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

Lessons From USAID's Ebola Response Highlight the Need for a Public Health Emergency Policy Framework

AUDIT REPORT 9-000-18-001-P
JANUARY 24, 2018

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MEMORANDUM

DATE: January 24, 2018

TO: Assistant to the Administrator for Policy, Planning and Learning, Wade Warren

FROM: Assistant Inspector General for Audit, Thomas E. Yatsco /s/

SUBJECT: Lessons From USAID's Ebola Response Highlight the Need for a Public Health Emergency Policy Framework (9-000-18-001-P)

This memorandum transmits the final report on our audit of USAID's preparedness for responding to international public health emergencies. Our audit objectives were to evaluate USAID's experience managing and coordinating the Ebola response, assess its processes for managing and coordinating future responses, and identify factors that may affect its ability to respond. 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 14 recommendations to ensure USAID is prepared to respond to a future Agency-wide effort. After reviewing information you provided after receiving the draft report, we consider seven resolved but open pending completion of planned activities (recommendations 2, 5, 9, 11, 12, 13, and 14), and seven unresolved (recommendations 1, 3, 4, 6, 7, 8, and 10). For the resolved recommendations, please provide evidence of final action to the Audit Performance and Compliance Division.

For recommendations 1, 3, 4, 6, 7, 8, and 10, please work with us to resolve the recommendations, or provide a revised plan, within 30 days, copying the Audit Performance and Compliance Division.

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

CONTENTS

INTRODUCTION 1

SUMMARY 1

BACKGROUND 2

USAID'S EBOLA STRATEGY PROVIDED FLEXIBILITY TO ADAPT, BUT DECISION-MAKING AND COORDINATION CHALLENGES WEAKENED THE RESPONSE 5

- USAID's Evolving Ebola Strategy Provided Needed Flexibility To Adapt to Changing Circumstances, but Faced Funding and Recovery Obstacles 5
- Differing Federal Agency Approaches, Lack of Initial Leadership Support, and Staffing Issues Complicated Response Efforts 8
- Coordination Challenges Internally and With Key Stakeholders Affected Operational Effectiveness 12

USAID LACKS A POLICY FRAMEWORK FOR RESPONDING TO FUTURE PUBLIC HEALTH EMERGENCIES 16

- USAID Has Not Developed Policies for Effectively Coordinating a Whole-of-Government Response 17
- USAID Lacks Policies for Assessing Health Threats and Responding to Needs 19
- USAID Is Not Equipped to Identify and Secure Needed Expertise and Resources in a Timely Manner 20
- USAID Did Not Learn From Past Responses and Has Not Established a Process for Assessing Agency-Wide Efforts 21

EXTERNAL FACTORS FURTHER COMPLICATED EBOLA RESPONSE EFFORTS 22

- Emergency Ebola Funding Was Not Approved for Months After Disaster Declaration 22
- USAID Efforts Were Affected by Weak International Response and Coordination in the Field 23
- Geography, Culture, and Viral Persistence in Host Countries Impeded Response Efforts 24

CONCLUSION 25

RECOMMENDATIONS 25

OIG RESPONSE TO AGENCY COMMENTS 27

APPENDIX A. SCOPE AND METHODOLOGY 30

APPENDIX B. STAFFING ISSUES AND SUGGESTIONS 32

APPENDIX C. TIMELINE OF KEY EVENTS 34

APPENDIX D. AGENCY COMMENTS 35

APPENDIX E. MAJOR CONTRIBUTORS TO THIS REPORT 46

INTRODUCTION

The U.S. Agency for International Development (USAID), through the Office of U.S. Foreign Disaster Assistance (OFDA), operated as the lead Federal agency to coordinate the U.S. response to the international Ebola virus disease outbreak although other USAID offices were integrally involved in the response. According to the World Health Organization (WHO), the 2014 Ebola epidemic in West Africa was linked to more than 11,000 deaths as of April 2016, making it one of the most fatal infectious disease outbreaks in modern history. The United States was the largest international donor in responding to the 2014 outbreak, appropriating around $5.4 billion, with four U.S. Government agencies providing the most support: USAID, the Department of State, the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC), and the Department of Defense (DOD).

Over the past 2 years, we have reported on the U.S. response and identified opportunities for USAID to strengthen its awards process and other management activities.[1] We conducted this audit to assess USAID's overall management and coordination of the Ebola outbreak, and its ability to react to future international public health emergencies. Specifically, we (1) assessed how USAID managed and coordinated the Ebola response and highlighted potential vulnerabilities for future public health emergencies, (2) evaluated its policies and processes for managing and coordinating future public health emergencies, and (3) identified external factors that may affect USAID's ability to respond.

To conduct our work, we reviewed available documentation and interviewed 94 current and former USAID staff at various levels in the Agency in Washington, DC, and in Guinea, Liberia, and Sierra Leone who were involved in Ebola response, recovery, and subsequent development activities. We also interviewed 80 individuals from other U.S. Government agencies, United Nations (UN) organizations, nongovernmental organizations (NGO), implementing partners, host-country officials, and academic institutions. Because of limited documentation, we had to rely heavily on the testimonial evidence we gathered to meet our audit objectives. Our scope and methodology are described in appendix A.

SUMMARY

USAID's Ebola response strategy provided needed flexibility to adjust operations as the disease and other circumstances evolved, but challenges related to funding and the transition to recovery weakened the Agency's response. Shortcomings in leadership,

[1] "Ebola Experience Highlights Opportunities To Strengthen USAID's Award Process and Reprogram Funds," 9-000-17-001-P, December 27, 2016; "Audit of Select Activities from the USAID/Food for Peace Response to the Ebola Crisis in West Africa," 7-962-16-003-P, March 16, 2016; and "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. OIG reports are available at oig.usaid.gov.

staffing, and coordination further hampered the response. For example, CDC and USAID disagreed on response priorities, adversely affecting the U.S. approach to control the outbreak in West Africa. Despite some early efforts by USAID operating units, significant international response efforts were late, technical expertise was not leveraged appropriately, and recovery efforts were delayed and not well coordinated with response activities. These experiences highlight potential vulnerabilities for future international public health responses.

To respond quickly to "incidents that may expand rapidly in size, scope, or complexity," the Department of Homeland Security calls for a readiness to act and adapt.[2] However, USAID has not developed a policy framework to better ensure that it is positioned to respond quickly to large-scale international public health emergencies. At the same time, USAID has not captured Agency-wide lessons from its experiences or codified some key management and coordination processes. Instead, the Agency has continued to rely on incomplete guidance for managing and coordinating response efforts—leaving responders to recreate processes as emergencies evolve.

USAID personnel cited a number of challenges that they considered beyond their ability to control, such as the release of emergency funding by Congress, geographic and cultural influences, and the type of health emergency. While external factors can further complicate response efforts, the challenges they present are common in the international area USAID operates in, and poor planning may have exacerbated these challenges. For example, failure to engage communities early to build trust and correct misinformation about the virus propelled national skepticism in affected countries. WHO guidance developed in 2013 emphasizes developing and maintaining public trust.

We made 14 recommendations to improve USAID's preparedness to respond to future international public health emergencies.

BACKGROUND

The Ebola virus causes one of the most fatal infectious diseases, and is transmissible through bodily fluids. The 2014 Ebola epidemic in West Africa was the largest recorded in the history of the disease, associated with 28,616 suspected, probable, and confirmed cases and 11,310 deaths as of April 13, 2016.[3] Although the outbreak spread to six African countries, the large majority of cases and fatalities were in Guinea, Liberia, and Sierra Leone.[4]

[2] Department of Homeland Security, National Response Framework, Second Edition, May 2013, http://www.fema.gov/media-library-data/20130726-1914-25045-1246/final_national_response_framework_20130501.pdf, accessed on April 26, 2016.
[3] Figures reported by WHO.
[4] According to CDC, Ebola cases also appeared in Mali, Nigeria, and Senegal.

In March 2014, WHO publicly announced an Ebola outbreak in Guinea. On August 8, 2014, WHO declared the outbreak in West Africa a public health emergency of international concern. The United States treated the outbreak as both a health crisis and a national security threat. USAID responded to WHO's flash appeals for Ebola response funds and was the top donor overall to WHO's Ebola response, providing $73.9 million.

In September 2014, President Obama announced the U.S. response strategy, which had four lines of effort: (1) control the outbreak, (2) manage the secondary consequences, (3) build coherent leadership and operations, and (4) ensure global health security. On December 16, 2014, Congress appropriated approximately $5.4 billion in emergency funding for U.S. Ebola preparedness and response, of which approximately $2.5 billion was provided to USAID and the Department of State. According to the Government Accountability Office (GAO), as of July 2016, USAID and State had obligated approximately $1.5 billion of the $2.5 billion.

USAID, through OFDA, was the lead Federal agency to coordinate the U.S. response to the international Ebola outbreak. USAID created the Ebola Secretariat,[5] to coordinate and oversee Ebola activities across its bureaus and units.

Once the U.S. Ambassador in an affected country declares a disaster, USAID protocols call for OFDA to send a Disaster Assistance Response Team (DART) to coordinate the implementation of the U.S. response in the field, while using a Response Management Team (RMT) to coordinate headquarters and field efforts. Table 1 describes the main USAID offices involved in the Ebola response and recovery activities.

The Department of State, CDC, and DOD also played major roles in the Ebola response, as did international organizations, NGOs, the private sector, host governments, and local communities.

On March 29, 2016, WHO declared the end of the public health emergency of international concern for the Ebola outbreak in West Africa. USAID offices continue to implement recovery activities to address secondary impacts of the disease and reduce the stigma surrounding survivors. USAID's Bureau for Global Health (GH) also continues to support developing countries in improving preparedness to deal with emerging health threats. The scientific community predicts that it is only a matter of time before the world confronts another international public health emergency, as demonstrated by the emergence of the 2015-2016 Zika virus epidemic.

[5] The Ebola Secretariat later transitioned into the Africa Ebola Unit (AEU).

Table I. USAID Offices Involved in Ebola Response

Office Description	Responsibilities/Actions
Africa Ebola Unit (AEU) Established by the Bureau for Africa on March 22, 2015, AEU assumed the Ebola Secretariat coordinating functions in May 2015.	Facilitate communications and coordination within USAID, and oversee implementation of activities to mitigate second-order effects of the Ebola outbreak.
Bureau for Africa Supports USAID's 33 regional and bilateral missions in Africa.	Assist the missions to provide coordination and support for U.S. Government efforts to fight Ebola in Guinea, Liberia, Senegal, Ghana, and Mali.
Bureau for Democracy, Conflict and Humanitarian Assistance (DCHA) Deploys agile funding through various offices, including Food for Peace (FFP) and OFDA, to respond to crises and mitigate disaster and conflict.	Provide resources and technical assistance to coordinate the Ebola response and recovery efforts.
Bureau for Global Health (GH) Supports field health programs and research and innovation to advance international health objectives, and coordinates with other donors to transfer new health technologies to the field.	Restore non-Ebola-related health services and assist countries in preventing and preparing for a potential Ebola outbreak within their borders.
Bureau for Legislative and Public Affairs Manages USAID's external affairs and serves as the point of contact for USAID's international development programs and policies.	Engage with the public and Congress about Ebola programming and funds.
Ebola Secretariat Coordinated response efforts within USAID and with other Federal agencies; dissolved on May 26, 2015, and AEU assumed coordination functions within USAID.	Provide coordination within USAID and with other Federal agencies.
Office of Food for Peace Provides emergency food assistance to communities affected by conflict and natural disaster, and development assistance to address the primary sources of food insecurity.	Restore food production and consumption in West Africa to pre-Ebola levels through the distribution of food aid, market research and recovery efforts, and food security monitoring.
U.S. Global Development Lab Coordinates with different partner organizations to find new and innovative solutions to development challenges.	Promote innovations applicable to the Ebola response effort, and enhance communications and information systems in affected countries.
Global Health Ebola Team (GHET) Established by GH on May 8, 2015.	Coordinate and manage the health component of USAID response and recovery efforts.
Office of Budget and Resource Management Supports USAID's resource planning processes, budget capabilities, and resource allocations.	Aggregate and report Ebola financial data.
Office of U.S. Foreign Disaster Assistance Provides emergency, nonfood humanitarian assistance, and devises, coordinates, and implements strategies for responding to international crises and disasters.	Serve as the lead operational platform for responding to the Ebola outbreak. OFDA's DART was responsible for planning, operations, logistics, and administration relating to the U.S. interagency Ebola response effort in the affected countries.

Note: USAID offices are listed in alphabetical order and not in order of involvement. This list is not exhaustive of all USAID offices involved in the Ebola response.
Source: OIG analysis of USAID documentation.

USAID'S EBOLA STRATEGY PROVIDED FLEXIBILITY TO ADAPT, BUT DECISION-MAKING AND COORDINATION CHALLENGES WEAKENED THE RESPONSE

The Ebola response called for a level of U.S. and international coordination that was unprecedented for USAID. While USAID effectively managed several aspects of its response to the Ebola outbreak, it faced many challenges, a number of which remain unaddressed. We identified weaknesses related to the roles of leaders in decision making, timing of response efforts, and internal and external coordination. USAID took action to fully or partially address some of these weaknesses, many that were specific to the Ebola response, but has not codified them in USAID policy to inform future health emergencies.

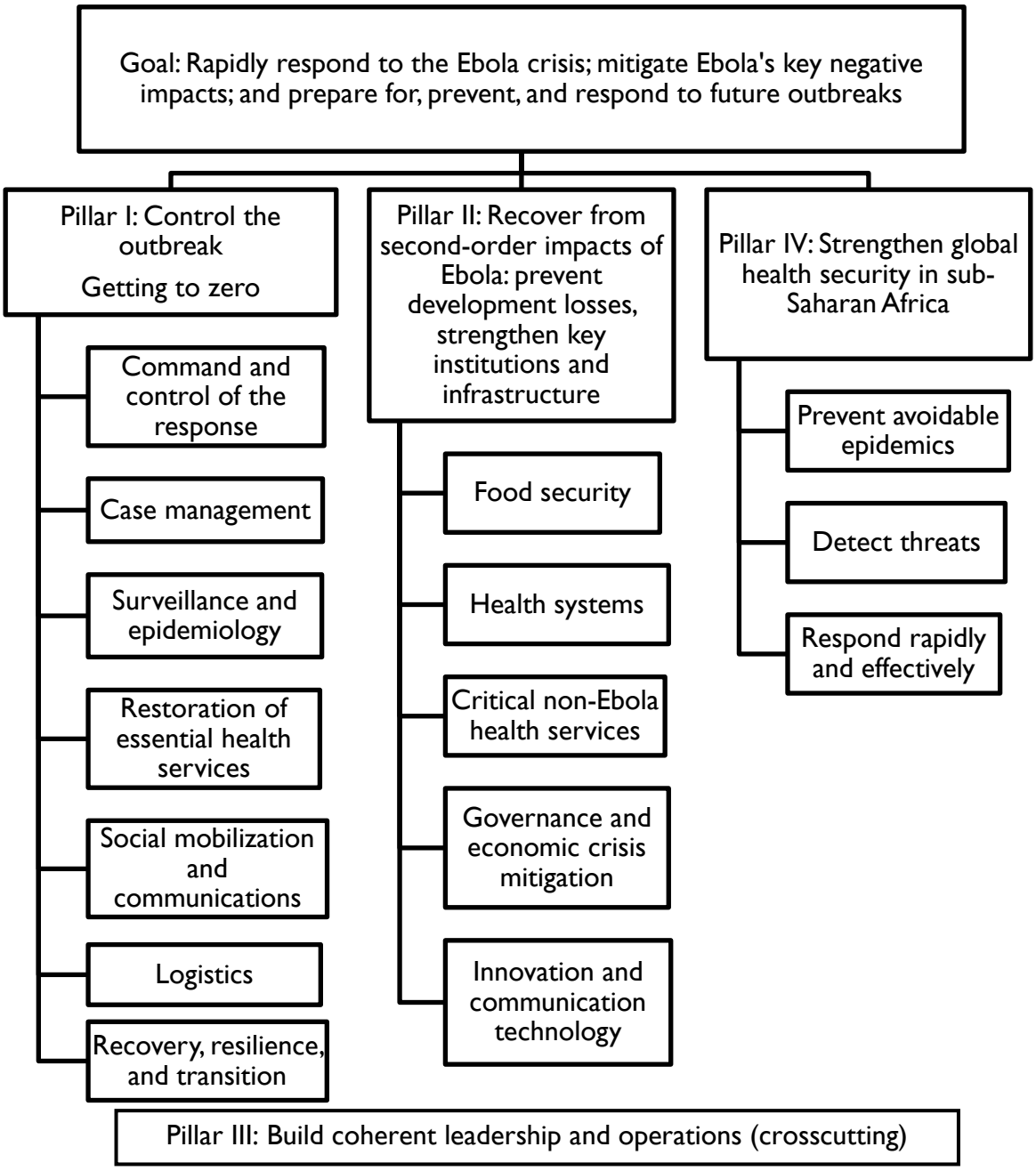
USAID'S EVOLVING EBOLA STRATEGY PROVIDED NEEDED FLEXIBILITY TO ADAPT TO CHANGING CIRCUMSTANCES, BUT FACED FUNDING AND RECOVERY OBSTACLES

At the start of the Ebola outbreak in West Africa, USAID lacked a strategy for responding to public health emergencies. According to USAID interviewees, in September 2014, USAID issued its first iteration of a strategy[6] to respond to the Ebola outbreak in West Africa that reflected the President's four-pillar approach. We found that the strategy largely aligned with the Ebola response strategies of those in the international community, such as WHO and other U.N. agencies. However, organizational obstacles related to funding decisions delayed response efforts and left resources susceptible to mismanagement; silos among response-to-recovery actors also impeded recovery progress.

The strategy has three operational pillars as well as one crosscutting pillar for coordination; USAID operating units were assigned to perform activities in operational pillars I, II, and IV (figure 1) and used the strategy as a communication platform to collaborate with one another. Pillar III was crosscutting, and USAID interviewees said it was added to address coordination issues.

[6] This strategy was USAID specific, but USAID also participated in a joint CDC-USAID strategy.

Figure 1. USAID Ebola Strategy



Source: Recreated by OIG based on information from USAID's Ebola Strategy as of July 2015.

The strategy allowed USAID to adapt its operations to changing circumstances including evolution of the disease. While the main pillars remained the same, the activities were fine-tuned over time. In addition, operating units and missions reported they were able to develop or modify their own strategies to carry out these activities and respond to the Ebola crisis, as the following examples show:

- Missions in Guinea and Liberia reviewed and adjusted their existing development strategies to incorporate additional Ebola health and education activities.
- GHET developed a results framework for implementing Ebola activities with key outputs and indicators.
- FFP modified its global Agriculture Task Force to address food response in a medical event.
- AEU developed a communications strategy in fall 2015 to increase its outreach effort.
- OFDA distinguished its approach from the U.S. Government approach by developing country strategies that shifted interventions based on need.

External stakeholders also noted that modifications were made to respond to changing priorities in caring for the populations affected by the outbreak. According to UNICEF, the United Kingdom's Department for International Development, and implementing partners, USAID was willing to take risks, adapt to changing circumstances, and fill response gaps. For example, USAID funded interim care kits and basic safety training to help the International Organization for Migration respond to people in Sierra Leone at risk of dying in their homes from dehydration. The kits included oral rehydration and basic personal protective equipment, such as gloves, aprons, and chlorine.

Despite the strategy's flexibility, obstacles related to funding and the transition from response to recovery took more time than USAID staff anticipated and presented implementation risks.

Funding

According to interviewees, aligning emergency funding to specific pillars, as USAID did, complicated response efforts because the funds are approved by Congress for accounts, not pillars. For example, the U.S. Global Development Lab, funded under pillar II, also had activities that fit under pillar IV. Furthermore, interviewees said USAID and congressional approval and authorization for funding GH programming delayed response programs and activities. Disagreements between missions and GH related to program funding, management, and interventions slowed program implementation.

According to USAID officials interviewed, USAID did not provide adequate oversight to ensure (1) an operating plan was in place and operating expenses were used appropriately, (2) skilled staff carried out major responsibilities, and (3) budget decisions were transparent.

OFDA allowed implementing partners to shift funds among activities, but five of its partners noted limitations, such as the inability to procure a drug that prevented hemorrhaging in pregnant women. Another interviewee from a partner organization noted awards were not flexible enough to quickly match the outbreak's evolution and time was wasted in one instance when instead of modifying an award, the organization was required to initiate a new one. Regarding reprogramming existing development

funds to Ebola response efforts, three USAID mission interviewees noted the process was time-consuming during the crisis.

Recovery

OFDA and other operating units discussed and developed a response-to-recovery transition strategy in August 2015, almost a year after the response began. Transition planning considered sustainability and how to incorporate response activities into existing mission and GH development programs, but USAID staff and a temporary duty (TDY) report said the plan was not implemented in a timely manner. Interviews with external partners indicated that response and recovery were compartmentalized, and the transition process from OFDA to other USAID operating units was not clearly communicated. Some interviewees also noted that recovery did not begin until after the country was declared free of Ebola transmission, and varied by country and implementing partner. According to interviewees, recovery should have started earlier because the activities involved take years to yield results. Interviewees also said missions should have used OFDA's response partners for recovery activities because they already understood the country and the context. Furthermore, NGOs were identified as having either humanitarian response expertise or development expertise, but not both.

DIFFERING FEDERAL AGENCY APPROACHES, LACK OF INITIAL LEADERSHIP SUPPORT, AND STAFFING ISSUES COMPLICATED RESPONSE EFFORTS

According to interviewees, differing views between USAID and CDC complicated the beginning of the U.S. Ebola response in West Africa. Within USAID, a lack of urgency and leadership support and challenges in filling staff vacancies further affected the response.

Differing Response Approaches Between CDC and USAID

The U.S. Government response took a clinical approach that emphasized preparing for a worst-case scenario, building treatment units, and provisioning beds in those units, which resulted in excessive capacity of unused beds. However, USAID advocated for community-based behavioral interventions—such as contact tracing, infection prevention, and safe burials—which proved significant in reducing the number of Ebola cases. USAID officials diverged from CDC on criteria to inform intervention decisions (table 2), but according to interviewees, USAID did not have evidence to sufficiently challenge CDC's clinical response.

Table 2. Key CDC and USAID Divergences on Criteria To Inform Decisions

Criterion	CDC	USAID
Cases reported	Total	Marginal—Daily and weekly changes in case numbers
Disease tracking	CDC's crisis management database	CDC database too detailed and built for epidemiologic research
Infection rate projections	Scenario models, including worst-case projections without additional interventions	Data OFDA heard in the field
Intervention focus[a]	Clinical	Community-based behavioral change

[a] USAID did not have strong historical data on the impact of community-based behavioral interventions that break the chain of transmission, such as safe burials. Conversely, CDC had scientific data and numbers supporting clinical interventions such as isolation and Ebola treatment units.
Source: USAID interviewees only.

Lack of Urgency and Initial Leadership Support

U.S. public health and DOD biosurveillance—as well as appeals by a Liberian health minister and USAID staff—signaled an emerging Ebola epidemic crisis months before WHO's August 2014 declaration of an international public health emergency. Two USAID operating units took early action. Specifically, in March and April 2014, GH's Security and Development Unit redirected program funds and used other WHO investments to send personal protective equipment supplies to West Africa; in March 2014, OFDA provided $600,000 for Ebola efforts; and in July 2014, OFDA deployed a public health adviser to conduct assessments in the affected countries. Despite these early efforts, USAID did not launch a full-scale response until the formal disaster declarations were made by the U.S. Ambassador of Liberia and Chargés d'Affaires in Guinea and Sierra Leone in August 2014. Disaster declarations that would trigger a large-scale response by OFDA were made an average of 118 days after the first confirmed Ebola cases (table 3).

Table 3. Elapsed Time From First Confirmed Ebola Case and Disaster Declarations

Ebola Events	U.S. Response	Days
Guinea		
March 23, 2014: WHO announced Ebola outbreak in Guinea after laboratory tests confirmed that the hemorrhagic fever outbreak was caused by the Ebola virus.	**August 15, 2014:** The Chargé d'Affaires in Guinea declared the Ebola outbreak in Guinea a disaster.	145
Liberia		
March 30, 2014: Liberia confirmed first Ebola cases.	**August 4, 2014:** The U.S. Ambassador to Liberia declared the Ebola outbreak in Liberia a disaster.	127
Sierra Leone		
May 24, 2014: Sierra Leone confirmed first Ebola case.	**August 13, 2014**: The Chargé d'Affaires in Sierra Leone declared the Ebola outbreak in Sierra Leone a disaster.	81

Source: OIG analysis of documentation.

Mission staff in Guinea and Liberia noted the lack of a major USAID response while the outbreak was growing. Mission staff did not fully understand the enormity of the outbreak, and USAID senior staff believed WHO that the outbreak was under control. According to one employee, USAID did not have a mechanism for elevating concerns—like those of technical advisers in June 2014—to appropriate officials. News agencies reported the belated response by the international community, including the U.S. Government, to the Ebola outbreak in West Africa. Furthermore, in September 2014, the United Nations warned that the outbreak had outpaced the response efforts on the ground and would become more difficult to control without significantly more resources. Ultimately, successful community-based interventions such as contact tracing, infection prevention, and safe burials contributed to controlling the outbreak, according to USAID.

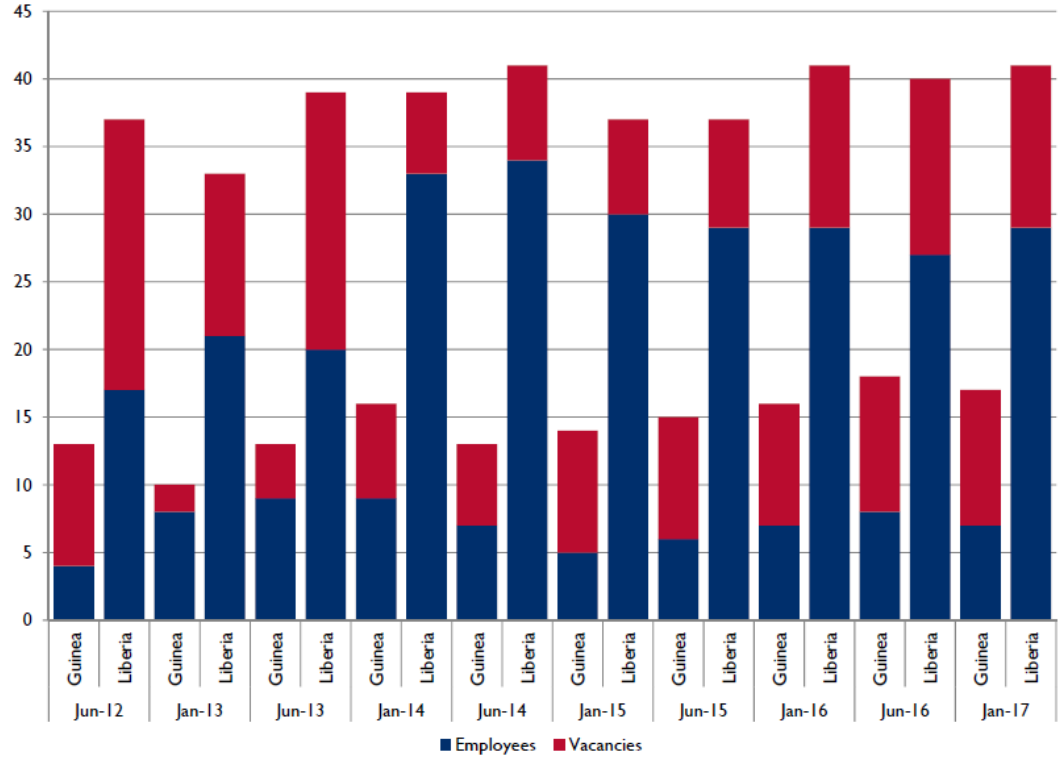
Across USAID units,[7] interviewees pointed to a lack of leadership—particularly a reluctance to prioritize the dedication of staff and resources to the response—as key factors that contributed to slow response and recovery. For example, a senior official indicated that in the months leading up to the declaration of a disaster, USAID continued to dedicate senior leader attention to its August 2014 Africa Summit—a 3-day conference in Washington, DC, that focused in part on the U.S. commitment to the African people, democracy, and security. However, the Presidents of Liberia and Sierra Leone cancelled their participation because of concerns about the Ebola outbreak.

Insufficient Staffing

At the outset, USAID operating units used contractors, detailees, and other temporary measures to fill staffing gaps, a persistent challenge throughout the response (figure 2). Staffing issues were mentioned in 71 interviews conducted with USAID or former USAID staff.

[7] Interviewees cited weaknesses with GH; the Office of Acquisition and Assistance (OAA); AEU; Africa Bureau; Policy, Planning and Learning; and USAID as a whole.

Figure 2. Staffing Vacancies



Note: Vacancies are of direct-hire staff. There were no direct hires in Sierra Leone from March 2013 through March 2014; one was hired in 2016. For Sierra Leone, staffing information was included with Guinea's in 2014 and 2015.

Source: USAID Staffing Pattern.

In Washington, DC, the Ebola Secretariat and AEU were chronically understaffed despite volunteers because some supervisors were reluctant to detail employees with key skills, according to staff in these units. Many of those detailed continued to carry out their regular full-time responsibilities as they worked on the Ebola response. Some staff offered to help with the response, but lacked the necessary skills or expertise. USAID interviewees highlighted the value of cross-training staff on emergency response.[8] Moreover, OFDA did not have a mechanism to systematically utilize mission, bureau, and operations staff based on their skills. For example, at the start of the response, OFDA did not use GH's water, sanitation, and hygiene experts or the U.S. Global Development Lab's technology experts. Eventually the Lab assisted the DART in developing more reliable data systems. These weaknesses were exacerbated in Sierra Leone. According to interviewees, staff who rotated through the country had differing priorities about which Ebola activities should be funded, and staffing in Guinea and Sierra

[8] In January 2017, USAID announced the intent to develop a process for training USAID staff interested in serving for OFDA during periods of heightened international disaster response efforts.

Leone was insufficient to properly manage the influx of funds. Appendix B lists more staffing issues identified by interviewees.

COORDINATION CHALLENGES INTERNALLY AND WITH KEY STAKEHOLDERS AFFECTED OPERATIONAL EFFECTIVENESS

Due to the magnitude and complexity of the whole-of-government response, coordination was essential to successfully respond to the Ebola crisis. USAID took proactive measures to encourage internal communication but encountered operating challenges including transitions among USAID units, information gaps, the lack of USAID and Federal project data systems,[9] and unclear roles among responders.

The Ebola Secretariat reported directly to the Administrator and promoted communication among USAID's multiple offices across the strategic pillars. At the height of the response, it held open meetings twice a day to update and share critical information among USAID attendees.[10] At the end of each quarter, USAID units presented an overview of their response activities in the previous quarter and plans for the next quarter to the Secretariat and, later, AEU. Additionally, the Secretariat and AEU provided the USAID Administrator weekly updates on the outbreak and units' response activities. USAID operating units were in continual communication with one another, coordinating trips to mission offices to assist field staff and get status updates.

While both the Ebola Secretariat and AEU took action to share updates and consolidate reporting, these activities were less effective when coordination transitioned from the Ebola Secretariat to AEU in May 2015—in part because the AEU reported to both the USAID Deputy Administrator and the Africa Assistant Administrator, blurring the lines of authority for the other operating units. In addition, AEU did not have written policies, procedures, or transition strategies for when it disbanded. According to interviewees, poor communication on AEU's purpose and role reduced its overall operational effectiveness.

The lack of an Agency-wide system for capturing and sharing program and project data further challenged internal communication and coordination. Instead, many USAID offices, bureaus, and programs have discrete data management systems that do not communicate with one another. For example, according to USAID staff, OFDA's system tracks its programs in each country, while Power Africa, the Office of Transition Initiatives, and other operating units have their own tracking systems. Documentation is also stored in multiple formats. Alternatively, other USAID staff said OFDA relies on a central email system to share information, while GHET uses a separate shared drive. Interviewees reported that in Sierra Leone, USAID did not know what programs were operating: responders found out about projects by chance. For example, responders using mapping software found a hospital project that had been ongoing since 2013, but no one in-country or in GHET knew about it. Ultimately, the Agency does not have a collective inventory of programs or partners operating in any given country to minimize

[9] The website http://www.foreignassistance.gov/ lists information on U.S. development programs by country, but is not complete.

[10] When the outbreak appeared to be under control, the task force met once a week.

duplication of effort and delays, or address existing problems that may otherwise be missed by lack of coordination. The U.S. Government similarly lacks a comprehensive system for capturing information on the use of its foreign assistance funds. This presented difficulties finding partners and creating synergies among programs.

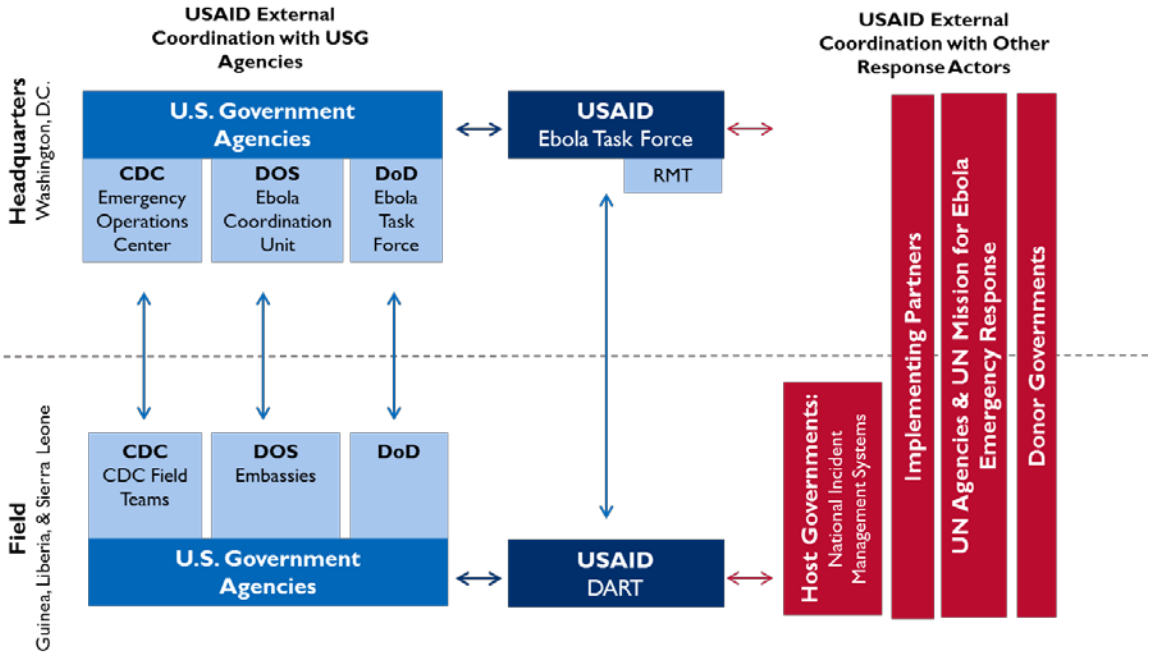
Foreign Service rotations, temporary duty assignments, including serving on DARTs, and the departure of staff from the Agency contribute to these information challenges. One senior USAID official indicated that institutional knowledge and other critical information are lost or not easily retrieved when staff leave because there is no collection mechanism for preserving the knowledge or a central repository where data can be recorded and accessed. Interviewees agreed that the Agency's data collection tools—ProgramNet and the Development Experience Clearinghouse—were not particularly useful. These information gaps created a major challenge in the Ebola response. Despite Agency policy requiring USAID to establish a coordinated records management program and properly train those responsible for implementation, interviewees noted issues with record keeping. They said Agency units follow different processes, and key decisions were not always being documented. Furthermore, USAID staff did not always follow USAID's process for clearing and reporting information.

One staff member from the U.S. Global Development Lab is working with the USAID's Office of the Chief Information Officer (CIO) to improve the Agency's tracking of programs by creating a development information system. The Lab and CIO aim to bring all USAID systems together, drawing on system models that other development institutions have had for years. However, it is not expected to be available for another 5 years, and until it is complete, one unit was discouraged from creating its own system. In the meantime staff will continue to be challenged to adequately secure documentation to maintain a sound audit trail—further hampering collaboration and decision making, management oversight, and accurate reporting to Congress and stakeholders.

Coordinating with multiple stakeholders—primarily other U.S. Government agencies, host governments, NGOs, and public international organizations (figure 3 shows headquarters and field stakeholders)—also challenged USAID efforts, particularly in the early stages of the response. But coordination improved over time. For example, after the National Security Council (NSC) designated USAID as the lead agency for managing and coordinating the U.S. Government response and CDC as the lead for medical and public health issues, USAID and CDC had a clearer understanding of their respective roles and accountability, which helped improve coordination.[11] Notably, GH engaged with CDC in weekly calls, meetings, and joint reports. USAID missions provided CDC with administrative support in the affected countries and assisted CDC in selecting implementing partners. OFDA interviewees also noted that including CDC staff on OFDA's DARTs helped collaboration. USAID interviewees similarly characterized collaboration between USAID and DOD as positive. The relationship between OFDA and DOD was well-defined historically and helped minimize confusion about DOD's role—that of acting in support of USAID as the lead Federal agency.

[11] The documented assertion of NSC's designation is found in an internal USAID after-action report.

Figure 3. USAID's External Stakeholder Coordination



Source: USAID OIG analysis.

Despite these efforts, interviewees reported gaps in responder coordination and the need for more clarity on the roles and support services that different U.S. agencies would provide. OFDA and DOD after-action reports similarly reported confusion of roles and responsibilities and difficulties in communication and coordination.

Key problems in coordinating responder activities included the following:

- **Interagency agreements.** OFDA acknowledged in its after-action report that agreements between USAID and CDC, which were created during the Ebola response, did not specify operational details, clearly define roles and responsibilities, or ensure a common understanding of standardized language such as "lead Federal agency," "operational platform," and "technical adviser."
- **Field decisions.** CDC field personnel required approval from CDC headquarters in Atlanta to make decisions that OFDA staff would typically make in the field. Similarly, USAID did not appropriately channel requests for field-level assistance from DOD,[12] and USAID's Civilian-Military Cooperation policy had to be updated as a result of challenges encountered during the Ebola response.
- **Approval for proposals.** In September 2014, the Department of State established the Ebola Coordination Unit as a point of contact to coordinate and approve proposals to fund Ebola activities. However, the unit was disbanded in March 2015

[12] The Mission Tasking Matrix is a tool USAID uses to request field-level assistance from DOD; instead, it was used to approve strategic policies during the Ebola response.

in the midst of response and recovery. For recovery programs, two interviewees noted unclear and slow processes for USAID to obtain approval for program proposals. Four interviewees noted the joint budget process with the Department of State delayed program approval.

- **Embassy relations.** During the height of the response, USAID had direct access to U.S. Ambassadors, who helped ensure interagency cooperation among U.S. agencies. However, USAID had difficulty obtaining additional space at the Embassies to accommodate the influx of personnel, and according to an informed senior USAID official, mission directors in Liberia and Guinea had difficulty interacting with their Ambassadors throughout the outbreak.

Implementing partners generally praised USAID staff for their technical expertise and can-do attitude—pointing to numerous USAID activities that supported coordination, including field visits, consortiums, support services, and information exchanges. However, USAID staff noted that coordinating the large number of partners on the ground remained a challenge, while staff at partner organizations noted that frequent turnover of OFDA DART staff led to varied interpretations of agreements and duplicate briefings. Coordination challenges with partners included the following:

- The United States focused most of its Ebola response efforts on Liberia, assuming France and the United Kingdom would take the lead in Guinea and Sierra Leone, respectively. When the outbreak surpassed the lead responders' capacity in Guinea and Sierra Leone, USAID increased its response efforts in both countries. USAID coordinated with the United Kingdom's Department for International Development in Sierra Leone.
- USAID consulted with host governments when making decisions, including negotiating the placement and closing of treatment units and community care centers, and helping to improve the ministries' capacity to implement response and recovery measures.[13] However, USAID officials said slow decision-making processes on the part of host governments delayed efforts.
- Throughout the response, USAID coordinated closely with U.N. agencies—particularly, WHO, UNICEF, and the World Food Programme. However, the United Nations did not activate the humanitarian cluster system to coordinate international field efforts, and the U.N. Office for the Coordination of Humanitarian Affairs was not involved in the beginning of the response,[14] causing OFDA and other implementing partners to spend more time on coordination. Instead of activating the cluster system, the United Nations set up the Mission for Emergency Ebola

[13] Community care centers are established to isolate and manage suspected Ebola patients.
[14] Typically during a humanitarian response, the U.N. Office for the Coordination of Humanitarian Affairs activates the humanitarian cluster system. Clusters are groups of humanitarian organizations, both U.N. and non-U.N., in each of the main sectors of humanitarian action—e.g., water, health, and logistics. They are designated by the Inter-Agency Standing Committee and have clear responsibilities for coordination.

Response in September 2014 to coordinate international efforts, but one USAID interviewee said that created a barrier to information flow.

WHO guidance states, "Accurate, timely information is one of the most valuable commodities during a health emergency or disaster."[15] Yet challenges in collecting and sharing data among U.S. agencies, WHO, and host countries compounded reporting weaknesses, as discussed below:

- USAID's Global Development Lab reported that gaps in digital connectivity during critical phases of the response hindered responders' ability to share data, and caseload counts were understated due to missing case data—which were collected on paper and manually digitized, making them susceptible to human error and delays. Standards, procedures, and agreements for sharing information among responders were not established for areas such as data management and communication during complex crises. Data sharing was hampered by nuanced and imprecise definitions of identifying probable, suspected, and confirmed Ebola cases; data variations across districts and countries; and patient privacy concerns and aggregation of publicly available situation reports. Ultimately, these data issues exacerbated responders' ability to properly contain, report on, and respond to the epidemic and changing conditions.
- Within USAID, the process for clearing documents for distribution and reporting during contingency operations was poorly understood.[16] For example, two USAID interviewees noted one task force did not follow clearance procedures for sharing information with Congress, resulting in incorrect information being shared. In addition, the chain of command for clearing documents with input from various operating units delayed the release of information and reports.

USAID LACKS A POLICY FRAMEWORK FOR RESPONDING TO FUTURE PUBLIC HEALTH EMERGENCIES

The U.S. Department of Homeland Security's May 2013 National Response Framework provides guidance for effectively responding to all types of disasters and emergencies in the United States, emphasizing a readiness to act and the need for a forward-looking posture against "incidents that may expand rapidly in size, scope, or complexity."

However, USAID does not have a policy framework that can be replicated when faced with a public health emergency and enable it to respond in a timely manner to large-scale international health emergencies. Such a framework would delineate internal procedures and responsibilities for (1) coordinating activities, (2) assessing the threat and responding, and (3) identifying and securing needed expertise. Moreover, USAID

[15] Pandemic Influenza Risk Management Interim Guidance, June 2013.
[16] Overseas Contingency Operations are activities operated by DOD and State with supplemental funding, in addition to their "base" budgets.

has not established mechanisms for assessing past experiences to make needed adjustments to its policies and processes for responding to future health emergencies. According to OFDA, it is working with interagency partners to develop a policy framework for responding to international public health emergencies.

USAID HAS NOT DEVELOPED POLICIES FOR EFFECTIVELY COORDINATING A WHOLE-OF-GOVERNMENT RESPONSE

USAID, through OFDA, had a significant role in coordinating a whole-of-government response to the Ebola outbreak overseas.[17] The 1996 Presidential Directive on Emerging Infectious Diseases recognized and addressed the need for standing up a unit to strategically plan and coordinate global surveillance and response to emerging infectious disease threats. Significant planning guidance and recommendations from strategy papers and reports in 2005, 2009, and 2012 stressed the importance of clear roles among response actors and U.S. agencies prior to an emergency in order for effective coordination to occur.[18]

Yet according to an internal DOD report, "Existing interagency structures and processes for conventional foreign disaster response are not well suited for dealing with an international health crisis, such as a regional infectious disease epidemic." They do not specify clear roles, responsibilities, and capabilities for U.S. agencies involved, which contributed to coordination issues.

USAID also lacks a strategy for effective communication and coordination in the event the U.N. humanitarian cluster system is not activated or is delayed. As OFDA's after-action report pointed out, "participants recognized the need for the activation of this system and noted numerous challenges that occurred due to its absence." Weaknesses in USAID processes relating to task forces and transition compounded coordination challenges.

Task Force

The primary mechanism for coordinating a USAID response is establishing a task force. Best practices recommended by WHO call for a task force to identify, document, and share clear roles and responsibilities with stakeholders. From a DCHA memo with Ebola task force survey results and recommendations, we identified the following components of an effective task force:

- Purpose and criteria to activate
- Decision-making authority
- Appropriate staffing mechanisms

[17] According to USAID staff we interviewed, NSC made high-level Ebola response decisions, including reviewing plans and providing direction.

[18] U.S. National Strategy for Pandemic Influenza, November 2005; Report to the President on U.S. Preparations for 2009 H1N1 Influenza, August 2009; An HHS Retrospective on the 2009 H1N1Influenza Pandemic to Advance All Hazards Preparedness, June 2012.

- Expected leadership and staff qualifications
- Necessary roles and responsibilities
- Transition procedures
- Required after-action review
- Criteria to disband

However, USAID does not have procedures or guidance for setting up or managing a task force or coordinating body. Instead, USAID task forces are typically ad hoc, with roles and responsibilities defined as crises unfold. While USAID interviewees suggested the Ebola Task Force should function like an RMT—an institutionalized process that is widely known across the Agency—the unit's authority was not clear. According to USAID staff, not all stakeholders were effectively consulted or included during the early phase of the response, and the task force did not have the organizational position or authority to request needed information or staff from other units. Furthermore, when coordination transitioned from the Ebola Secretariat to AEU, AEU did not use the guidance, position descriptions, or a transition document that the Ebola Secretariat had developed. Ultimately, staff were unclear about AEU's purpose, role, organizational structure, and authority.

While both the Ebola Secretariat and AEU re-created positions and guidelines, some USAID operating units already had or developed policies and procedures that allow them to quickly respond. For example:

- When two or more of its units are involved in a response, DCHA activates a Crisis and (Political) Opening Action Coordination Team to use resources efficiently and eliminate duplication of effort. Standard operating procedures outline criteria for establishing, deactivating, and transitioning from a team. DCHA also has an Office of Crisis Surge Support Staff to mobilize staff for a crisis response.
- OFDA uses RMTs to coordinate headquarters and field efforts, and has policies and procedures governing their activation, operations, demobilization, and roles and responsibilities.
- Recognizing the need for greater coordination of technical expertise and for policies to help manage the unique requirements of Ebola funding, the U.S. Global Development Lab organized matrix teams, and staff created standard operating procedures for budgeting, funding requests, travel, and the clearance process.
- GHET created a standard reporting template for implementing partners to share information that could be used in future emergencies, which was modified for the Zika response.

Transition From Response to Recovery

USAID's 2011-2015 Policy Framework highlights the need to partner within USAID and foster effective transitions from disaster response to development,[19] including using joint assessments and joint planning. Similarly, the National Health Security Strategy Implementation Plan states the "Appropriate recovery planning—that is well integrated with response planning from the beginning of an incident—will help to expedite the restoration of the health and well-being of affected individuals and communities."[20]

However, USAID has not established procedures for how the Agency intends to transition from response to recovery to development in a health emergency. Without such procedures, USAID may miss opportunities to convert emergency response assistance into development programs for long-term resiliency and preparedness. In addition, international partners in the field were unclear about the roles and responsibilities of USAID offices—some thought OFDA, GH, missions, and FFP were and operated like separate agencies. External interviewees acknowledged that the transition between response and recovery is something that donors and international organizations struggle with.

USAID LACKS POLICIES FOR ASSESSING HEALTH THREATS AND RESPONDING TO NEEDS

USAID has not developed policies for assessing health crises to determine the need for and timing of response activities to assist countries with disease outbreaks that have the potential to grow into an epidemic or pandemic. For example:

- USAID does not have a process to trigger rapid needs assessments. These assessments provide decision makers with essential information. According to OFDA's Field Operation Guide, proper initial assessments lead to effective activities and provide baseline data for monitoring outbreaks and determining whether a situation is improving or deteriorating. For example, one OFDA official stated that the Agency brought "too much stuff," while another OFDA official mentioned difficulty finding suitable in-country capacity to store excess commodities once the outbreak was over.
- USAID does not have policies for deploying a team to assess a health situation in collaboration with mission staff before a disaster declaration is made. USAID, through OFDA, leads the U.S. Government's response to overseas humanitarian crises. However, OFDA responds to a crisis after a U.S. Ambassador declares a disaster. Once the Ebola crisis was declared in August 2014, OFDA deployed multiple teams, but at that point, USAID's response was already behind the rapid spread of the disease. According to one USAID interviewee, technical advisers in the

[19] USAID Policy Framework, 2011-2015, https://www.usaid.gov/sites/default/files/documents/1870/USAID%20Policy%20Framework%202011-2015.PDF, accessed on July 29, 2016.

[20] U.S. Department of Health and Human Services, Implementation Plan for the National Health Security Strategy of the United States of America, May 2012, http://www.phe.gov/Preparedness/planning/authority/nhss/ip/Documents/nhss-ip.pdf, accessed on April 26, 2016.

Agency were concerned about the Ebola outbreak as early as June 2014, but there was no mechanism in place for those concerns to be raised within the Agency.

USAID IS NOT EQUIPPED TO IDENTIFY AND SECURE NEEDED EXPERTISE AND RESOURCES IN A TIMELY MANNER

Best practices and a retrospective report emphasize the importance of maintaining an inventory or other tracking system of all staff, stakeholders, and partners to quickly leverage the expertise needed to better ensure effective outcomes. The 2010 Center for Strategic and International Studies "Strengthening Global Health Preparedness" report recommended that the United States collaborate with WHO and other groups to create "an ongoing inventory of activities of all international groups, including NGOs, working to contribute to health preparedness capacity building in developing countries."[21]

While OFDA maintains a roster for rotating staff to a DART, USAID has not developed a system to identify other USAID staff who could rapidly respond to health emergencies and complex crises. The USAID Ebola task force and mission staff stated that critical positions were left unfilled because USAID could not find staff volunteers with the required expertise, or supervisors did not allow some to be detailed. Some interviewees said the Ebola crisis exacerbated systemic staffing challenges. Other weaknesses that were exposed included challenges due to the large number of partners—such as not knowing which organizations were on the ground and confusion about medical evacuation rules.

USAID guidance does not outline the steps a mission or bureau can take in the event of an emerging crisis. USAID mission staff reported limited flexibility in their ability to reprogram funds that would allow missions and operating units to redirect resources to Ebola response efforts. For example, in Liberia, implementing partners wanted to shift their existing health programs to help with Ebola, but providing justification and obtaining clearances to reprogram mission funds was challenging because guidance was unclear on how to do so.[22]

While OFDA's funding provided more flexibility, partners reported restrictions on what OFDA could fund, and noted award mechanisms were hard to modify when conditions changed. Interviewees said awards were not always adaptable and responsive to disease evolution or a changing field environment.

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[21] "Strengthening Global Health Preparedness: Recommendations for Expanding U.S. Engagement and Leadership," June 2010, http://csis.org/files/publication/100623_Nieburg_StengthenGlobalHealth_Web.pdf.
[22] According to GAO's Standards for Internal Control in the Federal Government, section 9.04, to be effective in meeting objectives, management should revise the internal control system on a timely basis, when necessary.

USAID DID NOT LEARN FROM PAST RESPONSES AND HAS NOT ESTABLISHED A PROCESS FOR ASSESSING AGENCY-WIDE EFFORTS

USAID reported that the scope and scale of the Ebola outbreak in West Africa were significant, but we found it was not USAID's first infectious disease response. OFDA responded to smaller Ebola outbreaks with CDC in 1976 and 2000. Similarly, GH was involved in implementing activities to prepare for H5N1 avian influenza outbreaks during the 2000s. In 2009, OFDA and GH worked together to respond to the H1N1 influenza pandemic. One interviewee said that recognizing the need to better prepare for future emergencies, OFDA and GH established a memorandum of understanding after the H1N1 response outlining cooperation between their offices, but it was not used in the Ebola response. In 2010, OFDA responded to a cholera outbreak after the earthquake in Haiti in collaboration with CDC. Despite these coordinated efforts, OFDA reported that prior to the Ebola response, it had few established relationships with CDC for working together to respond to large-scale international health emergencies.

An Agency-wide effort to learn from the Ebola outbreak was not evident, despite early identification of the need for such assessment and individual employee efforts. Instead, lessons that may lead to improvement were narrowly developed, specific to operating units, and mostly informal. For example, at the time of our audit, OFDA, the U.S. Global Development Lab, and several other USAID bureaus had conducted lessons learned from the Ebola crisis, and OFDA was in the process of implementing its own recommendations. Staff appreciated OFDA's after-action review process, but they said that a whole-of-Agency review would need to be conducted by another unit with the capacity and expertise to do so.

While USAID has strategies and policies to encourage organizational learning, it does not have a policy for specifically learning from its Agency-wide response efforts to improve processes and systemic issues; instead, USAID relies on individual missions and operating units to evaluate their programs. This appears to be due, in part, to the Agency's frequently shifting priorities, which redirect efforts and resources before lessons can be institutionalized, as evidenced by lessons regarding needed improvement from the Ebola response and recovery being previously identified but not captured in policy.

An independent review of the U.S. response to the Haiti earthquake, commissioned by USAID and issued in March 2011,[23] determined that existing agreements among U.S. Government agencies were insufficient to manage a whole-of-government response. The review contained a number of recommendations, including (1) structurally strengthening OFDA as the lead Federal agency for international disaster response; (2) strengthening an international response framework and monitoring data quality; (3) determining the need for and mobilizing resources; (4) elaborating on memorandums

[23] Independent Review of the U.S. Government Response to the Haiti Earthquake, Final Report. March 28, 2011, http://pdf.usaid.gov/pdf_docs/Pdacr222.pdf, accessed on March 9, 2017.

of agreement with other U.S. agencies; (5) using interagency staff as RMT technical advisers; and (6) improving the sharing of staff among USAID bureaus.

In response to the independent review, USAID stated that most of the recommendations were reasonable and actionable, and that implementing them would substantially improve the U.S. response to similar disasters in the future. Both USAID and HHS agreed with the need for an international response framework, using the National Response Framework as a guide. However, the many weaknesses and challenges identified in the Ebola response indicate that USAID did not fully implement the recommendations.

EXTERNAL FACTORS FURTHER COMPLICATED EBOLA RESPONSE EFFORTS

According to USAID personnel, the Agency faced a number of challenges in responding to the Ebola outbreak that were beyond their ability to control, including funding, coordination of international efforts, geographic and cultural concerns, and the nature of the disease itself. However, these and other external challenges have been identified in previous USAID responses and are common in the international space in which USAID operates. As such, they can be anticipated and planned for.

EMERGENCY EBOLA FUNDING WAS NOT APPROVED FOR MONTHS AFTER DISASTER DECLARATION

Congress passed the emergency funding for Ebola response efforts in December 2014—4 months after the disaster declarations and after the Liberia cases were on the decline (appendix C). To respond to the crisis before the availability of emergency funding from Congress, USAID obligated $401 million using existing appropriation accounts, which it later reimbursed.

USAID also took the following measures to expedite response activities:

- According to FFP officials, in August 2014, they used a competition waiver memorandum to provide flexibility in issuing awards, and in September 2014, FFP permitted the World Food Programme to immediately deploy Title II program in-kind food aid to all three countries.[24]
- Three interviewees noted that USAID used existing awards instead of issuing new awards to save time.

[24]U.S. in-kind food aid (Title II) is often used to respond to an emergency where local markets are not functioning, there isn't enough food in local markets to meet need, or beneficiaries do not have physical access to markets.

- GH's Security and Development Unit worked with the Office of Acquisition and Assistance to issue an award using its noncompetition waiver for rare events.[25]

Five interviewees pointed to the congressional notification process for releasing emergency funds, which releases funds in tranches, as constraining implementation of recovery activities. Some delays affected the start, pace, and synchronization of Ebola activities. For example, according to one interviewee, awards took 3 months longer than usual because funds were held up by Congress. The congressional delays, however, appear to be partially due to USAID submitting incorrect information for the funding. According to USAID staff, the expiration of some funds at the end of fiscal year 2016 affected planning and the sustainability of recovery programs. USAID staff stated that USAID had to quickly program activities and use existing funding mechanisms to expedite implementation. They said it was difficult planning and implementing recovery programs that only lasted 2 to 3 years. In Sierra Leone, implementers and USAID staff agreed that due to the short-term recovery funds, programming was not long enough for sustainable results, and some were concerned about leaving before country capacity was built to handle another outbreak. While these funding issues created certain barriers, poor transition planning and coordination with development actors also compromised sustainability.

USAID EFFORTS WERE AFFECTED BY WEAK INTERNATIONAL RESPONSE AND COORDINATION IN THE FIELD

USAID worked with the international community and host governments in responding to the Ebola outbreak. However, USAID reported that international coordination in the field was challenging because the United Nations did not activate the humanitarian cluster system.

According to USAID staff we interviewed, host-government decisions and priorities related to outbreak notifications, quarantine measures, and other response activities affected response and recovery activities, such as addressing food insecurity. Some host governments did not understand the constraints on the use of emergency funds, had different priorities for response and recovery activities, or lacked capacity and capability to respond effectively.

The lack of effective NGO partners further hindered USAID's response efforts. NGOs reportedly left the region due to concerns about Ebola and the ability to evacuate their staff in the event of infection. The remaining NGOs were not operating at full capacity, were overburdened, or did not have experience in responding to Ebola outbreaks. Further, the partners USAID relied on to implement response activities—which understood and had capabilities in either health emergencies or the humanitarian system, not both—exacerbated the difficulties in adapting to the rapidly changing circumstances in the field.

[25] The waiver was first approved in 2006 by the USAID Administrator for use in an emergency response to a known or potential pandemic threat.

GEOGRAPHY, CULTURE, AND VIRAL PERSISTENCE IN HOST COUNTRIES IMPEDED RESPONSE EFFORTS

Interviewees identified other complicating factors:

- **Geography.** Porous borders enabled Ebola to cross between the three affected countries, while limited road infrastructure and the rainy season limited transportation of people and supplies.
- **Culture.** Cultural traditions for caring for sick family members and burial practices caused Ebola to spread through family and community units. Mistrust of government also hindered response efforts.
- **Viral etiology.** Viral persistence and previously unknown transmission routes led to continued flareups after major outbreaks were under control. Uncertainties about how the Ebola virus would evolve and how survivors would be accepted in communities further frustrated response and recovery.

Despite these complexities, USAID's long history of working in environments with diverse governments, geographies, and cultural concerns provides valuable insight for identifying strategies to mitigate the impact of conditions over which USAID has little control—including those used on the front lines of the Ebola response. For example:

- OFDA recruited NGOs to set up in affected countries and assist with the Ebola response efforts.
- OFDA, in conjunction with partners, implemented border surveillance in West Africa.
- The Lab arranged with Coca Cola to use its supply routes during the rainy season.
- USAID reported that implementing partners helped develop culturally appropriate response activities.

The experience USAID and CDC have gained in assisting countries with implementing the International Health Regulations, health systems strengthening, and the Global Health Security Agenda has informed efforts that are underway to identify gaps and opportunities to improve the capacity of national governments to respond to disease outbreaks. The 2005 U.S. National Strategy for Pandemic Influenza emphasizes the need to increase response capacity in high-risk countries and states that "a critical element of pandemic planning is ensuring that people and entities not accustomed to responding to health crises understand the actions and priorities required to prepare for and respond to a pandemic." The plan also discusses the need for situational awareness internationally as well as domestically.

Finally, USAID has ongoing work related to identifying and understanding emerging infectious diseases so as to improve awareness of diseases that may cause outbreaks.

CONCLUSION

The capacity of host countries and the international community—as well as the transmission rate and characteristics of a disease—present significant challenges for responding rapidly and effectively to a public health outbreak. Coordinating the efforts of multiple U.S. Government and other international responders exacerbates these challenges. However, despite its experience with Ebola and other major disease outbreaks, USAID has not established an Agency-wide policy framework for response, recovery, and development that would mitigate challenges, reduce delays, and secure resources needed to mobilize an effective response. Lacking such policies and procedures, USAID is at risk of starting over with each new outbreak—which scientists generally agree is not a question of if but when the world confronts another public health emergency. Until the Agency develops and implements a comprehensive policy framework, it will continue to face challenges responding to health emergencies and risk lagging behind the epidemiological curve.

RECOMMENDATIONS

To ensure USAID is prepared to respond to a future Agency-wide effort and the appropriate support and resources are available, our recommendations are addressed to the Assistant to the Administrator for Policy, Planning and Learning.

We recommend that the Assistant to the Administrator for Policy, Planning and Learning direct the development of a policy framework to prepare for, manage, and coordinate the USAID response to an international public health emergency. In developing this framework, we recommend the following actions.

To help USAID coordinate responses to future emergencies, we recommend that the Assistant to the Administrator for Policy, Planning and Learning:

1. Direct the implementation of a communication and coordination strategy that would govern how the Agency will work with external actors (such as other U.S. Government agencies, the United Nations, international organizations, nongovernmental organizations) who can respond in the event of an international public health emergency. This communication and coordination strategy should also be sufficient in the event that the United Nations' humanitarian cluster approach system is delayed.

2. Work with other U.S. agencies to clearly identify, and regularly test, roles and capabilities, and responsibilities for use in a future international public health emergency. This should include policy related to the Office of U.S. Foreign Disaster Assistance's use of the Mission Tasking Matrix with the Department of Defense. And agreements should specify operational details; clearly define roles and responsibilities; and ensure a common understanding of standardized language.

3. Direct the creation and maintenance of an inventory, by country, of nongovernmental organizations and local actors who are involved in response, development, and other humanitarian activities; and determine which of these could potentially be called upon as implementing partners in an emergency.

4. Develop policies for rapid data and information sharing including with host governments, with the World Health Organization, and within the U.S. Government.

5. Direct the creation of procedures governing coordinating bodies (Secretariat, task force, etc.) including (1) criteria for when they are established, (2) how they are staffed, (3) their responsibilities and authorities in responding to an emerging crisis, (4) their expected level of interaction within USAID and with external stakeholders, (5) policies for how they clear documents for distribution and reporting, and (6) how they are disbanded, including the transfer of residual activities to relevant regional or functional bureaus at the conclusion of the crisis.

6. Direct the development of—and test procedures for—integrating response, recovery, and transition activities during a complex whole-of-Agency humanitarian or health emergency.

To help USAID assess health emergencies and identify expertise and resources, we recommend that the Assistant to the Administrator for Policy, Planning and Learning:

7. Direct the Office of U.S. Foreign Disaster Assistance, in collaboration with Global Health and health officers from other bureaus, to develop policies for identifying health response triggers, deploying a small team to assess a health situation in collaboration with mission staff, and provide an initial needs assessment before a disaster declaration is made.

8. Direct all regional and functional bureaus to identify and maintain a listing of key staff who would be involved in a whole-of-Agency emergency response, and provide those staff with abbreviated training on the Office of U.S. Foreign Disaster Assistance Disaster Assistance Response Team and Response Management Team to build a stronger cadre of cross-sectoral teams.

9. Direct the formation of a process for (1) identifying relevant technical experts across the Agency, (2) maintaining a catalog that includes how they can be reached in the event of another health crisis, and (3) temporarily reassigning them away from their existing duties.

10. Direct the establishment of guidelines outlining the steps missions and bureaus can take in the event of an emerging crisis, including how to reprogram existing funds (from central mechanisms and mission mechanisms) and transfer resources. This should be coordinated among the Office of Acquisition and Assistance, the Office of Budget and Resource Management, and the Chief Financial Officer.

11. Direct the Office of Acquisition and Assistance to determine what can be done to insert flexibility clauses into the missions' program awards, as appropriate, so that missions can respond to emerging crises using existing resources and nongovernmental organizations on the ground that are familiar with the country context, and implement a policy accordingly. This additional flexibility should be accompanied by sufficient controls to prevent abuse.

12. Direct the development of an Agency-wide content management system where decisions, documents, and lessons can be tracked and accessed by staff to improve the consistency of records management.

13. Direct the development of an Agency-wide system that tracks program awards and relevant contractors and partners implementing those awards to bring all systems together, reduce duplication, and increase collaboration and oversight.

To help USAID learn from its experiences and improve its operations, we recommend that the Assistant to the Administrator for Policy, Planning and Learning:

14. Direct the creation or appointment of a unit, and development of a policy that requires operating units involved in an emergency response or recovery to (1) collectively identify lessons learned, (2) develop after-action reports, (3) create a timeline for corrective actions to take place, and (4) follow up on those planned actions to ensure they occur, including updating the policy framework, if necessary.

OIG RESPONSE TO AGENCY COMMENTS

We provided our draft report to USAID on October 31, 2017, and on December 28, 2017, received its response, which is included as appendix D.

The report included 14 recommendations. We acknowledge management decisions on all the recommendations. We consider seven resolved but open pending completion of planned activities (recommendations 2, 5, 9, 11, 12, 13, and 14), and seven unresolved (recommendations 1, 3, 4, 6, 7, 8, and 10) for the reasons stated below.

For recommendation 1, we do not agree that providing input to guidance being developed by the NSC on how to respond to a public health emergency is a substitute for implementing a communication and coordination strategy by USAID. To resolve this recommendation, USAID should provide documentation that outlines how USAID will work with external actors and what steps USAID plans to take in the event a Public Health Emergency of International Concern results in a humanitarian emergency; giving sufficient consideration to the possibility that the U.N. humanitarian cluster system is delayed. While this may consist in part or in whole of the input that USAID provided to the NSC, it should reflect USAID's communication strategy.

For recommendation 3, while the Agency's participation in the mandatory annual Operational Plan process supports the maintenance of an inventory of NGOs and local actors involved in response, development, and other humanitarian activities, this process was found insufficient in the Ebola response. USAID needs to describe how it will enhance the capabilities of the Operational Plan process—specifically, how the Agency plans to use the process to determine which of the NGOs and local actors could potentially be called upon as implementing partners in an emergency. This should include documenting and maintaining an up-to-date inventory of organizations and local actors that is readily available to USAID staff and implementers.

For recommendations 4 and 6, we do not believe the Agency's management decisions fully address the recommendations. Although the Agency has supported improving digital health systems and developing the Humanitarian Data-Exchange to enable the transparent collection, interoperability, and sharing of data, this does not address the recommendation for the *rapid* sharing of data and information *within the U.S. Government and with external actors*. To resolve recommendation 4, USAID needs to develop a policy that describes how the Agency intends to compile and rapidly share data and information with other U.S. Government agencies and with external actors during humanitarian crises. To resolve recommendation 6, USAID needs to develop and document a plan that addresses the integration and the transition from response to recovery and development, and how the Agency plans to test these transition procedures.

For recommendation 7, we do not agree with the steps taken to address the recommendation because they identify measures USAID would take after a disaster is declared or after a situation has met Emergency Reserve Fund criteria. The intent of this recommendation is to identify triggers and assessments the Agency can take *before* that point. To resolve recommendation 7, the Agency should first outline how it has directed OFDA to collaborate with GH and health officers from other bureaus to develop the policies outlined in the recommendation. If OFDA should not be involved, the Agency should provide an explanation for its alternative approach. Second, the Agency should develop and provide documentation of the triggers that would prompt more significant response by USAID and the rest of the U.S. Government. Third, it is unclear if the Agency would deploy its own team in collaboration with mission staff or conduct its own initial needs assessment before a disaster declaration is made. The Agency should provide policy documentation that describes when GH would assist WHO and FAO with the rapid deployment of assessment teams during the initial stages of an international public health event or public health emergency, and when the Agency would deploy its own resources to conduct an initial needs assessment. Furthermore, the Agency should explain how assessments conducted by WHO and FAO first responders would factor into the scale of response by USAID in lieu of its own team and initial needs assessment.

For recommendation 8, we agree with the Agency's approach to broaden the number of available surge personnel in OFDA. However, the Agency has not proposed a plan to identify and maintain a listing of key staff in *all* regional and functional bureaus who could

be involved in a whole-of-Agency emergency response—whether serving on a task force or in a supporting bureau. Additionally, the Agency has not specified how these individuals would receive abbreviated training on the OFDA DART and RMT.

For recommendation 10, the Agency has not proposed a plan to establish guidelines or a checklist for mission and bureaus to use in the event of an emerging crisis. The Agency provided the Department of State/Office of Foreign Assistance Reprogramming Guidance, May 1, 2011, but this outlines just one action missions and bureaus can take. The Agency should establish other steps in the event of an emerging crisis aside from reprogramming existing funds and transferring resources.

APPENDIX A. SCOPE AND METHODOLOGY

We conducted our work from May 2016 through October 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.

The audit objectives were to identify how USAID's experience managing and coordinating the Ebola response prepared it for future international public health emergencies, assess its processes for managing and coordinating responses, and identify factors that may influence its ability to respond.

Our audit scope primarily includes Agency efforts from March 2014, when WHO publicly announced an Ebola outbreak, through February 2017. We also included relevant international health emergency preparedness activities the Agency engaged in prior to the 2014 outbreak.

To answer the first audit objective, we reviewed 101 documents that addressed strengths and weaknesses associated with the U.S. Government and USAID response to the Ebola outbreak and categorized them. These documents included:

- Periodic program reviews from USAID operating units including OFDA, GHET, AEU, U.S. Global Development Lab, FFP, Bureau for Food Security, and the Center for Accelerating Innovation and Impact.
- Congressional Research Service reports
- A USAID OIG Hotline complaint
- Congressional testimony
- Submissions from U.S. departments and agencies for quarterly Lead Inspector General reports to Congress for Operation United Assistance, the Ebola Overseas Contingency Operation
- Pertinent audit reports and newsletters from the Offices of Inspector General at the Department of Defense, Department of Homeland Security, and USAID
- Notes from interagency and international partner meetings related to issues identified during the Ebola response
- Press releases and fact sheets from CDC and the White House
- News articles and editorials
- Articles from scholarly, peer-reviewed journals

- A briefing paper prepared for senior USAID officials
- After-action reviews from USAID operating units and other U.S. agencies

At the time of our audit fieldwork, USAID OIG had several completed and in-progress audits related to the Ebola response. We reviewed 52 relevant interviews from these audits and categorized strengths and weaknesses identified within them. The interviews were with USAID and U.S. Government staff, implementing partners, and host-government officials. The collective analysis of background documents and relevant interviews were used to inform our approach to answering the second and third audit objectives.

To answer these objectives, the team conducted interviews to confirm our analysis and determine if processes were put in place to address the weaknesses and ensure strengths would be repeated in future emergency responses. We conducted 174 interviews, including current and former staff from USAID operating units involved in the Ebola response, recovery, and subsequent development activities in Washington, DC, and in Liberia, Sierra Leone, and Guinea.[26] We conducted interviews in Liberia and Guinea in June 2016, and Sierra Leone in August 2016 with USAID and U.S. staff and host-country officials. We also interviewed staff from U.N. organizations, NGOs, implementing partners, and academic institutions. We reviewed documents submitted by USAID operating units, and Ebola guidance such as WHO's roadmap and checklist. Our conclusions were developed based on information presented during interviews and analysis of available documentation.

Because of the size of the Ebola response, we were unable to interview all staff involved. We selected interviewees judgmentally based on their level of involvement in the response and recovery and included staff from all offices materially involved. Furthermore, we limited interviews of OFDA staff because the office completed an after-action review that surveyed those involved in the Ebola response.

We considered relevant Agency criteria including guidance, policies, plans, strategies, frameworks, and monitoring and evaluation tools. We analyzed 22 documents for best practices in infectious disease response frameworks from WHO and the United States and identified GAO reports with best practices in coordinating interagency efforts and responding to health emergencies.

The audit team met with auditors and evaluators from GAO and with the Inspectors General from DOD and the Department of Health and Human Services to identify any additional information that may exist about the USAID response.

[26] During the interviews we interviewed 94 current and former USAID staff at various levels within the Agency and 80 individuals from external organizations.

APPENDIX B. STAFFING ISSUES AND SUGGESTIONS

Staffing issues came up in 71 (76 percent) of the 94 interviews we conducted with USAID or former USAID staff. Table 4 lists the issues interviewees raised related to staffing the Ebola response and recovery; table 5 lists suggested improvements.

Table 4. Staffing Issues Raised by Interviewees

Staffing Issue	Times Raised
Capacity	
Headquarters and missions understaffed; staff overworked	39
Vacancies unfilled for extended periods	14
Supervisors' and bureaus' refusal to release staff for details	10
Frequent staff turnover due to rotations, temporary assignments, other hiring mechanisms	12
Staff skills not available or well matched to positions	14
Lack of understanding between development and response actors	7
Not enough dedicated staff for the amount of resources programmed	3
Lack of Ebola training prior to going to affected countries[a]	3
Lack of language training for contractors	1
Recruitment and Hiring	
Lengthy and complex recruitment and hiring processes	19
Difficulty recruiting skilled staff to work in West Africa	5
Lengthy security clearance process[b]	5
Congressional limits on Foreign Service Officers and direct hires	2
Fear and inflated media coverage's impact on recruitment	6
French language requirement (Guinea)	3
OAA understaffed, delaying solicitations and adjustments to portfolios	2
Temporary Duty Assignment (TDY)	
Mission reliance on TDY support to fill gaps	5
Inefficient and ineffective TDY practices	3
Failure to consult missions before assigning TDYs or to provide clear rationale for TDYs	3
Time lost explaining general USAID processes to contractors	4
Agency expertise not effectively leveraged during the crisis	4
Process/Guidance/Mechanism	
Inconsistent processes for assigning detailees	2
Unclear and poorly implemented onboarding processes	2
Lack of flexibility, clarity in guidance on use of Operating Expense (OE) funds and positions	2
Lack of a centralized hiring process	1
Lack of guidance on expedited hiring	1

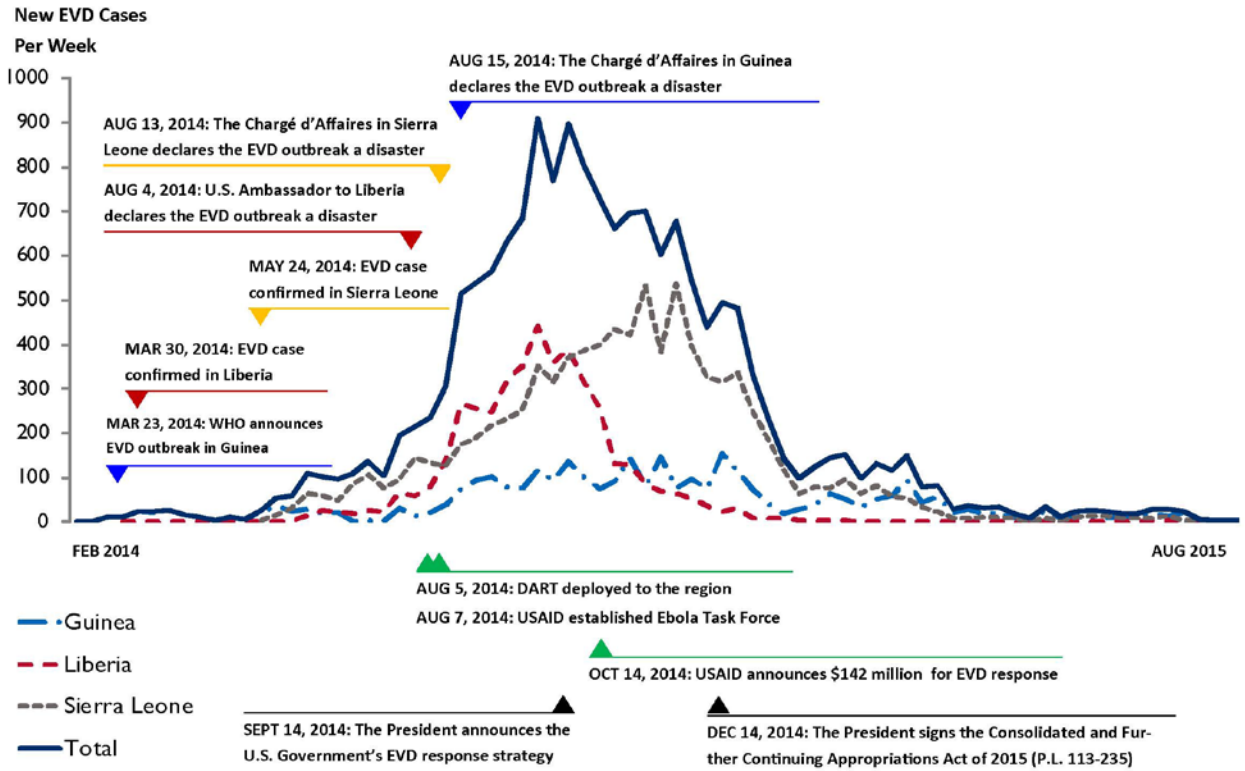
[a] Two interviewees mentioned U.S. Embassy training after arriving in-country.
[b] Two interviewees had contacts within the Office of Security and were able to get expedited clearances in just 5 days. And a Department of State unit set up to expedite security clearances was viewed as a success.

Table 5. Suggestions for Improvements Made by Interviewees

Suggestion for Improvement	Times Raised
Staffing Health Emergencies	
Provide incentives for getting USAID staff to the field and involved in emergency response[a]	7
Institute directed assignments	5
Train GH, mission, and development staff in emergency and OFDA's command and control system to develop a cadre of cross-trained staff	2
Develop hiring mechanisms other than short-term TDY to provide sustained support	3
Maintain knowledge of available Agency staff and capabilities, and develop a mechanism to mobilize Agency staff, mirroring OFDA's surge roster	2
Provide more flexibility to mobilize available staff	3
Provide a clear scope of work for TDY support	2
Leverage the civilian response corps	2
Fund the floating[b] of staff	2
Assign staff to emergencies full-time rather than as a collateral assignment	2
Hire a cross-sector and broader coalition of expertise, such as social scientists, anthropologists, behavioral economists, and psychologists	2
Centrally fund internal staff with the right skill sets rather than relying on implementing partners	2
Enforce the Automated Directives System requirement to pay detailed staff at their level of performance if they are detailed for an extended period	1
Extend details to longer than 3 months	1
Develop checklists and systems for staffing during an emergency	1
Do not use short-term TDY support for development programming	1
Provide early training	1
Recruitment for Emergencies	
Only use human resource staff with USAID experience	1
Start recruitment efforts earlier	1
Use networking and social media, not just USAJobs, to identify viable candidates	1
Develop a mechanism to access contractors on retainer	1
Use the short-term appointment roster to bring back retired USAID employees	1
Build in OE funds for the longer term	1
Detail staff from the Department of State Client Assistance Program to expedite hiring	1
Develop a worldwide process to solicit staff and volunteers for emergencies	1
Use short-term contracts to hire retired Foreign Service Officers	1
Balance hiring innovative staff with staff who understand bureaucratic processes	1

[a] For example, one interviewee explained that the United Nations provides Guinea staff rest and recuperation every 6 weeks, where USAID approves three times in 2 years.
[b] A float position rotates or is reassigned to fill positions that are vacant.

APPENDIX C. TIMELINE OF KEY EVENTS



Source: USAID OIG analysis of WHO data on Ebola cases and of CDC, USAID, and WHO information on key events.

APPENDIX D. AGENCY COMMENTS

December 28, 2017

MEMORANDUM

TO: Assistant Inspector General for Audit, Thomas E. Yatsco

FROM: Assistant to the Administrator for Policy, Planning and Learning, Wade Warren /s/

SUBJECT: USAID's Response to the Draft Audit Report Entitled, "Lessons From USAID's Ebola Response Highlight the Need for a Public Health Emergency Policy Framework" (9-000-18-001-P)

Thank you for the opportunity to respond to the draft report produced by the Office of Inspector General (OIG) entitled, "Lessons from USAID's Ebola Response Highlight the Need for a Public Health Emergency Policy Framework" (Report No. 9-000-18-001-P), dated October 31, 2017.

The International Health Regulations (2005) (IHRs) define a Public Health Emergency of International Concern (PHEIC) as "an extraordinary event which is determined…. to constitute a public health risk to other States through the international spread of disease; and to potentially require a coordinated international response." The Director-General of the World Health Organization (WHO) has declared only four PHEICs since the IHRs entered into force on June 15, 2007: H1N1 Influenza, in 2009; Poliomyelitis, in 2014; Ebola, in 2014; and Zika Virus, in 2016. Of these, only the Ebola outbreak resulted in a humanitarian emergency.

USAID agrees with the underlying premise of the OIG's audit that the Agency should have managed its participation in the response by the U.S. Government (USG) and the international community to the Ebola PHEIC more effectively. USAID also recognizes that the Ebola crisis demonstrates that the United States must be prepared to respond more quickly to outbreaks of infectious disease that could pose a danger to the whole world, in some cases even before an official declaration of a PHEIC by the WHO. The Agency has learned an extraordinary amount as a result of the unprecedented, multi-sectoral battle to contain Ebola, and is committed to strengthening the aspects of coordination and organization highlighted by the OIG, particularly our policies, structures and systems for preparing for, responding to, and learning from public health crises around the globe, including PHEICs.

USAID must point out, however, that many challenges the OIG identified depend on international actions beyond the control of the Agency. Responding to a PHEIC is not the purview of USAID or the USG alone, but is a shared global responsibility.

The following are USAID's responses to the OIG's recommendations:

Recommendation 1: Direct the implementation of a communication and coordination strategy that would govern how the Agency will work with external actors (such as other USG Agencies, the United Nations [UN], international organizations, non-governmental organizations [NGOs]) who can respond in the event of an international public health emergency. This communication and coordination strategy should also be sufficient in the event that the UN humanitarian cluster approach system is delayed.

USAID Response: USAID concurs with Recommendation 1, and the Agency has taken the following steps to address the issue.

A communication and coordination strategy for working with external actors is critical to how USAID and the rest of the USG will respond to an international public health crisis, so as to optimize the allocation of human and financial resources as the United States reacts. Following after-action reviews of the Ebola response, USAID provided critical input to the National Security Council to help develop a playbook for decision-making and leadership when a PHEIC results in a humanitarian emergency. This includes engagement with the international community to advocate for the appropriate use of international coordination systems, including the UN cluster system for humanitarian emergencies.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureaus/Offices: Bureau for Global Health (Lead); Bureau for Democracy, Conflict, and Humanitarian Assistance (DCHA)/Office of Foreign Disaster Assistance (OFDA).

Recommendation 2: Work with other U.S. Agencies to clearly identify, and regularly test, roles and capabilities, and responsibilities for use in a future international public health emergency. This should include policy related to OFDA's use of the Mission-Tasking Matrix with the U.S. Department of Defense (DoD). And agreements should specify operational details, clearly define roles and responsibilities, and ensure a common understanding of standardized language.

USAID Response: USAID concurs with Recommendation 2, and has taken the following steps to address this issue.

As a result of after-action reviews of the Ebola response, USAID launched the Infectious-Disease Pandemic Initiative (IDAP), which enhances readiness for USAID and its partners, including the USG interagency, to respond to outbreaks that become humanitarian emergencies. Led by DCHA/OFDA in coordination with the Global Health

Bureau, the IDAP engages with other Departments and Agencies to define roles and responsibilities and standardize language and operational details in advance of public health emergencies, through a series of trainings and exercises. The IDAP is working closely with the Office of Infectious Diseases in the Global Health Bureau at USAID to develop an operational framework for responses to infectious-disease outbreaks that become humanitarian emergencies, which will be a part of a larger international framework. The IDAP has assisted in the development of the NSC playbook, which is a decision-making rubric that outlines interagency roles and responsibilities when responding to emerging infectious-disease threats. See Tab 1a: IDAP Fact Sheet.

USAID has clarified with our staff the purpose and use of the Mission-Tasking Matrix in appealing for assistance from DoD in the field during an international humanitarian response.

Administrator Mark Green recently met with the new Director of the Centers for Disease Control and Prevention (CDC) within the U.S. Department of Health and Human Services (HHS), and they discussed the need to refine the existing arrangements for collaboration between the two institutions, including before and during the declaration of a PHEIC. Senior leaders at USAID and HHS/CDC will review the existing agreements between the two Agencies to specify operational details, clearly define roles and responsibilities, and ensure a common understanding of standardized language, where necessary.

Target Closure Date: June 30, 2018
Responsible USAID Bureaus/Offices: DCHA/OFDA (Lead), Bureau for Global Health.

Recommendation 3: Direct the creation and maintenance of an inventory, by country, of non-governmental organizations and local actors who are involved in response, development, and other humanitarian activities; and determine which of these could potentially be called upon as implementing partners in an emergency.

USAID Response: USAID concurs with Recommendation 3, and has taken the following steps to address this issue.

Since Fiscal Year (FY) 2007, USAID has participated in the mandatory annual Operational Plan (OP) process managed by the Office of Foreign Assistance Resources (F) within the U.S. Department of State. The review and approval of OPs captures in a database each implementing partner USAID and the Department of State propose to engage to implement the annual appropriation, and specifies the sector and countries for which the organizations will receive goods and/or services, and in what amount. USAID effectively used this database in its response to Ebola to identify NGOs and local actors that could assist in the affected countries. See Tab 1b: FY 2017 State Department/F OP Guidance.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureau/Office: Bureau for Global Health.

Recommendation 4: Develop policies for rapid data- and information-sharing, including with host governments, with the WHO, and within the USG.

USAID Response: USAID concurs with Recommendation 4 to the extent that it is within the manageable interest and control of the Agency.

In response to the OIG's recommendation to integrate data systems, since 2016 USAID has supported the UN Office for the Coordination of Humanitarian Assistance (UNOCHA) and other partners in the development and expansion of the Humanitarian Data-Exchange (HDX). This platform enables the transparent discovery, collection, coordination and sharing of data in humanitarian crises.

USAID has also invested in a number of activities to improve digital health systems at both the country and global level. Among these are harmonizing data standards and interoperability guidelines, and enabling data systems to "speak to" one another, including by helping countries establish Health-Information Exchanges, coordinate investments in digital health programs to avoid duplication and fragmentation, and support national strategies for establishing systems that can quickly share health information. In addition, USAID supports the adoption of the WHO's data-sharing policies under the IHRs.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureaus/Offices: DCHA/OFDA(Lead), Bureau for Global Health, Global Development Lab.

Recommendation 5: Direct the creation of procedures governing coordinating bodies (Secretariat, Task Force, etc.) including (1) criteria for when they are established; (2) how they are staffed; (3) their responsibilities and authorities in responding to an emerging crisis; (4) their expected level of interaction within USAID and with external stakeholders; (5) policies for how they clear documents for distribution and reporting; and, (6) how they are disbanded, including the transfer of residual activities to relevant regional or functional bureaus at the conclusion of the crisis.

Recommendation 6: Direct the development of—and test procedures for—integrating response, recovery, and transition activities during a complex whole-of-Agency humanitarian or health emergency.

Recommendation 14: Direct the creation or appointment of a unit, and development of a policy that requires operating units involved in an emergency response or recovery to (1) collectively identify lessons learned; (2) develop after-action reports; (3) create a timeline for corrective actions to take place; and, (4) follow up on those planned actions to ensure they occur, including updating the policy framework, if necessary.

USAID Response: USAID concurs with Recommendations 5, 6 and 14, which the Agency views as inextricably linked, and has begun taking steps to organize our structures and procedures to address them holistically together. Recommendation 5, 6, and 14 cover the life-cycle of a Task Force, starting with the criteria for its establishment, standard structures, templates, reporting, staffing, composition of the team(s), and close-out. Recommendation 6 addresses the transition from one phase of activity to the next (i.e., response to recovery/development). Recommendation 14 captures the final stages of a Task Force's life-cycle: cataloguing and disseminating results, lessons learned and after-action reports. We have concluded we can resolve these three recommendations under the same set of actions, and the Agency recommends the consolidation of the three into a single recommendation in the OIG's final report.

USAID's own initial findings showed a lack of consistency with respect to the creation, functions and closure of Task Forces. As a result, in early 2017 the Agency Counselor formed a working group that examined how USAID Task Forces have functioned in the past, identified lessons for them going forward, and developed a blueprint for policies and standard operating procedures (SOPs) for Task Forces. This draft blueprint provides a useful outline to guide a more-robust effort that the Bureau for Policy, Planning and Learning (PPL), with support from the Management Bureau, will lead over the next six months to finalize SOPs for the six areas identified under Recommendation 5, as well as to develop the policies called for in Recommendations 6 and 14.

Senior Agency leadership has determined USAID's current organizational structure does not have a unit with the appropriate mandate or personnel to carry out the functions identified in Recommendations 5, 6 and 14. The Agency's Transformation Task Team (T3), which manages the Redesign process, will take immediate responsibility to determine where to house this new entity, and develop a concrete idea to include with the rest of the proposed organizational changes that will accompany the President's FY 2019 Budget request.

Target Closure Date: December 31, 2018
Responsible USAID Bureaus/Offices: PPL, Bureau for Management, and T3.

Recommendation 7: Direct the Office of U.S. Foreign Disaster Assistance, in collaboration with the Bureau for Global Health and health officers from other Bureaus, to develop policies for identifying health response triggers, deploying a small team to assess a health situation in collaboration with mission staff, and provide an initial needs assessment before a disaster declaration is made.

USAID Response: USAID concurs with Recommendation 7, and has taken the following steps to address the issue.

According to the IHRs, the WHO Secretariat has specific responsibilities for undertaking early detection and risk-assessments for global public health events or emergencies, and as the UN Inter-Agency Standing Committee Global Health Cluster Lead Agency. The

WHO's Emergency Response Framework (2017), developed as a result of lessons learned from the Ebola response, clearly articulates health-response triggers, a grading process, and coordination steps for the international community.

The Bureau for Global Health has pre-positioned resources with the WHO and the UN Food and Agriculture Organization (FAO) to help enable the rapid deployment of assessment teams during the initial stages of an international public health event or public health emergency. WHO and FAO first responders will assess a situation and determine whether an event constitutes the early stage of a public health emergency, which could merit a more significant response by USAID and the rest of the USG.

Furthermore, Section 7058(c)(1) of the Department of State, Foreign Operations, and Related Programs Appropriations Act, 2017 (Div. J, P.L. 115-31) (SFOAA), established an Emergency Reserve Fund (ERF) of $70 million to address emerging health threats, especially outbreaks of contagious infectious diseases. Pursuant to the legislation, USAID may petition the Secretary of State to make funds from the ERF available when the following conditions are met: (1) the outbreak is an emerging health threat; (2) the outbreak poses severe threats to human health; and, (3) it is in the national interest to respond. USAID believes the ERF provides the resources and policy framework to answer the points in Recommendation 7, especially when action is needed before the WHO Director-General declares a PHEIC, and in situations in which he or she will not do so. In October 2017, Administrator Green wrote to Secretary Tillerson to request the release of $5 million from the ERF to assist in containing the outbreak of pneumonic plague in Madagascar, which the Secretary granted shortly thereafter. The Agency disbursed the funding after the appropriate Congressional notification.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureau/Office: Bureau for Global Health.

Recommendation 8: **Direct all regional and functional Bureaus to identify and maintain a listing of key staff who would be involved in a whole-of-Agency emergency response, and provide those staff with abbreviated training on the DCHA/OFDA Disaster-Assistance Response Team and Response-Management Team to build a stronger cadre of cross-sectoral teams.**

USAID Response: USAID concurs with Recommendation 8, and has taken the following steps to address this issue.

As a result of after-action reviews of the Ebola response, USAID identified the need to create and maintain a cadre of technical staff from across the Agency who could be activated in the case of a whole-of-Agency emergency response. In July 2017, DCHA/OFDA launched the On-Ramp Program, which prepares qualified USAID staff to become a part of DCHA/OFDA's emergency staffing pool to broaden the number of available surge personnel. Agency staff apply for the program and receive the appropriate training upon supervisory approval. Seventeen staff from nine Bureaus have

submitted materials to initiate participation in the program to date. See Tab 1c: DCHA/OFDA On-Ramp Program Briefer.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureau/Office*:* DCHA/OFDA.

Recommendation 9: Direct the formation of a process for (1) identifying relevant technical experts across the Agency, (2) maintaining a catalog that includes how they can be reached in the event of another health crisis, and (3) temporarily re-assigning them away from their existing duties.

USAID Response**:** USAID concurs with Recommendation 9.

The Office of Human Capital and Talent Management (HCTM) has determined that a workforce-planning system developed under the Agency's Human-Resource Transformation can fulfill the function of maintaining a standing roster of technical experts from which to draw in an international health crisis. The Bureau for Global Health will work with HCTM to select the fields for this system to track, by examining other similar systems (including one created by HHS/CDC), and HCTM will administer a mandatory survey of personnel in all hiring categories across the Agency to populate the roster. This structure will enable the Agency to pull trained, technically sound experts with skills useful in the area of health emergencies, regardless of hiring mechanism, to work on Task Forces in Washington or in the field on a surge basis.

Target Closure Date: June 30, 2018.
Responsible USAID Bureaus/Offices: HCTM (Lead), Bureau for Global Health.

Recommendation 10: Direct the establishment of guidelines outlining the steps Missions and Bureaus can take in the event of an emerging crisis, including how to reprogram existing funds (from central mechanisms and Mission mechanisms) and transfer resources. This should be coordinated among the Office of Acquisition and Assistance, the Office of Budget and Resource Management, and the Chief Financial Officer.

USAID Response: USAID concurs with Recommendation 10.

Since FY 2007, State/F has had authority for the Department of State-USAID budget process. Since the creation of the USAID Office of Budget and Resource Management (BRM) in 2009, the Agency has significantly expanded its budget-management capacity, including oversight and support for reprogramming funds. Formal authorities for approving reprogramming requests still reside with State/F, which issued programming guidance on May 1, 2011; the Agency used this guidance during the Ebola response in 2014. Reprogramming funds for Ebola still required approval from USAID Bureaus and Offices, State/F, the Office of Management and Budget (OMB), and Congress. See Tab

1d: Department of State/Office of Foreign Assistance Reprogramming Guidance, May 1, 2011.

USAID believes that additional flexibilities for reprogramming in a PHEIC are necessary, but lacks the ability to create them. We note that the provisions of Section 7058(c)(1) of the ERF created by the SFOAA that allow for the Secretary of State to waive normal requirements for Congressional notification could serve as a model for delegations of authority to allow the Administrator to move more quickly to reallocate already-appropriated resources in a crisis. The Joint Redesign process with the Department of State reached no conclusion on the issue of authority for reallocation, but the Administrator intends to continue to raise the issue with the Secretary of State over the course of 2018.

Target Closure Date: USAID recommends closure of this recommendation upon issuance of the final audit report.
Responsible USAID Bureau/Office: BRM.

Recommendation 11: Direct the Office of Acquisition and Assistance in the Bureau for Management to determine what can be done to insert flexibility clauses into Missions' program awards, as appropriate, so that Missions can respond to emerging crises by using existing resources and nongovernmental organizations on the ground that are familiar with the country context and implement a policy accordingly. This additional flexibility should be accompanied by sufficient controls to prevent abuse.

USAID Response: USAID believes we can implement the intent of Recommendation 11 in a different way than OIG has identified in the draft report.

To respond to an emerging crisis, the scope of a contract, grant or cooperative agreement must be written broadly enough to cover the situation; a standard clause would not necessarily be sufficient to allow a contractor or grantee to pivot to the new/emerging crisis. For example, a contract whose scope is to reduce the incidence of malaria would not be sufficiently broad to cover an emerging crisis, but a scope to remedy adverse health concerns, specifically malaria and other emerging diseases, would allow the contractor to pivot to address an outbreak of a previously unknown disease, if needed. The Agency will reap the greatest flexibility if each Program Office, after consideration of the country context, drafts a broader scope for grants, cooperative agreements and grants to respond to a potential PHEIC in the region.

The Administrator has already issued instructions for Bureaus and Missions to "[build] flexibility and rigorous competition into new activity designs and existing awards" under Agency Executive Message-General Notice 08129 - "Programming and Obligations Planning Considerations," and guidance document "Programming and Obligations Planning Considerations." See Tabs 1e and 1f. Nevertheless, he will issue a supplementary guidance document to instruct Bureaus and Missions to draft their health-related awards to account for the possibility of shifting resources quickly to deal with an

acute public health crisis. USAID will also institutionalize the Expedited Procedures Package upon which the Agency relied to authorize certain acquisition and assistance actions to redirect energies to deal with Ebola so the procedures are already available for future PHEICs and other health emergencies.

The Agency notes that OMB must review and approve any standard clauses for contracts, grants and cooperative agreements proposed by Departments and Agencies. OMB has generally declined to accept contingency contract clauses on the grounds that they circumvent the *Bona Fide* Needs Rule[1], and are unnecessary given the justification and approval process that allows an Agency to change the scope of an award with proper Agency approvals. Nevertheless, USAID will explore with OMB the creation of a "flexibility clause" for global health awards, narrowly tailored to public health crises in certain regions of particular concern.

Target Closure Date: December 31, 2018.
Responsible USAID Bureau/Office: Bureau for Management.

Recommendation 12: Direct the development of an Agency-wide content-management system where decisions, documents, and lessons can be tracked and accessed by staff to improve the consistency of records management.

***USAID Response*:** USAID agrees in part with Recommendation 12.

The Office of the Chief Information Officer (M/CIO) coordinates closely with the Information and Records Division (M/MS/IRD) within the Bureau for Management to ensure the Agency's information systems make adequate provisions for the requirements of electronic records standards, and that the design and development of information systems fully address records-management responsibilities.

USAID follows standard records-management processes, such as the submission of annual Records Inventory and Disposition Plans (also known as the File Plans) on Form AID 502-4, which lists the active records in an office, and describes their organization and maintenance.
A good File Plan is one of the essential components of a record-keeping system, and the key to a successful records-management program. The purpose of a File Plan is to document office activities effectively, identify records consistently, retrieve records quickly, identify the disposition of records, and meet related statutory and regulatory requirements. Submitting the File Plan provides accountability for the official records of the Agency, both paper and electronic, as required by the National Archives and Records Administration.

The Bureau for Management understands and recognizes that a 21st-century electronic operating environment creates many challenges to managing records efficiently,

[1] The *Bona Fide* Needs Rule as established by the Comptroller of the Treasury states, "A Fiscal Year appropriation may be obligated only to meet a legitimate, or *bona fide*, need arising in, or in some cases arising prior to but continuing to exist in, the Fiscal Year for which the appropriation was made."

including documenting and retrieving records to support decision-making, preserving institutional knowledge, reporting to Congress and making information available to the public under the Freedom of Information Act.

Nevertheless, USAID does not believe that the development of a new Agency-wide Content-Management System (CMS) is a viable solution to addressing the issues of inconsistencies in records-management that stem from the complexities inherent in fulfilling the Agency's world-wide mission in a digital age. The Agency already has various approved CMS platforms (e.g., Google Drive, Huddle, Documentum) to meet our objectives. Nevertheless, we recognize that the adoption of these tools is uneven.

Therefore, the Bureau for Management (specifically, M/MS/IRD and M/CIO) will undertake the following to address Recommendation 12:

1. Provide mandatory, on-line records-management training for each employee, regardless of labor category, to inform all employees of their responsibilities in law and in policy;
2. Continue to deliver instructor-led records-management training worldwide to teach the applicability of law and policy;
3. Issue reminder notices, conduct annual reviews and assessments, and continue to provide technical assistance for Bureaus, Independent Offices, and the Bureau for Management to ascertain and encourage compliance with current policies, which are essential to sound records-management; and
4. Expand training for staff in Washington and the field in the use of our existing CMS tools.

Target Closure Date: December 31, 2018.
Responsible USAID Bureau/Office: Bureau for Management.

Recommendation 13: Direct the development of an Agency-wide system that tracks program awards and relevant contractors and partners implementing those awards to bring all systems together, reduce duplication, and increase collaboration and oversight.

USAID Response: USAID concurs with Recommendation 13, and has taken the following steps to address this issue.

In addition to the already existing Global Acquisition and Assistance System (GLAAS) and Phoenix accounting systems, which track awards, USAID is creating the Development Information System (DIS) to deliver an Agency-wide portfolio-management system to every Mission, Bureau and Independent Office. Built with substantial input from stakeholders in both Washington and overseas, DIS integrates data from various systems throughout the Agency. Once fully deployed, DIS will enable USAID staff to have a comprehensive view of all of their investments and expenditures. DIS is designed to align with operational processes and procedures, which will help transform USAID into a more-agile organization better able to capitalize on development

opportunities. DIS will meet the Agency's demand for streamlined operational and data-management support at all stages of the Program Cycle, and ensure only one data-entry point, which will reduce the time spent by USAID staff on managing information. See tabs 1g and 1h: DIS and GLAAS Information Sheets.

Target Closure Date: December 31, 2018.
Responsible USAID Bureau/Office: Bureau for Management

Attachments:

Tab 1a – Infectious Disease and Pandemic (IDAP) Initiative Fact Sheet
Tab 1b – FY 2017 State Department/F Operational Plan Guidance
Tab 1c – Office of Foreign Disaster Assistance On-Ramp Program Briefer
Tab 1d – State Department/F Reprogramming Guidance
Tab 1e – USAID Agency Notice: Program and Obligation Planning Considerations
Tab 1f – USAID Agency Guidance on Program and Obligation Planning
Tab 1g – DIS Information Sheet
Tab 1h – GLAAS Information Sheet

APPENDIX E. MAJOR CONTRIBUTORS TO THIS REPORT

The following people were major contributors to this report: Van Nguyen, director; William Murphy, previous director; Ryan McGonagle, assistant director; Brianna Dallos, lead auditor; James Amoroso, auditor; Steven Kaffen, auditor; Steven Ramonas, auditor; Deanna Scott, auditor; Calvin Siow, analyst and subject matter expert; Karen Sloan, communications officer; and Donald Thompson, M.D., subject matter expert.