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

COVID-19: Audit of USAID's Vaccine Readiness Efforts

Audit Report 4-936-24-001-U
April 3, 2024

Office of Audits, Inspections, and Evaluations

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

MEMORANDUM

DATE: April 3, 2024

TO: Bureau for Global Health, Assistant Administrator, Dr. Atul Gawande

FROM: Africa Regional Office, Audit Director, Rob Mason /s/

SUBJECT: COVID-19: Audit of USAID's Vaccine Readiness Efforts (4-936-24-001-U)

Enclosed is the final audit report on USAID's COVID 19 vaccine readiness efforts using American Rescue Plan Act of 2021 (ARPA) funding for activities notified by Congressional Notification (CN) #18. The Office of Inspector General (OIG) contracted with the independent certified public accounting firm of Williams, Adley & Company-DC LLP (Williams Adley) to conduct a performance audit. The contract required the audit firm to perform the audit in accordance with generally accepted government auditing standards.

In carrying out its oversight responsibilities, OIG reviewed the audit firm's report and related audit documentation and discussed the findings with the firm's representatives. The audit firm is responsible for the enclosed report and conclusions. That said, we found no instances in which Williams Adley failed to comply, in all material respects, with applicable standards.

The audit objectives were to (1) describe major global technical assistance activities initiated with ARPA funding as notified by CN #18; (2) describe major activities by country initiated with APRA funding as notified by CN #18; and (3) determine to what extent USAID is monitoring implementer performance of the activities in accordance with the agency's standard policies and procedures.

To answer the audit objectives, the audit firm assessed USAID guidance and directives; performed walkthroughs with the Bureau for Global Health and selected mission personnel; and spoke with select USAID-funded organizations (commonly referred to by USAID as implementers), program beneficiaries, host government officials, and other stakeholders. The audit firm also reviewed documentation related to funding allocation and monitoring. During the audit, Williams Adley conducted field work in 12 recipient countries that were allocated just over $56 million in ARPA funding for COVID-19 activities as notified by CN #18. Field work took place between September 2022 and August 2023.

The audit firm concluded that the COVID-19 funding as notified by CN#18 was appropriately allocated, expended, and monitored. As such, we have no recommendations.

We appreciate the assistance provided to our staff and the audit firm's employees during the engagement.

USAID
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U.S. Agency for International Development

Audit of USAID's COVID-19 Vaccine Readiness Efforts

March 26, 2024

March 26, 2024

Ms. Toayoa Aldridge
Assistant Inspector General for Audits, Inspections, and Evaluations
Office of Inspector General
U.S. Agency for International Development

Dear Ms. Aldridge:

Williams, Adley & Company-DC, LLP performed an audit of U.S. Agency for International Development's (USAID) COVID-19 vaccine readiness efforts. We performed the audit in accordance with our Task Order No. 72001G22R00006, dated September 13, 2022. Our report presents the results of the audit.

We conducted our audit in accordance with applicable Government Auditing Standards, 2018 revision, technical update April 2021. The audit was a performance audit, as defined by Chapter 8 of the 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 objectives of the audit were to describe the major global technical assistance and country specific activities supported with funds notified in Congressional Notification (CN) #18 and to determine to what extent USAID is monitoring implementer performance of the activities in accordance with Agency's standard policies and procedures.

To accomplish our objectives, we interviewed personnel from the USAID Bureau for Global Health as well as Mission personnel, project implementers, and project beneficiaries in 12 recipient countries. We also reviewed documentation related to funding allocation and monitoring. We conducted fieldwork from September 2022 through August 2023. Appendix I provides a more detailed description of our objective, scope, and methodology. We appreciate the opportunity to have conducted this audit. Should you have any questions or need further assistance, please contact us at (202) 371-1397.

Leah Southers

Leah Southers, CPA, CISA, CGFM, CFE
Partner

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RESULTS IN BRIEF

We conducted an independent performance audit of USAID's allocation and monitoring over its COVID-19 vaccine readiness efforts. Our performance audit was conducted both remotely as well as at overseas Mission, implementer, and recipient locations in 12 countries: Bangladesh, Eswatini, Ghana, Indonesia, Lesotho, Malawi, Mozambique, Philippines, Senegal, South Africa, Tanzania, and Vietnam.

We determined the COVID-19 funding was allocated and expended consistent with Agency policies and the Agency's stated justifications for the funding in Congressional Notification #18, and monitored in accordance with Agency's standard policies and procedures.

BACKGROUND

USAID is a U.S. international development and disaster assistance agency that works in over 130 countries to promote global health, support global stability, provide humanitarian assistance, catalyze innovation and partnership, and empower women and girls. Established in 1961, USAID's work advances U.S. foreign policy, demonstrates American generosity, and supports partners to become self-reliant. USAID's mission is to promote democratic values abroad and advance a free, peaceful, and prosperous world. USAID is headed by an Administrator appointed by the President and confirmed by the Senate. USAID manages more than $25 billion in combined annual appropriations. USAID plays a key role in the U.S. government's global response to the COVID-19 pandemic and its secondary impacts.

The U.S. COVID-19 Global Response and Recovery Framework ("Framework"), published in July 2021, outlines the U.S. government's lines of effort with the overarching goal to end the COVID-19 pandemic around the world, mitigate its impacts, support the global recovery, and strengthen international readiness for future biological threats. The Framework contains the following objectives:

1. Accelerate widespread and equitable access to and delivery of safe and effective COVID-19 vaccinations.
2. Reduce morbidity and mortality from COVID-19, mitigate transmission, and strengthen health systems, including to prevent, detect, and respond to pandemic threats.
3. Address acute needs driven by COVID-19, mitigate household shocks, and build resilience.
4. Bolster economies and other critical systems under stress due to COVID-19 to prevent backsliding and enable recovery.
5. Strengthen the international health security architecture to prevent, detect, and respond to pandemic threats.

American Rescue Plan Act Background

USAID received the following amounts under the American Rescue Plan Act of 2021 (hereafter referred to as "ARPA"):

- $905 million for global health activities to prevent, prepare for, and respond to coronavirus, including a contribution to a multilateral vaccine development partnership to support epidemic preparedness.

- Approximately $3.1 billion to prevent, prepare for, and respond to coronavirus, including support for international disaster relief, rehabilitation, and reconstruction, for health activities, and emergency food security needs.
- $930 million to USAID to prevent, prepare for, and respond to coronavirus, including activities to address economic and stabilization requirements resulting from the coronavirus.

USAID is also programming $800 million in Title II food aid appropriated under ARPA. In addition, the U.S. Department of State was appropriated $3.75 billion to mitigate the effects of coronavirus on PEPFAR programs. $3.5 billion of that amount was for a required contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria. A majority of these remaining funds were apportioned to USAID (referred to as "ARPA PEPFAR").

Vaccine Readiness Efforts Background

Under Objective 1 of the Response Framework, the Biden Administration aimed to accelerate widespread and equitable access to and delivery of safe and effective COVID-19 vaccinations. At the first Global COVID-19 Summit conducted on September 22, 2021, President Biden announced his support of the World Health Organization's (WHO's) strategy to achieve a global COVID-19 vaccination of at least 70% of the world's population by September 2022.[1] At the time this goal was established, it was estimated that low-income countries and lower middle-income countries (LICs/LMICs) needed "to increase their ability to administer COVID-19 vaccines, improving "vaccine readiness", by three to six times what they were currently doing in order to ensure shots got into the arms of people who needed them the most."[2]

While vaccine supply shortages were the biggest constraint at the time of the first Global COVID-19 Summit, the White House predicted that improving on-the-ground uptake would soon become the most critical constraint. A significant ramp-up of support was required to meet the 70% target by supporting countries to increase COVID-19 vaccine access and uptake, with particular focus on addressing challenges around vaccine confidence and demand. According to USAID, "While many LICs and LMICs have experience introducing vaccines for their population delivered during childhood, COVID-19 vaccine deployment required new strategies and approaches to reach new populations, development of new data tools and systems, management of complex supply and cold chain requirements, and combating vaccine hesitancy and misinformation. Countries also needed technical support in decision-making on appropriate vaccines for their target populations, preparing the health workforce, navigating complex regulatory and registration processes, and ensuring proper systems are in place to detect and respond to adverse events following immunization."[3]

To help address this issue, USAID notified Congress (CN #18) in December 2021 that $195 million in ARPA funds would be used to support vaccine efforts in the 92 COVID-19 Vaccines Global Access (COVAX) Advance Market Commitment (AMC)[4] economies (AMC 92) and 8

[1] The White House (2021, September 24). Global COVID-19 Summit: Ending the Pandemic and Building Back Better. Retrieved July 3, 2023, from https://www.whitehouse.gov/briefing-room/statements-releases/2021/09/24/global-covid-19-summit-ending-the-pandemic-and-building-back-better/.

[2] Congressional Notification #18, page 2.

[3] Congressional Notification #18, page 2.

[4] A listing of the 92 Gavi COVAX AMC eligible countries was published by Gavi on July 31, 2020, at the following link: https://www.gavi.org/news/media-room/92-low-middle-income-economies-eligible-access-covid-19-vaccines-gavi-covax-amc.

African Union Self-Financing Participant (SFP)[5] countries. Specifically, $40 million in ARPA funds would be used to support global activities to address barriers impacting vaccine access and uptake. The additional $155 million in ARPA funds would be used to support countries' efforts to successfully introduce and deploy COVID-19 vaccines.

USAID-funded HBC-80 refrigerators ready for distribution in a warehouse near Hanoi, Vietnam (photo by Williams Adley).

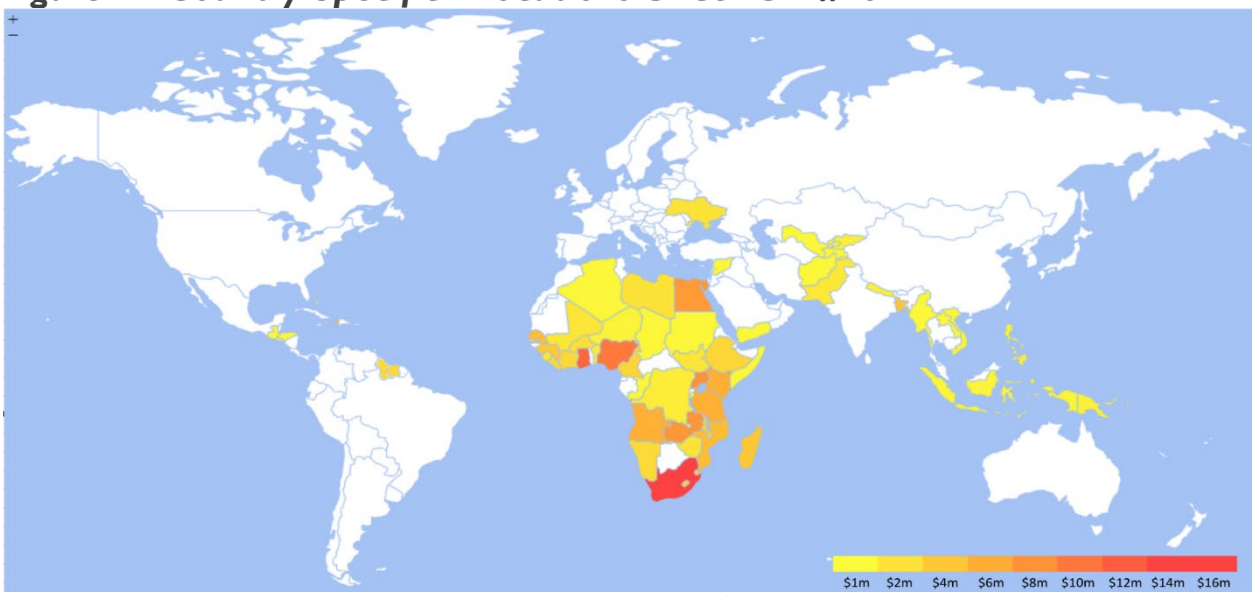
USAID prioritized its interventions to support vaccine readiness and deployment in affected developing countries based on the highest degree of need for vaccine implementation support. Factors considered in allocating funding included:

- *COVID-19 burden* - The population not yet fully vaccinated against COVID-19, current COVID-19 mortality rate, and risk factors for COVID-19 (adult obesity rate, population over 65).
- *Health systems capacity* - Health system capacity based on the Global Health Security Index classification of health systems and the Health Access and Quality index.
- *Financial resources for vaccine implementation* - World Bank summary of external financing for COVID-19 Vaccination (per capita) and domestic health expenditure (per capita).
- *Coverage, wealth, geography, and inequality disparities* - Disparities in composite coverage index, by wealth and geography, the inequality-adjusted human development index, and the multidimensional poverty index.

Using these factors, USAID provided vaccine readiness support to over 50 different countries as shown below.

[5] The eight African Union SFPs are Botswana, Equatorial Guinea, Gabon, Libya, Mauritius, Namibia, Seychelles, and South Africa.

Figure 1 - Country-Specific Allocations Under CN #18



Source: Map created by auditors based on funding allocation documentation provided by Global Health.

To facilitate the successful and equitable delivery of COVID-19 vaccines and rapidly increase throughput, the activities funded by USAID focused on the following four priority areas:

1. Campaigns and mass vaccination efforts.
2. Vaccine access, demand, and confidence, with a focus on gender equity and reaching the most at risk populations.
3. Critical immunization services support, including human resources, operations and logistics, data and analytics.
4. Planning and coordination at the national and sub-national levels.

AUDIT RESULTS

Overall, we found that the funds allocated under CN #18 for vaccine readiness efforts were consistent with the intended purpose and justification of the funds, including the illustrative activities described in the CN, and complied with agency and federal standards. The results related to each of our audit objectives are described below.

Audit Objective 1: Describe Global Technical Assistance Activities

Of the total notified funding notified under CN #18, $40 million was to be allocated to global activities to address critical barriers impacting vaccine access and uptake and was to focus on the following three strategic areas:

- Strengthening vaccine information systems, data availability and data use;
- Identifying, adapting, and catalyzing effective approaches to scaling up access to and demand for vaccines; and
- Supporting coordination and accountability of country readiness and delivery efforts.

USAID-funded vaccine outreach gazebo in the parking lot of the Kopaong Old Age Home Clinic in Gauteng, South Africa (photo by Williams Adley).

USAID's COVID-19 Task Force and the Global Health Vaccine Access and Delivery Technical Working Group, with input from Missions and Regional Bureaus, conducted a process to identify country level needs and critical bottlenecks to vaccine delivery. The process involved the review of existing plans and funding, consideration of critical gaps or catalytic opportunities, and determination of the most appropriate mechanism for supporting needed activities. The COVID-19 Task Force and Vaccine Access and Delivery Technical Working Group made obligation recommendations for global activities to Global Health leadership via action memos. The action memos were required to: document the specific programmatic need; provide a robust program justification; and explain how one of the following two criteria has been met, permitting the funds to be obligated on a global or regional basis under an exemption to the usual requirement that the Agency obligate funds by country and project when responding to a PHEIC (PHEIC exemption):

1. The activity's scope of work or position description is standardized across countries and can be made widely available without significant differentiation; or
2. The programmatic need is urgent and requires an immediate response to be effective and the timeline cannot be met if the obligation process is not begun before country-level needs are established.[6]

Based on our review of documentation such as award justification forms, activity plans, contract modifications, grant awards and amendments, and approved action memos, we noted 11 global technical assistance activities, with obligated funding totaling $27.9 million, that were conducted with funds notified in CN #18. We determined that all eleven activities appropriately related to one of the three strategic areas identified in the CN; did not exceed the approved funding limits in the CN; and met at least one of USAID's PHEIC exemption criteria.

Table 1 – Global Technical Assistance Activities Funded Under CN #18

Global Activity Name	Implementing Partner	Total Obligation
Country Health Information Systems and Data Use	JSI	$400,000
Meeting Targets and Maintaining Epidemic Control	FHI 360	$3,815,000

[6] The USAID policy and program requirements for programming during a Public Health Emergency of International Concern (PHEIC) are outlined in the July 26, 2019, Agency Notice *Process for Programming Resources During a Declared Public Health Emergency of International Concern and subsequently updated via an Agency Noticed dated February 21, 2020*. As USAID's standard process includes identifying predetermined country allocations prior to obligating funds, the PHEIC exemption allowed USAID to obligate funds prior to country allocation determination.

Global Activity Name	Implementing Partner	Total Obligation
Procurement and Supply Management	Chemonics	$4,450,000
UNICEF: Polio & Immunizations	UNICEF	$5,000,000
WHO: Polio & Immunizations	WHO	$3,000,000
WHO: Polio & Immunizations II	WHO	$1,000,000
Breakthrough Action	John Hopkins University	$3,500,000
Momentum Routine Immunization Transformation & Equity	JSI	$5,350,000
Medicines, Technologies, and Pharmaceutical Services	Mgmt. Sciences for Health, Inc.	$250,000
Digital Square	PATH	$850,000
ADVISE	Devtech Systems, Inc.	$320,000
Total Assistance Under CN #18:		**$27,935,000**

Source: Allocation information provided by Global Health

As displayed in the table above, approximately $28 million of the $40 million was obligated to global activities. Williams Adley discussed the remaining $12 million with Global Health personnel and reviewed activities supported with the funds, which used the tools and expertise developed through global technical assistance activities to address critical gaps and bottlenecks to vaccine delivery at the country level. This country-specific application of the global tools aligned with the technical categories outlined in CN 18 based on the need and Missions' ability to effectively absorb and implement the ARPA funding. We determined this use of funds was reasonable, and the initiated activities supported vaccine readiness efforts.

Audit Objective 2: Describe Country-Specific Technical Assistance Activities

Of the total notified funding under CN #18, $155 million was to be allocated to countries/regions to fund activities focused on supporting vaccine efforts in the COVAX AMC 92 and 8 African Union SFP countries. The amounts were allotted to the Regional Bureaus for programming through their Missions utilizing the process described below:

1. USAID developed a model that assessed COVAX AMC 92 and African Union SFP countries across four domains (with related indicators).
2. Based on model results, countries were categorized into groups such as Strong Performer, Catalytic and Strategic, High Potential, and High Barrier, reflecting their impact on vaccination efforts and required U.S. government investment.
3. USAID, in collaboration with the Centers for Disease Control and Prevention created an illustrative list, emphasizing high potential countries, to guide funding discussions. The list was adjusted based on feedback from Regional Bureaus accounting for various on the ground realities. Table 2 below identifies the final list of countries and their allocated funding.

Table 2 – Country-Specific Funding Allocation Under CN #18

Country/Region	Total Allocation		Country/Region	Total Allocation
1. Afghanistan	$500,000		30. Liberia	$2,500,000
2. Algeria	$500,000		31. Libya	$2,000,000
3. Angola	$6,000,000		32. Madagascar	$4,000,000

Country/Region	Total Allocation	Country/Region	Total Allocation
4. Bangladesh	$4,200,000	33. Malawi	$3,150,000
5. Benin	$1,500,000	34. Mali	$1,715,000
6. Burkina Faso	$2,420,000	35. Mozambique	$4,800,000
7. Burma	$500,000	36. Namibia	$2,555,000
8. Burundi	$500,000	37. Nepal	$1,000,000
9. Cameroon	$3,000,000	38. Niger	$750,000
10. Chad	$500,000	39. Nigeria	$10,600,000
11. Congo (Brazzaville)	$500,000	40. Pakistan	$1,500,000
12. Côte d'Ivoire	$3,000,000	41. Papua New Guinea and Pacific Islands[7]	$900,000
13. Democratic Republic of the Congo	$5,246,810	42. Philippines	$1,000,000
14. East Timor (Timor-Leste)	$500,000	43. Senegal	$5,000,000
15. Eastern and Southern Caribbean	$2,225,000	44. Sierra Leone	$2,000,000
16. Egypt	$7,300,000	45. Somalia	$500,000
17. El Salvador	$200,000	46. South Africa	$15,000,000
18. Eswatini	$2,500,000	47. South Sudan	$1,750,000
19. Ethiopia	$2,850,000	48. Sudan	$500,000
20. Ghana	$11,200,000	49. Syria	$500,000
21. Guatemala	$500,000	50. Tajikistan	$500,000
22. Guinea	$4,000,000	51. Tanzania	$5,753,190
23. Haiti	$5,260,000	52. Uganda	$8,000,000
24. Honduras	$500,000	53. Ukraine	$2,000,000
25. Indonesia	$600,000	54. Uzbekistan	$500,000
26. Kenya	$6,340,000	55. Vietnam	$600,000
27. Kyrgyz Republic	$1,000,000	56. Yemen	$500,000
28. Laos	$500,000	57. Zambia	$8,550,000
29. Lesotho	$3,100,000	58. Zimbabwe	$2,000,000
Total Country-Specific Funding Under CN #18:			**$167,065,000**

Source: Allocation information provided by Global Health

Upon determination of final allotment amounts for each country, the Regional Bureaus/Missions were notified of the available funding. Based on their knowledge of the countries' current needs and gaps, the Missions, in consultation with Regional Bureaus, determined the applicable activities and developed detailed implementation plans in collaboration with the local government, Ministry of Health, and/or implementing partner, as applicable. The implementation plan and Award Justification Form were submitted to Regional Bureaus who then coordinated programmatic (agreement and contract officer representatives (A/COR)) and technical (Global Health COVID technical teams) clearances. Upon final programmatic and technical clearance, the funding was allowed to the USAID missions or operating unit and subsequently was obligated to the selected implementing partner to initiate the activities.

[7] Pacific Islands included Fiji, Kiribati, Micronesia, Solomon Islands, Tonga, and Vanuatu (assistance may include other countries with emerging needs, such as Marshall Islands and Palau).

Based on the testing conducted, we determined:

- funding was allocated to countries in accordance with CN #18 and was reasonable;
- the sampled activities (identified in Table 3) appropriately focused on providing support for the country gap/need identified and the identified gap/need were consistent with the justification and illustrative activities described in CN #18 and the USAID ARPA Health Funding Vaccine Implementation Guidance[8]; and
- the sampled activities were conducted within the identified period of performance and sufficiently met the needs of the recipients.

We further noted (as displayed in Table 2 above), that the difference of $12 million is the global technical assistance provided at the country-level, which as discussed under Audit Objective 1 above, we determined was reasonable.

Audit Objective 3: To What Extent has USAID Monitored Implementer Performance

Performance monitoring is critical to USAID's ability to track progress and determine whether the funding is accomplishing what it was intended to achieve. However, the COVID-19 pandemic created challenges to performance monitoring efforts, including movement restrictions and technology challenges.[9] To assist Missions in performance monitoring during the pandemic, Global Health provided monitoring policy flexibilities related to remote monitoring and site visits, as well as guidance designed to help Missions. Key guidance issued during the audit period related to performance monitoring included:

- COVID-19 Monitoring, Evaluation, and Learning Plan (first issued on July 2, 2021, updated on October 25, 2021): This guidance outlined the indicators and data to be collected for the activities implemented with ARPA funding.
- Global Health COVID-19 Indicators (published in August 2020, last updated on October 4, 2021): This guidance provided standard indicator definitions and was updated throughout the pandemic to reflect changing circumstances.
- USAID ARPA Health Funding Vaccine Implementation Guidance (issued December 20, 2021; last updated January 5, 2022): This document provided additional technical and operational guidance for Operating Units (OU).

A detailed monitoring, evaluation, and learning (MEL) plan was created for each sampled activity. Although each MEL plan was unique and tailored to the specific activities, they all contained standard performance monitoring requirements per ADS 201 as well as the reporting requirements for the applicable COVID-19 indicators.

[8] CN #18 identified the following areas of country-specific support in which activities could be focused: policy, planning, coordination; pharmacovigilance and monitoring adverse events following immunization; supply chain and logistics; human resources for health, including training and supervision; communications and advocacy; communication, community engagement, and demand; and evaluation and health information systems. Further, the USAID ARPA Health Funding Vaccine Implementation Guidance identified an additional two areas of support: data analytics, monitoring, evaluation, learning and health information systems and service delivery.

[9] USAID OIG, *USAID Adapted to Continue Monitoring During COVID-19, But the Effectiveness of These Efforts Is Still to Be Determined* (9-000-21-007-P), May 21, 2021.

Per review of the activity specific MEL plans and the results of the interviews conducted (see Appendix 3), Missions adapted their monitoring process primarily by significantly increasing the frequency of their communication with stakeholders (e.g., implementing partner, local government, ministry of health, other donors, etc.). For example, the USAID South Africa ADAPT Contracting Officer's Representative and the former CEO of Right to Care (the implementing partner for the ADAPT activity) communicated almost daily to address issues, respond to changing needs, and develop solutions. These discussions were in addition to various other weekly, monthly, and quarterly meetings conducted.

Another change in the monitoring process was the addition of the voluntary reporting of various COVID-19 indicators. Given the evolving nature of the pandemic, Global Health sought to obtain real-time tracking of results and the ability to make course corrections based on available data. As such, Global Health collected, processed, and analyzed data from various Missions and implementing partners on a more frequent basis to strategically direct its resources and interventions.[10] Beginning in September 2021, Global Health requested the implementing partners to voluntarily[11] submit data, including both quantitative and narrative results, on the activities supported by ARPA funding. The guidance issued by Global Health identified the indicators to be reported on, the frequency of reporting and defined the indicators. In response to the evolving nature of the pandemic, Global Health revised the indicators at least twice throughout the pandemic. The results of our audit indicated that the frequency of reporting the voluntary performance indicator data such as information on commodities, cold chain management, and other key metrics varied by implementers; however, Global Health also had other mechanisms in place to monitor the use of the funds.

Due to the nature of the pandemic, funding was being obligated and changes were occurring at a rapid pace and the Missions felt the increased communication was the best way to ensure challenges were resolved in a timely manner. As the funding notified in CN #18 was not available for obligation until December 2021, most movement restrictions had been lifted prior to activity implementation. As such, there were no identified instances in which either the Mission and/or implementing partner personnel were unable to conduct in-person site visits.

Based on the results of our testing, we determined that the performance monitoring performed by Global Health and at the Mission/Regional bureau level was in accordance with Agency requirements.

[10] USAID American Rescue Plan Health Funding Vaccine Implementation Guidance (first issued December 20, 2021; last updated, January 5, 2022).

APPENDIX 1: OBJECTIVES, SCOPE AND METHODOLOGY

Our audit objectives were:

1. To describe major global technical assistance activities initiated with obligated funding under CN #18;
2. To describe major activities by country initiated with obligated funding under CN #18; and
3. To determine to what extent USAID is monitoring implementer performance of those activities in accordance with the Agency's standard policies and procedures.

To accomplish the objectives of the audit, Williams Adley identified the applicable criteria against which to assess USAID's allocation and monitoring. In addition, we (1) met with USAID Global Health management and the USAID Office of Inspector General to conduct an entrance conference, (2) inquired about investigations or legal proceedings involving the audit objective, and (3) reviewed the applicable internal policies and procedures.

We reviewed agency directives, such as the USAID Operational Policy (ADS) and Mission guidance. We performed walkthroughs with Global Health and select Mission personnel. We also spoke with select implementers, beneficiaries, host government officials and other stakeholders to determine the impact of USAID's vaccine readiness.

We reviewed all global technical assistance activities initiated under CN #18 to determine whether the activities were in alignment with the three support areas identified in the CN. In addition, we reviewed the allocation methodology performed by Global Health in determining the amount of funding countries would receive to determine whether all key metrics identified in the CN were considered.

We also selected nine countries that received support from funding notified in CN #18 for on-site visits: Bangladesh, Ghana, Lesotho, Malawi, Mozambique, Philippines, Senegal, South Africa, and Vietnam. Due to Mission and Country Office availability, we conducted testing at three additional sites virtually: Eswatini, Indonesia, and Tanzania. See our Country Selection Methodology in Appendix 2. The total amount allocated to these 12 countries notified in CN #18 was $56 million, which represents 33% of the $167 million allocated to the 58 countries (identified in Table 2 above).

For each country selected, we conducted interviews with Mission personnel, implementer personnel, beneficiaries (such as hospitals), host government officials (such as Ministries of Health), and other stakeholders. The purposes of these interviews were to identify the successes and challenges of the vaccine readiness efforts and to gain a better understanding of the initiated activities and USAID's allocation and monitoring of these activities. These interviews were primarily conducted in-person, with the exception of interviews in Eswatini, Indonesia, and Tanzania, which were conducted virtually. See list of stakeholder interviews conducted in Appendix 3.

In addition to the interviews above, we reviewed supporting documentation such as the award justification form, award document and/or modifications, and workplan for one vaccine readiness award in each country. We also reviewed select monitoring documentation and progress reports. As each country received multiple awards for vaccine readiness efforts, we selected the activity that received the largest funding amount. Selected activities are shown in Table 3 below:

APPENDIX 1: OBJECTIVES, SCOPE AND METHODOLOGY

Table 3 - Vaccine Readiness Projects Selected and Amount Obligated

Country	Activity Name	Obligated Funding
Bangladesh	Community Health Systems Strengthening	$1,830,000
Ghana	Reaching Impact, Saturation, and Epidemic Control	$4,000,000
Indonesia	Country Health Information Systems and Data Use	$600,000
Malawi	Strengthening Community Outcomes through Positive Engagement	$700,000
Mozambique	Global Health Supply Chain Program– Procurement and Supply Management (GHSC-PSM)	$1,400,000
Eswatini	Triple R	$700,000
Lesotho	Accelerating Development Against Pandemic Threats	$1,500,000
Vietnam	UNICEF Polio & Immunization II	$600,000
Philippines	ReachHealth	$850,000
Senegal	Breakthrough Action	$1,925,000
South Africa	Accelerating Development Against Pandemic Threats	$13,000,000
Tanzania	Meeting Targets and Maintaining Epidemic Control	$1,500,000
Total:		**$28,605,000**

Source: Auditor generated list. Activity name and obligated funding amounts are based on the award justification forms provided by Global Health.

We assessed the reliability of the data provided by (1) performing testing of certain data elements, (2) reviewing existing information about the data, and (3) interviewing agency and implementer officials knowledgeable about the data. In addition, we traced a sample of data to source documents. We determined that the data was sufficiently reliable for the purposes of this report.

We assessed the significance of internal controls by (1) reviewing USAID's SOPs; and (2) performing walkthroughs with Global Health personnel to get an understanding of controls over the process.

We conducted this performance audit 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.

APPENDIX 2: COUNTRY SELECTION METHODOLOGY

We visited nine overseas Missions to conduct our audit of the vaccine readiness efforts. In addition to the nine Missions visited in-person, we also held interviews with three Missions virtually due to Mission availability and other issues that made in-person visits impractical.

Our contract with U.S. Agency for International Development (USAID) Office of Inspector General required us to conduct six separate audits of American Rescue Plan Act of 2021 (ARPA) funding notified under various Congressional Notifications and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (herein referred to as "funding streams"):

- CN #16 – Oxygen Ecosystem
- CN #18 – Vaccine Readiness
- CN #41 – Rapid Response (2)
- CN #164 – Global Health Security
- CN #165 – Rapid Response (1)
- ARPA PEPFAR

For efficiency, we utilized a holistic approach to country selection, taking into consideration which countries would allow us to perform testing for multiple audits in one visit. Therefore, countries where activities were notified under numerous funding streams were more likely to be selected than those that had activities with small amounts of funding notified under one funding stream.

To determine which countries would be selected for in-person or virtual visits, we obtained a universe of the countries receiving support from funds notified under Congressional Notifications #16, 18, 41 164, 165, as well as ARPA PEPFAR. We then utilized the following data points to determine which locations to visit:

- **Travel Advisories.** Countries that received a State Department Travel Advisory rating of *3-Reconsider Travel* or *4-Do Not Travel* were excluded from our sample selection.
- **Received Funding Under At Least One Allocation.** To be eligible the country must have received support from funds notified in CNs 164, 165, 41, 18, 16, or ARPA PEPFAR.
- **Total Dollar Amount Allocated.** We obtained a listing of allocations by country for each CN and ARPA PEPFAR. Countries that received support from the highest amount of total funding were more likely to be selected.
- **Total Number of CNs and ARPA PEPFAR Allocations.** To ensure our sample of countries is sufficient to achieve our audit objectives for all six audits under our contract, we gave greater weight to countries that received support from funding under multiple CNs and ARPA PEPFAR.
- **Whether the Mission Oversaw a Non-Presence Country.** We received a listing of non-presence Missions from Global Health and the Mission that was responsible for their oversight. Missions that oversaw activities in non-presence countries had a higher probability of being selected.

APPENDIX 2: COUNTRY SELECTION METHODOLOGY

Our country selection yielded 16 countries, of which 12 received funding under CN #18 for vaccine readiness projects, as shown below.

Table 4 - List of Countries Selected and Amount Allocated Under CN #18

Country	Region	Funding Allocated Under CN #18	Interviews Conducted Person or Virtually
Bangladesh	Asia	$4,200,000	In Person
Ghana	Africa	$11,200,000	In Person
Indonesia	Asia	$600,000	Virtual
Malawi	Africa	$3,150,000	In Person
Mozambique	Africa	$4,800,000	In Person
Eswatini	Africa	$2,500,000	Virtual
Lesotho	Africa	$3,100,000	In Person
Vietnam	Asia	$600,000	In Person
Philippines	Asia	$1,000,000	In Person
Senegal	Africa	$5,000,000	In Person
South Africa	Africa	$15,000,000	In Person
Tanzania	Africa	$ 5,753,190	Virtual
Total:		**$56,003,190**	

Source: Auditor generated list. Allocated funding totals are based on information provided Global Health. Note: Eswatini and Lesotho are non-presence countries. USAID personnel are located at respective in-country offices and supported by the USAID Southern Africa Regional Mission. We visited project recipients in Lesotho and spoke with implementer staff based in South Africa and USAID personnel in the Southern Africa mission.

APPENDIX 3: STAKEHOLDER INTERVIEWS

As described in the Objectives, Scope and Methodology section in Appendix I, we conducted various interviews with Mission personnel, project implementers, project beneficiaries, and other stakeholders. These interviews are listed below.

Table 5 - List of Interviews Conducted

Country	City or Province	Organization(s) Interviewed/Visited	In Person/ Virtual	Type
Bangladesh	Dhaka	USAID Mission	In Person	Mission
Bangladesh	Dhaka	Expanded Programme on Immunization (EPI)	In Person	Host Country Government
Bangladesh	Dhaka	BRAC	In Person	Implementer
Bangladesh	Dhaka	Ministry of Health	In Person	Host Country Government
Bangladesh	Dhaka	Directorate General of Health Services (DGHS)	Virtual	Host Country Government
Eswatini	Mbabane	Triple R Project	Virtual	Implementer
Eswatini	Mbabane	USAID Mission	Virtual	Mission
Ghana	Accra	USAID Mission	In Person	Mission
Ghana	Accra	Jhpiego (RISE Project)	In Person	Implementer
Ghana	Accra	Ghana Health Services (GHS)/Public Health Division	In Person	Host Country Government
Ghana	Accra	Nsawam Government Hospital	In Person	Healthcare Facility
Ghana	Accra	GHS/Institutional Care Division	In Person	Host Country Government
Ghana	Kumasi	GHS/Regional Health Directorate (RHD)	In Person	Host Country Government
Ghana	Accra	GHS/Greater Accra Regional Health Directorate	In Person	Host Country Government
Ghana	Kumasi	Ghana Health Services/Kumasi Metropolitan Health Department	In Person	Host Country Government
Ghana	Kumasi	Manhyia District Hospital	In Person	Healthcare Facility
Indonesia	Jakarta	USAID Mission	Virtual	Mission
Indonesia	Jakarta	Country Health Information Systems and Data Use (CHISU)	Virtual	Implementer
Lesotho	Mafeteng	Ha Salae Community Outreach Site (ADAPT Activity)	In Person	Other Stakeholder
Lesotho	Maseru	USAID Mission	Virtual	Mission
Lesotho	Maseru	Right to Care (ADAPT Project)	Virtual	Implementer
Malawi	Lilongwe	USAID Mission	In Person	Mission
Malawi	Lilongwe	World Relief	In Person	Implementer
Malawi	Lilongwe	Malawi Ministry of Health HES	In Person	Host Country Government
Mozambique	Maputo	USAID Mission	In Person	Mission
Mozambique	Maputo	Chemonics (PSM Project)	In Person	Implementer
Mozambique	Maputo	Zimpeto Warehouse	In Person	Storage Facility

APPENDIX 3: STAKEHOLDER INTERVIEWS

Country	City or Province	Organization(s) Interviewed/Visited	In Person/ Virtual	Type
Philippines	Manila	USAID Mission - Health Office Director	Virtual	Mission
Philippines	Caloocan City	Llano Elementary School	In Person	School
Philippines	Quezon City	City Epidemiological Surveillance Unit (CESU)	In Person	Host Country Government
Philippines	Quezon City	Quezon City Vaccination Site at Philippine Medical Association	In Person	Healthcare Facility
Philippines	Cebu City	Cebu Province Local Government Team	In Person	Host Country Government
Philippines	Cebu Province	Emergency Rescue Unit Foundation (ERUF)	In Person	Other Stakeholder
Philippines	Caloocan City	Llano Health Center	In Person	Healthcare Facility
Philippines	Manila	ReachHealth - Team	In Person	Implementer
Philippines	Manila	USAID Mission	In Person	Mission
Philippines	Manila	Philippines Department of Health - Assistant Secretary	In Person	Host Country Government
Philippines	Manila	Philippines Department of Health - BIHC Director	In Person	Host Country Government
Philippines	Rizal	Casimiro Ynares Sr. Memorial Hospital	In Person	Healthcare Facility
Philippines	Cebu City	ReachHealth - Visayas Team	In Person	Implementer
Philippines	Cebu City	Philippines Department of Health - Region 7	In Person	Host Country Government
Senegal	Dakar	USAID Mission	In Person	Mission
Senegal	Dakar	Breakthrough Action team - John Hopkins University (JHU)	In Person	Implementer
Senegal	Dakar	Hann Mariste Health Center	In Person	Healthcare Facility
Senegal	Dakar	Niakhar Health Center	In Person	Healthcare Facility
Senegal	Dakar	Senegalese Health Journalists Network	In Person	Other Stakeholder
Senegal	Dakar	Directorate of Laboratories of the Ministry of Health	Virtual	Host Country Government
Senegal	Dakar	Centre des Operations d'Urgence Sanitaire (COUS)	In Person	Host Country Government
South Africa	Pretoria	Right to Care (ADAPT Project)	In Person	Implementer
South Africa	Gauteng	Esangweni CHC	In Person	Healthcare Facility
South Africa	Gauteng	Winnie Mandela Clinic	In Person	Healthcare Facility
South Africa	Gauteng	Kopanong Old Age Home	In Person	Other Stakeholder
South Africa	KwaZulu Natal	Prince Mshiyeni Gateway Clinic - Umlazi	In Person	Healthcare Facility
South Africa	KwaZulu Natal	Umlazi N Clinic/Outreach Site Umzali N	In Person	Healthcare Facility
South Africa	Cape Town	Gustrouw CHC (ADAPT Activity)	In Person	Healthcare Facility
South Africa	Cape Town	Nomzamo CHC & Outreach (ADAPT Activity)	In Person	Healthcare Facility
South Africa	Cape Town	Michael Mapongwana CHC (ADAPT Activity)	In Person	Healthcare Facility
Tanzania	Dar es Salaam	USAID Mission	Virtual	Mission
Tanzania	Dar es Salaam	FHI-360 (EpiC Project)	Virtual	Implementer
Vietnam	Hanoi	USAID Mission	In Person	Mission
Vietnam	Hanoi	Ministry of Health	In Person	Host Country Government

APPENDIX 3: STAKEHOLDER INTERVIEWS

Country	City or Province	Organization(s) Interviewed/Visited	In Person/ Virtual	Type
Vietnam	Hanoi	UNICEF	In Person	Implementer
Vietnam	Hanoi	National Expanded Program on Immunization (NEPI)	In Person	Host Country Government

Source: Auditor generated based on interviews performed.

APPENDIX 4: MANAGEMENT RESPONSE

TO: Rob Mason, Audit Director, USAID OIG Africa Regional Office

FROM: Dr. Atul Gawande, Assistant Administrator, Bureau for Global Health /s/

DATE: February 27, 2024

SUBJECT: Management Comment(s) to Respond to the Draft Audit Report Produced by the Office of the Inspector General (OIG) titled, Audit of USAID's Vaccine Readiness Efforts (4-936-24-001-U) (Task No. 441V0622)

The U.S. Agency for International Development (USAID) would like to thank the Office of the Inspector General (OIG) for the opportunity to respond to this final report which contains no recommendations for the Agency. We appreciate the extensive work of the OIG engagement team, and the specific findings that will help USAID capitalize on lessons learned during the COVID-19 pandemic and achieve greater effectiveness during future pandemics.

For more than half a century, the United States has been the largest contributor to global health security and humanitarian assistance. Investments by USAID and other U.S. Government Departments and Agencies in global health substantially advance U.S. foreign-policy and national-security interests by protecting Americans at home and abroad, promoting social and economic progress, and supporting the rise of capable partners better able to solve regional and global problems.

In order to combat the deadly impact of the COVID-19 pandemic, the U.S. stepped up as a bold leader of the global COVID-19 response, advancing both U.S. foreign policy and national security interests. The U.S. government's commitment to battling COVID-19 is outlined in the Global Response and Recovery Framework (GRRF), first published in 2021 and revised in 2022. The framework presents the government's three objectives in the global COVID-19 response: vaccinate those at highest risk and those who are hardest to reach; scale and integrate testing and treatment; and prepare for future COVID-19 variants and pandemic threats.

As a leader in this global response, USAID partnered with other U.S. government agencies to launch the U.S. Initiative for Global Vaccine Access, known as Global VAX. Global VAX supported Objective 1 of the GRRF to accelerate widespread, sustained, and equitable access to and delivery of safe and effective COVID-19 vaccinations and integrate COVID-19 vaccination into health systems while minimizing disruptions to other routine immunizations and health

services. With American Rescue Plan Act of 2021 (ARPA) funding for activities notified in Congressional Notification (CN) #18, USAID implemented Global VAX, initiating support for countries to increase, in many cases dramatically, access to and delivery of lifesaving COVID-19 vaccines for their most vulnerable populations. This initial support for Global VAX was augmented by additional ARPA funding for Objective 1 activities notified in subsequent CNs.

Complementing the U.S. government's donation of more than 691 million vaccines to 117 countries and economies to date, USAID's support through Global VAX ensured that countries that received COVID-19 vaccine doses also received the necessary support to deliver and administer COVID-19 vaccines rapidly and equitably. This whole-of-government effort worked to increase equitable vaccination by increasing demand and vaccinating priority populations–such as immunocompromised, other high-risk groups and those living in hard-to-reach places.

Because of this support, as of November 23, 2023, the percentage of people who received a complete primary series of the COVID-19 vaccine exceeded 59 percent in lower-middle-income countries and had increased by more than 25 percentage points in low-income countries since the launch of Global VAX.[1] From December 1, 2021, to December 6, 2023, the percentage of the total population of the 11 Global VAX surge countries who received a complete primary series grew from 5 percent to 36 percent due to the efforts of Global VAX together with host country governments and organizations.[2]

In line with World Health Organization guidance, USAID supported countries to achieve their coverage goals for eligible populations, with particular focus on reaching those most at risk for morbidity and mortality from COVID-19. By March 31, 2023, Global VAX surge countries had greatly accelerated vaccination coverage levels among health care workers, pregnant women, and older adults. By the end of March 2023, with support from USAID, Zambia, Uganda, Senegal, and Eswatini achieved 100 percent vaccination of their health care workers with the primary series, with Lesotho at 99 percent, and Tanzania, Ghana, Côte d'Ivoire, and Nigeria all above 50 percent. In this same period USAID supported Cote d'Ivoire to achieve a 100 percent coverage rate in older adults, with Tanzania not far behind and Zambia, Lesotho, Nigeria, Eswatini, Ghana, Angola, South Africa, and Uganda all above 50 percent coverage with lifesaving protection for this elderly population at highest risk for COVID-19 related morbidity and mortality.

Below are examples from Global VAX surge countries receiving intensive USAID support, initiated with ARPA funding notified in CN #18 and augmented by additional ARPA funding tranches notified in subsequent CNs, that showcase acceleration of vaccination rates among eligible and high priority populations.

- In **Tanzania**, with support from USAID, rapid progress was made in expanding its COVID-19 vaccination coverage among the eligible population, now standing at over 90 percent fully vaccinated with the complete primary series. Vaccinations increased from an average of 106,000 weekly doses administered in January 2022 to more than one million weekly doses administered each week during July and August 2022. In just seven months,

[1] Source: USAID Country Teams or WHO Immunization Information System (WIISE)
[2] Id.

coverage increased from 15 percent in June 2022 to over 90 percent by December 2022, far surpassing the country's goal to vaccinate 70 percent of the eligible population by the end of that year. Prioritizing those at highest risk for severe outcomes of COVID-19 infection, USAID also supported 100 percent COVID-19 vaccination coverage among eligible populations in the refugee camps of Nyarugusu and Nduta in Kigoma Region and 97 percent coverage of eligible populations in the 11 PEPFAR-supported regions of Tanzania, where HIV prevalence is the highest.

- In **Zambia**, over 75 percent of their population aged 12 and older has now been vaccinated with the complete primary series, up from 43 percent in July 2022. The Zambian Government started its COVID-19 vaccine rollout in April 2021, setting a national target of fully vaccinating 70 percent of the eligible population by the end of 2022. USAID's intensive support was critical in targeting high priority populations and in enabling the Ministry of Health to administer COVID-19 vaccines through HIV treatment clinics and other health service providers.

- In **Côte d'Ivoire**, with support from USAID, the country has continued to demonstrate its strong commitment to controlling COVID-19 nationally. The country originally set a vaccination target of 70 percent of the 28.5 million eligible population (people aged 18 and older) by the end of December 2022, and in March 2022, Côte d'Ivoire expanded COVID-19 vaccination eligibility to include adolescents and teenagers aged 12 to 17, subsequently increasing their national vaccination target for number of people fully vaccinated from 14,570,259 to 19,971,080. With intensive support from USAID, by the end of July 2022, 42 percent of the eligible population had been fully vaccinated, and as of June 30, 2023, over 61 percent of the eligible population had completed their primary series.

- In **Uganda**, with USAID support, from November 2021 to May 2023, vaccination coverage among the eligible population of those aged 18 and older receiving at least one dose of the COVID-19 vaccine rose from 20 percent to 82 percent.

These examples highlight how USAID and our implementing partners, with intensive support starting with ARPA funding notified under CN #18, worked closely with host country governments, other multilateral and donor partners, and local experts to prioritize the support and approaches that would best enhance country-led programs and work toward country goals for vaccinating those at highest risk of COVID-19.

By partnering with governments to achieve their individual COVID-19 vaccination targets and goals, USAID supported countries in strengthening local planning and leadership, helping to streamline coordination and creating effective programs that reached people with COVID-19 vaccines in the short term and bolstered national health systems over the long term.