETER) system. PETER is a readiness and deployment database being designed by OFDA to support the unique qualification, activation, and human resource requirements of both OFDA and the Office of Food for Peace. PETER is currently in production and an initial release is expected in early 2018. PETER will assist managers in identifying and tracking the qualifications, experience, and availability of personnel for all types of disasters and complex emergencies. Additionally, supervisors and Responsible Units will use PETER to schedule response staff for on-call and deployable positions. While all of these functions currently take place through other means, PETER will provide one consolidated system that allows complete visibility for managers at all levels.

Target Date for Closure: December 30, 2018

APPENDIX E. MAJOR CONTRIBUTORS TO THIS REPORT

The following people were major contributors to this report: Van Nguyen, director; Jon Chasson, previous director; William Murphy, previous director; Ryan McGonagle, assistant director; Donell Ries, previous assistant director; Jill Randall, lead program analyst; Simone Duncan, auditor; Andrian Smith, auditor; Marianne Soliman, auditor; and Allison Tarmann, writer-editor.