Memorandum on the Republic of Ghana
Programme Audit report

The attached Gavi audit report sets out the conclusions of the programme audit of Gavi's support to the Government of Ghana's national immunisation programme.

The audit team reviewed the MoH and implementing partners' management of Gavi support to the routine immunisation programme provided during the period 1 January 2020 to 31 December 2024. The audit scope included the following grants: Health Systems Strengthening, Rotavirus vaccine, PCV vaccine, MR campaign, COVID-19 Vaccine Delivery Support (CDS) funds, as well as other vaccines and cold chain equipment.

Funds directly executed by WHO and UNICEF were not subject to our programme audit and were considered out of scope, in accordance with the United Nations single audit principle.

The report's executive summary (pages 3 to 7) summarises the key conclusions, details of which are set out in the body of the report:

1. There is an overall audit rating of **"ineffective",** which means, "Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised".
2. In total, 17 issues were identified in the following areas: (i) governance and oversight; (ii) programme management; (iii) vaccine supply chain management; (iv) digital immunisation information systems; (v) immunisation data management; and (vi) budget and financial management.
3. To address the risks associated with the issues, the audit team raised 17 recommendations, of which 10 (59%) were rated as high priority.

4. Key findings were that:
    a. Ghana's key immunisation governance structures—the Inter-agency Coordinating Committee (ICC), National Immunisation Technical Advisory Group (NITAG), and Health Sector Working Group (HSWG)—were not operating effectively, weakening oversight and accountability. The ICC lacked formal Terms of Reference, met irregularly, and had poor documentation, while the NITAG overstepped its technical role and was not reconstituted after its membership expired in 2024. Although the HSWG met regularly, it failed to consistently address critical issues such as transition planning, financing, and programme performance. Overall, the absence of clear mandates, accountability mechanisms, and coordination across these bodies undermined strategic governance of the immunisation programme.
    b. Ghana, which began its accelerated immunisation transition in 2022 and aims for full

self-financing by 2030, faces major challenges in governance, planning, and surveillance. Although a transition roadmap and National Immunisation Strategy (NIS) were developed, neither was endorsed or effectively implemented, resulting in weak oversight, delayed activities, and poor linkage between plans, budgets, and monitoring. Key reforms—including governance updates, cold chain planning, and procurement arrangements—remain unfinished, while late co-financing payments and currency depreciation have strained vaccine financing. Surveillance systems for vaccine-preventable diseases are underperforming, hindered by weak community engagement, data quality issues, and slow laboratory processing. Persistent weaknesses highlighted in annual reviews have not been addressed through costed improvement plans, and poor financial and operational discipline risks Ghana reaching full self-financing without sustaining immunisation performance, undermining progress achieved over the last two decades.

c. During the audit period, Ghana's vaccine supply chain faced major inefficiencies in forecasting, coordination, and accountability. Forecast assumptions were not regularly reviewed despite large gaps between planned and actual supplies, and informal stock benchmarks were used without formal national guidance. As a result, key vaccines like fell below minimum levels, triggering widespread stockouts across regions and districts. Limited visibility beyond the national level, reliance on manual reporting, fragmented partner systems, and poor coordination between vaccine and supply distributions further weakened the system. Inventory discrepancies across all storage levels showed weak controls and reconciliation, reducing accountability and obscuring supply risks. Without improvements in forecasting, information systems, and supply chain oversight, Ghana remains exposed to recurrent vaccine shortages and disruptions in immunisation services.
d. The audit found persistent weaknesses in Ghana's financial management of Gavi funds, undermining transparency and accountability. Both the Ministry of Health and Ghana Health Service struggled to accurately track and reconcile Gavi funds held in pooled accounts, with incomplete documentation, inconsistent reconciliations, and unexplained variances between expected balances, accounting records, and bank statements. Funds were sometimes used for inter-account borrowing or recorded prematurely as expenditures, while sub-national advances were poorly monitored and often remained unretired beyond the allowed period. Weak financial controls and documentation led to the audit team questioning USD 706,381 due to missing records, non-compliant procurement, and unapproved per diem practices. Despite similar issues flagged in the 2019 audit, corrective actions were insufficient, leaving significant fiduciary risks, weak compliance with Gavi requirements, and reduced reliability of financial reporting.

The findings of the programme audit were discussed with the Ministry of Health and implementing partners. They accepted the audit findings, acknowledged the gaps identified, and committed to implement a detailed management action plan.

Gavi requested the country to:

- Commit to reimburse Gavi and provide a payment plan regarding expenditures totalling USD 706,381 deemed as misused.
- Commit to recover and return the following amounts to the Gavi designated in-country accounts to make funds available for Gavi supported programmes
    - USD 24,944 (or GH¢ 256,927) related to identified ineligible VAT payments;
    - USD 226,429 (or GH¢ 2,189,569) related to identified ineligible VAT payments from the previous Gavi programme audit (2019) and other Gavi refunds in SAGE accounting system; and
    - USD 160,425 (or GH¢ 1,551,313) related to the identified variance between the expected Gavi fund balance and the bank reconciliation balance on 31st December 2024.

The Gavi Secretariat continues to work with the Ministry of Health to ensure that the above commitments are met.

Geneva, May 2026

PROGRAMME AUDIT REPORT

Republic of Ghana
April 2026

Gavi
The Vaccine Alliance

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1. Executive Summary

1.1 Overall audit opinion

Audit opinion:

The audit team assessed the Ministry of Health's management of Gavi support during the five-year period (January 2020 to December 2024) as "ineffective" which means, "**Multiple significant and/or material issues were noted.** Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised."

Through our audit procedures, we identified high risk issues relating to governance; programme management; vaccine management; and budgeting and financial management.

To address the risks associated with these issues, the audit team raised 17 recommendations of which 10 (59%) were rated as high risk. These recommendations need to be addressed by implementing remedial measures according to the agreed management actions.

1.2 Summary of audit issues

** The audit ratings attributed to each section of this report, the level of risk assigned to each audit issue and each recommendation, are defined in Annex 3 of this report.*

1.3 Summary of key issues

Through our audit procedures, we identified 16 issues (9 high risk, 7 medium risk) relating to the use and management of Gavi support. Section 3 of this report provides details of Ghana's context and specific challenges in delivering its immunisation programme. The high-risk issues are summarised below, followed by the detailed observations in Section 4 of this report.

A central issue highlighted throughout this report is Ghana's readiness for transition. Although Ghana is expected to transition from Gavi support in 2030 and developed a transition plan in 2023, that plan was never formally endorsed and has not been implemented. The country also continues to face major challenges in mobilising domestic resources to finance the immunisation programme activities. It is therefore critical that Ghana updates its strategic plans—including clear prioritisation and costing—and strengthens governance structures to adequately prepare for the transition from Gavi support while sustaining the gains achieved over the past two decades.

Governance and oversight
Gavi guidance identifies the Inter-agency Coordinating Committee (ICC) as the primary mechanism for providing strategic oversight, coordination, and accountability for the immunisation programme, with strong linkages to the broader health sector coordination platform. WHO guidance further emphasises that ICC arrangements should be formalised through country-specific Terms of Reference (ToRs), regular meetings, clear documentation, and defined escalation and follow-up mechanisms. In Ghana, immunisation governance is exercised through the ICC, the National Immunisation Technical Advisory Group (NITAG), and the Health Sector Working Group (HSWG).

During the audit period, these governance arrangements were not functioning as intended. The ICC operated without formal ToRs, met infrequently, and had gaps in meeting documentation. At the same time, NITAG agendas included operational and programmatic matters that fall outside its technical advisory mandate, and the committee was not reconstituted after its membership expired in 2024. Also, although the HSWG met regularly, strategic issues like transition planning were not escalated, routine immunisation challenges were not consistently addressed at sector level, particularly after the Covid-19 period, and key issues such as financing, transition readiness, and programme performance were not systematically reviewed.

Taken together, the weaknesses noted in the governance mechanisms denote weakened oversight and accountability over the immunisation programme.

Programme management
Ghana entered the accelerated transition phase in January 2022 and is expected to fully self-finance its immunisation programme by 2030. Although a transition roadmap for 2024–2029 was developed in 2023, it had not been endorsed or put into operation at the time of the audit. Oversight was weak: the transition steering committee met only once, there was no systematic follow-up, and progress depended heavily on individuals rather than institutional mechanisms, making it vulnerable to leadership changes. Planned 2024 activities were not carried out, the 2025 workplan was not approved, and several critical actions—including governance reforms, vaccine policy decisions, cold chain sustainability planning, and post-transition procurement arrangements—remained incomplete. This lack of planning rigor became more evident when Ghana revised its national birth cohort upward by about 30% in 2025, yet did not update the financial projections in the roadmap to account for increased vaccine and delivery costs.

While Ghana ultimately met its annual co-financing obligations, payments were consistently late, prompting Gavi to advance funds to avoid stockouts. Macroeconomic challenges, particularly currency depreciation, further inflated local vaccine procurement costs. As a result, the transition roadmap is not serving as a reliable planning or monitoring tool.

Similarly, although the National Immunisation Strategy (NIS) 2025–2030 was finalised in 2024 and aligned with the transition roadmap, it had not been formally endorsed and therefore did not guide operational planning or performance monitoring in its first year. National annual workplans were inconsistently produced, poorly linked to strategic objectives, lacked documented budgets and funding sources, and were not reviewed regularly. While Ghana made commitments to increase health and immunisation financing, domestic allocations remain low compared with peer countries, constraining fiscal space as external support reduces.
The NIS identifies outbreaks and emergencies as a strategic priority, and WHO guidance stresses the need for integrated facility and community-based surveillance with strong laboratory support and routine data analysis. However, during the audit period, vaccine-preventable disease (VPD) surveillance systems did not function effectively. Case detection relied mainly on facility reporting, with limited evidence of active community surveillance or recent community volunteer engagement, reducing detection in hard-to-reach areas. Surveillance data in Surveillance Outbreak Response Management and Analysis System (SORMAS) was incomplete and inconsistent, with missing immunisation status, duplicate records, and gaps in laboratory reporting, and there was no indication of routine data quality checks. Laboratory investigations were slow—with turnaround times up to 90 days—and reagent stockouts frequently hindered timely testing. Additionally, there was no structured mechanism for joint review of VPD surveillance indicators between Disease Surveillance and EPI teams, and feedback to lower levels following case investigations was unclear.

Annual programme reviews repeatedly identified similar weaknesses—such as poor data quality, inequitable coverage, under-immunisation in urban and remote areas, and gaps in adverse events following immunisation (AEFI) reporting—but these findings were not translated into prioritised, costed improvement plans, allowing issues to persist year after year. Weak planning discipline was also reflected in delays in disbursing campaign funds to districts, often after activities had already taken place.

Collectively, these weaknesses in programme management - transition management, strategic and operational planning, and VPD surveillance - increase the risk that Ghana will reach full self-financing without meeting key transition milestones. This creates continued uncertainty around immunisation financing and threatens the significant gains achieved over the past two decades.

Vaccine Supply Chain
During the audit period, vaccine supply planning and stock management did not function as intended. Forecast assumptions were not periodically reviewed or recalibrated, despite significant variances between forecasted vaccine quantities and doses received. Also, the programme operated against informal planning benchmarks for minimum and maximum months of stock at national and sub-national levels; that were not documented in national guidance. At the time of the audit, stock levels for several key antigens at the national cold room (particularly PCV, Rotavirus, and BCG) were below minimum operational benchmarks, and projected deliveries were insufficient to restore adequate buffer stock in the near term. These constraints cascaded down the supply chain, with all regional and district vaccine stores visited reporting stockouts of one or more vaccines during the audit period.

Supply chain visibility below regional level remains limited. The National Cold Room relied on periodic, manually consolidated reports and had no direct visibility of stock balances at district or facility levels, where manual ledgers were still in use. Parallel partner-supported systems were introduced to partially address these gaps, but this fragmented the national information landscape and undermined sustainability. At the same time, misalignment between vaccine distribution through the National Cold Room and dry-supply distribution through the Central Medical Store disrupted bundling at service delivery level, leading to stockouts of injection supplies at districts and health facilities when vaccines were available. Oversight of third-party logistics deliveries was also weak, with no real-time visibility of distributions and no defined performance indicators to manage last-mile delivery effectiveness.

These visibility gaps were compounded by significant discrepancies between recorded stock balances and physical counts across national, regional, and district stores, indicating weaknesses in inventory control and

reconciliation. As a result, accountability for vaccine stocks was reduced, emerging supply risks were not detected early, and service delivery was disrupted when either vaccines or essential injection supplies were unavailable at the point of service delivery.

Without strengthening forecasting, end-to-end visibility, accountability for vaccines and coordination between national and subnational levels, the supply chain remains vulnerable to recurrent stockouts, inefficiencies and missed vaccination opportunities.

Budget and financial management

Gavi grant agreements and Ghana's public financial management rules require that Gavi funds be accurately recorded, traceable, and regularly reconciled, including where commingled (donor-pooled) bank accounts are used. These requirements are intended to ensure transparency, prevent unauthorised use of funds, and enable reliable financial reporting to Gavi. During the audit period, weaknesses were identified in the tracking and reconciliation of Gavi funds at both the Ministry of Health (MoH) and Ghana Health Service (GHS). Gavi funds were held in commingled accounts alongside other donor funds, but supporting schedules and reconciliations required to clearly identify Gavi balances were incomplete or inconsistent. At MoH, a significant variance existed between expected Gavi fund balances and bank balances, partly due to inter-account borrowing that had not been reimbursed in a timely manner. At GHS EPI, material differences were noted between expenditure listings, accounting system balances, and bank balances, including unreconciled variances, delayed reversals of duplicate postings, and dormant balances relating to VAT refunds. Regular, systematic reconciliation between bank accounts, accounting records, and expenditure reports was not evident. As a result, Gavi refunds of USD 226K and Gavi cash balances of USD 160K were not made available for Gavi supported immunisation activities as these balances remained as reconciling items between the bank and SAGE accounting system since 2022.

Also, advances issued by GHS Headquarters and EPI to Regional and District Health Directorates were recorded as final expenditure at the point of disbursement, rather than as advances at the time of expenditure reporting. Statements of Expenditure submitted by sub-national levels were not systematically reviewed or validated, and accounting adjustments were not made where variances or delays were identified. In addition, advances were frequently utilised and retired well beyond the 90-day limit prescribed in national procedures, with some advances remaining unretired for more than a year.

The audit also noted weaknesses in financial controls and documentation across the Ministry of Health, Ghana Health Service, and sub-national levels. Of the USD 3 million in expenditures reviewed, USD 706,381 was questioned due to inadequate supporting documentation, non-compliance with procurement and payment procedures, use of unapproved and inconsistent per diem rates, unsupported transactions and ineligible expenditures. Common issues included missing or incomplete activity documentation, weak fuel and vehicle usage records, lump-sum per diem payments without evidence of attendance or duration, and inconsistent application of per diem rates across levels which were non-compliant with Gavi approved rates.

Similar weaknesses in financial management had been highlighted in the 2019 Gavi programme audit, indicating that corrective actions have not been fully effective. These weaknesses undermine accountability, impede compliance with the Partnership Framework Agreement, reduce assurance over the accuracy of financial reports submitted to Gavi and increase fiduciary risk.

1.4 Financial consequences of the audit

The audit team reviewed a sample of expenditures amounting to USD 3 million during the audit period (1 January 2020 to 31 December 2024). The sample included expenditure incurred at Ghana Health Service Expanded Programme of Immunisation (GHS EPI), Ghana Health Service Headquarters (GHS HQ), Ministry of Health (MoH), selected Regional Health Directorates (RHDs) and District Health Directorates (DHDs). Funds from partners - United Nations Children's Fund (UNICEF) and World Health Organisation (WHO) that were disbursed to GHS EPI are also part of the sample. As a result of examining the documentation available, the audit team questioned expenditures totalling to USD 706K. The audit also identified VAT charged to Gavi activities and Gavi funds garnished from the Gavi HSS account as summarised in the tables below.

Table 1: Summary of questioned expenditure

Details	Amount Questioned (USD)	as a % of tested	Details (report ref)
Irregular Expenditure	141,858	23.5%	4.6.1
Unsupported Expenditure	21,911		
Ineligible Expenditure	6		
Inadequately Supported Expenditure	542,607		
Total expense questioned	**706,381**		

Table 2: VAT charged to Gavi

Details	Amount (GH¢)	Amount (USD)	Details (report ref)
VAT identified from current audit testing	256,927	24,944	Annex 14b
VAT and other Gavi refunds as indicated in the SAGE accounting systems – funds not availed for programme activities	2,189,569	226,429	4.6.2

The country will be requested to refund such amounts to the Gavi in-country Health Systems Strengthening (HSS) account upon recovery from the Ministry of Finance.

Table 3: Gavi funds unavailable in the MoH bank accounts as at 31 December 2024

Details	Amount GH¢	Amount USD	Details (report ref)
Gavi funds subjected to garnishment by the Government of Ghana as of 31 December 2024	1,551,313	160,425	4.6.2

The country will be requested to refund such amounts to the Gavi in-country Health Systems Strengthening (HSS) account upon recovery from the Ministry of Finance

1.5 Cash balances

Table 4: Gavi funds unspent, at central level by implementer as of 31 December 2024.

Account	Grant	Amount GH¢	Amount USD	Source of information
GHS HQ USD account	Health Systems Strengthening (HSS)	7,595,813	534,541*	As per expenditure listing provided
	Covid 19 Delivery Support (CDS)	73,426,992	5,167,276*	
GHS HQ Cedi account	HSS	15,298,035	1,076,568	As per expenditure listing provided
GHS EPI Cedi account	Inactivated Polio Vaccine (IPV)	4,470,310	314,589	As per expenditure listing provided
	Malaria Vaccine Implementation Programme (MVIP)	209,693	14,757	As per expenditure listing provided.
	Measles Rubella (MR)	998,444	70,263	
	CDS	11,495,968	809,005	
MoH Cedi account	HSS	2,117,108	148,987	
	CDS	8,156	574	
Total		**115,620,519**	**8,136,560**	

**These funds are still held on the USD account but have been converted using the 2024 year end rate for report purposes.*

2. Objectives and scope

2.1 Audit objectives

In line with the respective Partnership Framework Agreement (PFA) signed 11 July 2014 and with Gavi's transparency and accountability policy, all countries that receive support are periodically subject to programme audit, for which the primary objective is to provide reasonable assurance that the resources were used for intended purposes in accordance with Gavi's agreed terms and conditions and were applied to the designated objectives.

The audit team assessed the various processes and programme management arrangements governing Gavi's support (vaccines and cash grants) for which the respective entities were responsible, including the current design and effectiveness of the governance structures , the country's readiness for transition, the effectiveness of the coordination, collaboration and implementation arrangements of Gavi-funded programme activities, the design and operating effectiveness of the assurance mechanisms within the financial and fixed assets management processes , the effectiveness of data management and data quality processes to ensure that data used for decision making is reliable and the design and operating effectiveness of vaccine chain processes to ensure delivery of vaccines to the intended recipients.

The team also reviewed the relevance and reliability of the internal control systems relative to the accuracy and integrity of the books and records, management, and operational information; the effectiveness of operations; the physical security of assets and resources; and compliance with national procedures and regulations.

2.2 Audit scope

The audit scope covered the five-year period from 1 January 2020 to 31 December 2024. The total cash, vaccine and ancillary support provided by Gavi to Ghana as of 31 December 2024 is presented in the table below.

Table 5: Cash, equipment, and vaccine support as of 31 December 2024 in USD

Cash grants	2020	2021	2022	2023	2024	Total
Health System Strengthening (HSS)	473,903	1,079,431	(47,031)	4,633,572	1,971,951	8,111,826
Polio, Malaria, Rota virus	225,343	-	-	-	439,770	665,113
Measles Rubella	-	-	-	-	2,368,800	2,368,800
Yellow Fever	33,728	42,310	45,169	153,759	-	274,966
COVID 19 delivery support	-	2,470,690	11,243,764	2,322,819	7,929,890	23,967,163
Total Cash (a)	**732,974**	**3,592,431**	**11,241,902**	**7,110,150**	**12,710,411**	**35,387,868**
PEF TCA						
COVAX TCA	-	400,316	974,064	1,425,381	-	2,799,761
PEF TCA	1,130,967	655,923	1,012,724	803,347	709,744	4,312,705
Total PEF TCA (b)	**1,130,967**	**1,056,239**	**1,986,788**	**2,228,728**	**709,744**	**7,112,466**
Equipment Support						
COVAX and CCEOP (c)	**-**	**762,071**	**(54,844)**	**(172,680)**	**-**	**534,547**
Vaccine Support						
COVID19	-	28,586,121	111,860,800	(597,842)	(719,012)	139,130,067
Inactivated Poliovirus Vaccine	2,460,934	1,808,230	2,359,456	3,285,407	2,629,798	12,543,825
Malaria	-	-	-	9,776,440	4,125,776	13,902,216
Meningococcal	767,843	795,363	563,097	647,711	512,506	3,286,520
Measles Rubella	-	-	-	-	5,342,787	5,342,787
ORAL Cholera	-	-	-	-	1,519,959	1,519,959
Pneumococcal conjugate	2,558,356	4,698,472	5,400,797	1,479,797	6,459,819	20,597,241
Pentavalent	2,223,317	962,599	2,105,738	291,807	2,136,137	7,719,598
Rota Virus	2,682,284	75,355	1,041,340	648,855	1,093,703	5,541,537
Yellow Fever	646,679	1,225,244	2,712,860	58,605	1,197,564	5,840,952
Injection Safety Devices	(226,688)					(226,688)
Total Vaccine (d)	**11,112,725**	**38,151,384**	**126,044,088**	**15,590,780**	**24,299,037**	**215,198,014**
Total (a+b+c+d)	**12,976,666**	**43,562,125**	**139,217,934**	**24,756,978**	**37,719,192**	**258,232,895**

Gavi support to Ghana over the audit period was channelled through the WHO, UNICEF, MoH and Gavi Expanded partners. Gavi disbursed amounts totalling USD 42,500,334 to the various implementers as illustrated in Table 4 below.

Table 6: Total Gavi cash disbursements to Ghana by grant and by implementor in USD in the period 2020-2024

Cash grant	Recipient	Total funds	Audit comments
COVID-19	JSI	316,050	*In scope
	MoH	22,407,141	In-scope
	PATH	770,336	*In scope
	UNICEF SD	473,636	Scoped out by audit team
Sub-total COVID19		**23,967,163**	
HSS	MoH	6,218,960	In-scope
	ROCQUE	674,090	*In scope
	UNICEF SD	1,218,776	Scoped out by audit team
Sub-total HSS		**8,111,826**	
Polio, Malaria, Rota	MoH	665,113	In-scope
Sub-total Polio, Malaria, Rota		**665,113**	
MR	MoH	2,368,800	In-scope
Sub-total MR		**2,368,800**	
YF	MoH	274,966	In-scope
Sub-total YF		**274,966**	
COVAX TCA	PWC	714,791	*In scope
	UNICEF	1,161,137	Partially in scope^
	WHO	923,833	Partially in scope^
Sub-total COVAX TCA		**2,799,761**	
PEF TCA	BUCKLE	102,600	Scoped out by audit team
	CDC	223,000	Scoped out by audit team
	IBRD	431,173	Scoped out by audit team
	JSI	482,962	*In scope
	MAHA	140,433	Scoped out by audit team
	MMGH	55,716	Scoped out by audit team
	NOG	121,413	Scoped out by audit team
	PATH	581,851	*In scope
	PWC	12,786	Scoped out by audit team
	UNI OF OSLO	87,643	Scoped out by audit team
	UNICEF	1,185,934	Partially in scope^
	WHO	887,194	Partially in scope^
Sub-total PEF TCA		**4,312,705**	
Grand Total		**42,500,334**	

^Funds directly executed by UN agencies was not subject to our audit review, due to the UN single audit principle. See table 5 below for funds sub granted by WHO and UNICEF, expenditure reported and samples selected by audit team

**Funds received by Rocque, JSI and PATH were used to support various interventions. While the audit did not review specific expenditure at these implementers, detailed work was done on the review of programmatic activities undertaken at national and sampled regions.*

Table 7: Percentage of Gavi expenditure reviewed by the team

Recipient	Expenditure reported (USD)	Sample reviewed at National level (USD)	Sample reviewed at sub-national level (USD)	% of sample reviewed
Reported expenditure at GHS EPI, GHS HQ, MoH	24,678,991	1,593,826	970,250	10.3%
Funds sub-granted by UNICEF and WHO to government	2,165,447	403,837	29,404	20.1%
Total	**26,884,438**	**1,997,663**	**999,654**	***11%***

The audit focused on funds disbursed directly to the MoH, and funds sub-granted by WHO and UNICEF to MoH and to regional health directorates and the four sampled regions. In total, the transactions reviewed totalled ***USD 2,997,317*** and represented 11% of the reported expenditure at both the national level and at sub national level.

2.3 Audit approach

This programme audit was conducted in two phases, a one week in-country scoping visit between 22 and 26 September 2025, followed by three weeks fieldwork conducted between 03 and 21 November 2025. Overall, the audit team visited 1 Central Vaccine Store, 4 Regional Vaccine Stores, 7 District Vaccine Stores, 4 Regional Health Directorates, 7 District Health Directorates, and 14 Health Facilities.

See Annex 4 for the full list of sites visited by the audit team.

During this engagement, the team interacted with key stakeholders including: MoH, GHS HQ and the EPI teams, Gavi Alliance partners, expanded partners and CSOs.

2.4 Exchange rate

Most cash expenditures were incurred using the Ghana Cedi (GH¢), which, for reporting purposes, the transactions were converted to the United States Dollar (USD). For the expenditures reviewed, the rate applied was based on the average bank rate provided when the funds were converted from USD in the years 2020 to 2024.

Year	USD 1 = GH¢
2020	5.68
2021	6.05
2022	6.94
2023	11.03
2024	14.21

3. Background

3.1 Introduction

Ghana is located on the West Coast of Africa, bordering Burkina Faso to the north, Côte d'Ivoire to the west, and Togo to the east, with the Gulf of Guinea to its south. The national capital, Accra, is located in the Greater Accra Region of southern Ghana. The country has a total area of 238,533 km² and a tropical climate. Ghana's diverse geography spans coastal, forest and savanna zones, with distinct rainfall patterns. The south has a bimodal rainfall pattern (two wet seasons), while the north experiences a single, intense rainy season. Ghana has abundant natural resources such as gold, bauxite, diamonds, timber, manganese and oil, and it is the second-largest producer of cocoa in the world.

Administrative arrangements

Ghana operates a multi-party democratic system with a separation of powers across the executive, legislature and Judiciary. The president, elected by popular vote, serves as both the head of state and head of government and is the commander-in-chief of the armed forces. Administratively, Ghana is divided into 16 regions, each overseen by a Regional Minister appointed by the president. The regions are further subdivided into 261 districts managed by Metropolitan, Municipal and District Assemblies (MMDAs) with over 131,000 localities[1]. The local government system is decentralised, with assemblies operating as the primary units of grassroots administration. They function through elected assembly members and a network of urban, town, area, and unit committees.

Economy and demographics

The population of Ghana is estimated to be 33 million[2], with a birth cohort of around 1.3 million. This number is projected to increase to 37.2 million, and 52.5 million in 2030 and 2050 respectively, making strategic investment in healthcare and specifically in immunisation not just a social imperative, but a crucial factor for national stability and economic growth.

Ghana is classified as a lower-middle-income country, with a Gross National Income (GNI) per capita of roughly USD 2,300 and a GDP of approximately USD 75–80 billion in 2023. Ghana's Gross Domestic Product (GDP) in 2024 was approximately USD 82.8 billion with a Gross National Income of USD 79.7 billion. The projected nominal GDP for 2025 is USD 112 billion according to the International Monetary Fund (IMF). Health expenditure has increased gradually, from around USD 17 per capita in 2000 to about USD 85 in 2021 though expenditure remains below requirements for Universal Health Coverage (UHC) benchmarks. In 2021, Ghana was one of the countries that signed the Abuja declaration to allocate at least 15% of total government expenditure to health, and recently the Abidjan declaration of 2024.

The MoH budget, in nominal terms increased from GH¢ 15.3 billion in 2023 to GH¢ 15.6 billion in 2024. This represented an increase of 2% in nominal terms. However, adjusted for inflation, the MoH budget declined by 11.4% in real terms from 2023 to 2024. The 2024 budget allocated 6.3% of total government expenditure in health, down from 6.8% in 2023 and below the 15% of government expenditure targeted by the Abuja Declaration. [3]

3.2 Overview of Ghana's Healthcare System

Ghana's healthcare system is a blend of public and private sector services. The MoH and GHS lead the public sector, which is organised at the national, regional, district, sub-district, and community levels. Primary healthcare is delivered at the community, sub-district and district levels, with district health teams responsible for implementing immunisation and other primary health programs. The system also includes non-governmental organisations (NGOs) and community-based health workers and volunteers, who support implementation of immunisation and other primary health care services at the periphery including remote areas. Community-based Health Planning and Services (CHPS) approach[4] is the national strategy in addressing community levels service delivery gaps in access to quality health services at the community level. CHPS is equity-focused and has an implementation modality that has strong support of the government and development partners in the health sector. The CHPS is thus recognised as the lowest level of health service delivery in the health sector. The sub-district level comprises of health centers, which serve as the next referral level after CHPS and provide oversight.

[1] Ghana NIS, 2025-2030, draft 2
[2] Ghana Statistical Year Overview, 2024
[3] UNICEF Health Budget Brief 2024 report
[4] NIP, cMYP, 2020-2024

3.3 Immunisation in Ghana

The National Expanded Programme on Immunisation (EPI), a unit located within the Diseases Control Department (DCD) of the Public Health Division (PHD) of the GHS is responsible for the immunisation programme in Ghana. Ghana's EPI was launched in 1978 with six antigens (BCG, measles, diphtheria-pertussis-tetanus and oral polio for children under one year of age together with tetanus toxoid (TT) vaccination for pregnant women) as a direct response to WHO's call for childhood routine immunisation in 1974. The Programme currently vaccinates against 15 vaccine preventable diseases namely: tuberculosis, poliomyelitis, diphtheria, neonatal tetanus, whooping cough (pertussis), hepatitis B, haemophilus influenza type B, measles, rubella, yellow fever, rotavirus diarrhoea, pneumococcal, malaria (in 11 regions), covid 19 and meningococcal diseases. Refer to Annex 5a) for Ghana's immunisation schedule.

At the national level, the MoH maintains policy setting, planning, and coordination. Service delivery is done through the GHS. Immunisation services are integrated into the public health system and form part of overall child health care services at the regional, district and sub-district levels. However, at the national level, the child health department functions under the Family Health Division, of the same level as the Public Health Division.

The policy of decentralisation allows for autonomy at these levels in planning and budgeting for service delivery including immunisation services. At the regional level, the Regional Director for Health Services provides direction for the Programme whilst the Deputy Director for Public Health, with the support of the Regional EPI Coordinator, is responsible for the Programme management at the regional level. District Director for Health Services is responsible for Programme implementation at the district level. Sub-district and facility in-charges are responsible for EPI activities at the sub-district and facility levels respectively. Immunisation performance is an integral part of the performance assessment of health managers at all levels.

Ghana's EPI has contributed significantly to the reduction in neonatal, infant and under 5 mortalities. No measles related death was recorded from 2003 to 2021. Ghana has maintained its polio free status, with no Wild Polio Virus (WPV) reported since 2008. Furthermore, the country achieved elimination of maternal and neonatal tetanus in 2011. The country's WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC[5]) estimates were at 99% and 97% coverage for Diphtheria-Tetanus-Pertussis Containing Vaccine 1 (DTPCV1) and DTPCV3 in 2024 up from 94% in 2020 for the two antigens. Bacillus Calmette–Guérin (BCG) coverage increased from 93% in 2020 to 97% in 2023 and 2024 estimates were at 92% which showed a reduction. Inactivated Polio Vaccine 1 (IPV1) and Pneumococcal Conjugated Vaccine 3 (PCV3) coverage increased from 93% and 95% in 2020 to 95% and 96% in 2024 respectively. Rota virus vaccine coverage also declined from 89% in 2020 to 82% in 2024. The decline in Rota coverage is related to the global supply constraints of the Rotarix vaccine, which resulted in a forced switch to a different formulation of the vaccine – Rotavac.

3.4 Gavi's relationship with Ghana

The Republic of Ghana, through the Ministry of Health has received vaccines and cash-based support from Gavi since 2006 including through partners. Cash support for the period 2020 – 2024 totalled USD 17.62million including funding for technical assistance. Ghana also received vaccine support of USD 76.29 million for IPV, Pentavalent, MR, Malaria, Men-A, OCV, Rotavirus, Yellow Fever and PCV Vaccines, and USD 0.53 million for equipment support.

At the national level, the MoH maintains policy setting, planning, coordination. Service delivery is done through the Ghana Health Service. The National Expanded Programme on Immunisation (EPI), a unit located within the Diseases Control Department (DCD) of the Public Health Division (PHD) of the Ghana Health Service is responsible for the immunisation programme in Ghana.

Financial support from Gavi is managed through performance-based grants and targeted technical programs to ensure accountability and effectiveness in reaching immunisation goals.

3.5 Entities involved in executing and managing Gavi grants

Gavi employs the direct support method of funding where funds are disbursed to GHS at the National level into a pooled commercial bank account. Funds are subsequently disbursed to the sub-national levels, who also maintain pooled bank accounts with commercial banks, for implementation. This method strengthens existing government systems and there are also minimal delays in disbursement of funds as compared to direct support through Ministry of Health or budget support through Ministry of Finance and Economic Planning. During the audit period, Gavi also disbursed funds to

[5] WUENIC data (2020-2024)

Gavi also disburses technical assistance and HSS funds through Alliance partners WHO, UNICEF and extended partners including PATH International, John Snow Inc. (JSI) and Roque Advisory. The MoH through EPI oversees and coordinates all immunisation activities while WHO, UNICEF, PATH, JSI and Rocque Advisory provide technical expertise, policy guidance, programme monitoring, vaccine rollout support, logistics and health system strengthening. The MoH also has a memorandum of understanding with the Ghana Coalition of NGOs in Health which plays a crucial role in community engagement, outreach, awareness raising and reaching underserved populations.

3.6 Progress on previous audit recommendations

Gavi conducted its second programme audit in Ghana in 2019 which focused on budgeting and financial management, vaccine supply management, procurement and immunisation data quality and use. A total of 12 recommendations were raised by the audit team. This audit corroborated whenever possible on the ongoing recommendations, with some outstanding recommendations from the previous audit superseded by recommendations articulated in the present audit report and others maintained for follow-up (see Annex 18). This is because this audit has considered the current country context, as the country is now in accelerated transition phase, to provide updated recommendations.

3.7 Good Practices

The audit team takes note of the following good practices:

- **Political commitment for immunisation financing:** Ghana's Universal Health Coverage (UHC) Roadmap (2020–2030) commits the National Health Insurance Scheme (NHIS) to allocate at least 50% of resources to Primary Health Care (PHC) by 2025. In 2025, the government significantly increased NHIS funding, with Parliament approving GH¢ 10.7 billion — representing a 66% increase from GH¢ 5.8 billion in 2024. This increase resulted from the government uncapping the National Health Insurance Levy and creating new opportunities for sustainable immunisation financing. The opportunities need to be leveraged to address gaps noted in issue 4.2.1
- **Documented transition roadmap:** A transition roadmap has been developed to guide advocacy and strategy, including identified funding gaps in immunisation. A monitoring and evaluation plan is also in place to track the implementation of the transition plan. See opportunity for improvement noted in issue 4.2.1
- **Immunisation governance and oversight:** Governance structures, including the Health Sector Working Group (HSWG) and National Immunisation Technical Advisory Group (NITAG), were active during the audit period. However, some opportunities for improvement were noted in issue 4.1.1
- **National Immunisation Strategy (NIS):** The country developed a National Immunisation Strategy (2025–2030) following the 2020–2024 Comprehensive Multi-Year Planning (cMYP). The NIS is well-aligned with the Immunisation Agenda 2030 (IA2030) requirements. The NIS requires enhancement as noted in issue 4.2.2
- **Cold chain infrastructure and management:** More sizeable walk-in cold rooms (80m^3) have been installed at regional levels to compensate for the deficit at the National Cold Room. Trained cold-chain management teams were in place at national and regional vaccine stores. Routine Temperature Monitoring Devices (RTMDs) were installed in national and regional cold rooms. Functional cold-chain transportation systems existed at all levels, including refrigerated trucks at regional level and vaccine carriers and cold boxes at district and lower levels.
- **Vaccine supply management:** EPI logisticians had enhanced visibility of the vaccine order pipeline through Thrive 360, a UNICEF application, coupled with electronic Vaccine Arrival Reports (e-VAR) at the national cold room. An automated stock quantification tool was used for vaccine ordering at sub-national levels, ensuring adherence to minimum and maximum stock levels at regional and district levels. However, improvements are required as noted in issue 4.5.1
- **Vaccine Preventable Diseases (VPD) surveillance:** VPD surveillance was well established across all levels. The country launched comprehensive Integrated Disease Surveillance and Response (IDSR) guidelines in 2020. All regions visited had a VPD surveillance focal person with access to the Surveillance Outbreak Response Management and Analysis System (SORMAS) for case-based reporting. DHDs also had VPD focal persons and surveillance guidelines. The focal persons received formal training to perform their roles effectively. However, some significant gaps remain as noted in issue 4.2.4
- **Digital information systems:** Ghana's national logistics management information system (GhiLMIS) demonstrates strong system governance and its support is provided through regional and district WhatsApp groups that provide real time issue escalation and basic system trouble shooting from peers and focal persons. The system also has an inbuilt AI chatbot for user support that can be accessed on the system menu and provides a conversational stepwise guide. Improvements required are noted in issue 4.3.1

4. Audit issues

4.1 Governance and oversight

4.1.1 Governance and oversight mechanisms over the immunisation programme need strengthening

Context and Criteria

Gavi recognises Coordination Forums (typically the Inter-agency Coordinating Committee (ICC) or equivalent) as the primary mechanism for providing strategic direction, oversight, and transparency for the Expanded Programme on Immunisation (EPI) within the broader health system. According to the Gavi Alliance Guidance on Country Coordination Forums (*Version 1.0 – November 2016*), Coordination Forums are expected to ensure a coherent view of EPI strategy, financing, performance, and sustainability, and to promote strong linkages between immunisation and wider health sector planning and financing.

The guidance sets out explicit requirements and recommendations covering:

- the mandate of Coordination Forums across strategic planning, programme financing, coordination, operational planning and performance oversight, and information dissemination;
- governance arrangements, including the existence of formal Terms of Reference (ToRs), leadership at senior Ministry of Health (MoH) level, meeting frequency, documentation, decision-making procedures, and secretariat support; and
- linkages with broader health sector coordination platforms, recommending strong functional relationships between the ICC and the health sector coordination forum (HSCC/HSWG), including escalation of critical issues and alignment of priorities.

Complementing this, the WHO Guidelines on Interagency Coordinating Committees (2022) provide guidance on the design, functionality, and sustainability of ICCs. While the WHO guidelines are not prescriptive, they explicitly emphasise that ICC guidance is intended to be adapted to country context, formalised through country-specific ToRs and standard operating procedures, and institutionalised through national governance arrangements rather than applied as generic global guidance.

In Ghana, governance and oversight of the EPI is exercised through three main bodies: the ICC, the National Immunisation Technical Advisory Group (NITAG), and the Health Sector Working Group (HSWG). The ICC was established in 1998 as the national immunisation coordination forum. NITAG, established on 16 May 2018, provides independent technical and scientific advice on vaccines and immunisation in accordance with its Internal Procedures Manual (adopted in May 2021). The HSWG, led by the MoH and chaired by the Minister for Health or delegated deputy ministers, serves as the principal sector-wide platform for coordination and oversight of the health sector.

Condition

The HSWG did not provide adequate oversight over the routine immunisation programme: Although the group was active during the audit period—holding 18 meetings between 2020 and 2024—review of the minutes showed no evidence that routine immunisation governance issues were systematically addressed at the sector level. Key areas identified in Gavi guidance as core responsibilities of Coordination Forums, such as programme financing, transition planning, grant performance, partner coordination, and performance oversight, were not reflected as agenda items or discussion points in HSWG meetings.

From 2020 to 2022, HSWG discussions focused largely on Covid-19, which was expected during the pandemic. However, there was no indication that routine immunisation was reinstated as a standing priority for sector-level oversight after this period. This gap weakened governance of the programme during a critical phase of accelerated transition.

ICC governance arrangements were not sufficiently formalised. The audit found that the ICC operated without formal Terms of Reference (ToRs), relying instead on the WHO ICC Guidelines (June 2022), which had not been adapted to the Ghana context. The Gavi Technical Working Group (TWG), established in 2023, also operated without ToRs. In addition, the ICC did not meet with the expected frequency and lacked adequate documentation. Gavi and WHO guidance recommends that ICCs meet at least four times per year and that meetings be scheduled in advance. However, only six ICC meeting minutes were provided for our review for the period January 2020 and December 2024, compared with the 20 quarterly meetings expected. Also, some minutes also referenced earlier meetings for which documentation could not be provided, denoting a gap in documentation and archival of meeting minutes.

NITAG's mandate was not consistently upheld. Although NITAG was active during the audit period, with evidence of 13 meetings held, review of meeting minutes showed that several agenda items focused on programmatic updates, operational briefings, and campaign implementation matters—areas more aligned with ICC responsibilities than with NITAG's technical advisory role, thus affecting their independent role. Gavi guidance differentiates between strategic coordination bodies and technical advisory groups and emphasises the need for clear structures to ensure that operational issues are escalated appropriately to maintain the independence of the advisory governance structure. Also, NITAG's membership expired in 2024 and had not been formally reconstituted in line with its Internal Procedures Manual. As a result, the committee was nonfunctional during the audit fieldwork, creating a gap in the country's national technical advisory capacity for immunisation.

Coordination and follow-up within governance structures was weak. There was no evidence of structured escalation or systematic review of decisions across the ICC, NITAG, and HSWG. None of these bodies maintained dashboards or action-tracking mechanisms to monitor progress, nor did they include standing agenda items to review the status of previous decisions. At the sub-national level, similar gaps were observed, with no systematic follow-up of action points at either regional or district level.

Recommendation 1

To strengthen governance and oversight over programme management, MoH and GHS management should:

- Develop country-specific ToRs for ICC, HSWG, and Gavi TWG. These can be aligned with WHO guidelines but tailored to local systems. The ToRs should be endorsed and disseminated to all members.
- Reconfirm the ICC leadership structure per WHO guidance. The Minister or Chief Director should be the chair, with designated alternates at MoH director level. The ToRs should include expectations of MoH leadership attendance.
- Reconstitute the NITAG Immediately by accelerating the formal selection/renewal process as prescribed by the IPM. The distinction between NITAG and ICC roles should also be reinforced by the Secretariat.
- Develop and enforce structured agendas for the ICC and HSWG meetings that include updates on grant performance, transition roadmap, NITAG recommendations and routine immunisation performance.
- Introduce a standing agenda item for reviewing decisions from previous meetings. The responsibility for tracking action points should be assigned to a designated secretariat officer.

Root Causes

- Insufficient formalisation of governance arrangements, including the absence of country-specific ToRs for the ICC, HSWG, and TWG, resulting in unclear mandates, leadership expectations, meeting discipline, and follow-up mechanisms.
- Weak escalation and linkage mechanisms between immunisation coordination and sector-wide oversight, leading to routine immunisation not being systematically elevated to the HSWG for strategic discussion and accountability.
- Limited secretariat capacity and governance discipline, affecting meeting scheduling, documentation, and tracking of decisions.
- Lack of clear ownership and forward planning for NITAG reconstitution, resulting in a lapse of the technical advisory function.

Management comments

See detailed management responses in Annex 19

• Inconsistent implementation of governance practices at sub-national level, including meeting regularity and action follow-up.		
Risk / Impact / Implications • Strategic oversight and accountability for routine immunisation, including transition readiness, programme financing, and grant performance, prioritisation broader health sector context to ensure alignment with national planning and financing processes were weakened. As such, the immunisation may not be well prepared for transition from a governance perspective. • The independence, continuity, and focus of technical immunisation advice were placed at risk. • Decision-making and implementation follow-through were compromised due to infrequent meetings, limited senior leadership engagement, and absence of action tracking.	Responsibility See detailed management responses in Annex 19	Deadline / Timetable See detailed management responses in Annex 19

4.2 Programme management

4.2.1 Operationalisation of the transition roadmap has been delayed

Context and Criteria

Under Gavi's Eligibility and Transition Policy, countries become eligible for Gavi support if their most recent gross national income (GNI) per capita was less than or equal to the eligibility threshold (according to the latest World Bank data published in July each year). The threshold for eligibility for Gavi support was US$ 1,730 GNI per capita in 2023 and this threshold is adjusted for inflation on an annual basis.

A Gavi-eligible country enters the accelerated transition phase when its three-year average GNI per capita as well as its most recent GNI per capita are above the eligibility threshold, and the country is co-financing at least 35% of vaccine costs. The duration of the accelerated transition phase is eight years, during which period the country remains eligible to apply for new vaccine support in any year.

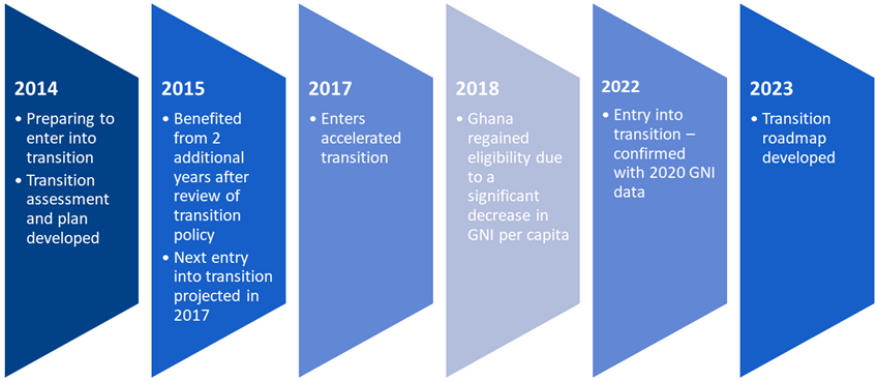
Countries entering the accelerated transition phase are expected to progressively assume full financial and programmatic responsibility for their immunisation programmes through early, government-owned transition planning and execution. This includes the development, endorsement, and operationalisation of a transition roadmap addressing financing, governance, service delivery, and monitoring, well in advance of the transition deadline. Accurate population estimates are a critical input to vaccine forecasting, financing, and transition planning, and material changes in target populations are expected to be reflected in national plans and financing projections. Ghana entered the accelerated transition phase in January 2022 and is expected to become fully self-financing by 2030. Ghana therefore had four years (at time of audit field work) remaining in which it is eligible to access new vaccine support, provided that such support strengthens routine immunisation and improves coverage and equity.

Gavi's co-financing policy further requires governments to meet annual vaccine co-financing obligations in full and on time to minimise risks of vaccines stockout, with settlements expected by 31 December (or by end of country fiscal year if agreed with country).

Condition

The figure below shows Ghana's history along the Gavi transition continuum.

Figure 1: Ghana's progression towards transition in the last decade



Recommendation 2

To adequately prepare for transition, the Ministry of Health should:

- Review and update the transition roadmap to reflect current realities, including revised population estimates, feasibility-based costing, and prioritisation of activities aligned to the remaining accelerated transition period. Ensure that the updated roadmap is aligned with the National Immunisation Strategy.
- Formally endorse the revised transition roadmap to establish clear government ownership and accountability.
- Operationalise governance arrangements for the transition by strengthening oversight through existing structures, including the Health Sector Working Group (HSWG), ICC,

The transition roadmap was not endorsed or operationalised**:* Although a transition roadmap for 2024–2029 was developed in 2023, it was not endorsed by the Minister of Health or the Government, and none of the planned activities for 2024 were implemented. At the time of the audit, the 2025 workplan had also not been approved. As a result, several critical transition-related actions remained outstanding, including: • increasing operational expenditure for non-core immunisation functions (including human resources); • optimising governance structures; • finalising the pneumococcal conjugate vaccine (PCV) switch; • preparing a costed plan for cold chain maintenance and expansion beyond approved CCEOP support; and • assessing vaccine procurement options for the post-transition period. ***Governance arrangements for overseeing transition implementation were weak*:** A transition steering committee was established in 2023 to oversee implementation of the transition roadmap. However, only one meeting was held—in February 2025—and planned meetings for the second and third quarters of 2025 did not take place. There was no evidence of systematic follow-up on agreed actions or monitoring of progress against transition milestones. Implementation of the transition roadmap was also heavily dependent on individual personnel rather than institutionalised processes, and was therefore impacted by changes in senior leadership. ***The transition roadmap was not updated to reflect the revised population assumptions: In 2025, Ghana revised its estimated birth cohort upward by approximately 30%, from 900,000 to 1.2 million. However, financing projections within the transition roadmap had not been updated to reflect this change. Given the direct link between population estimates and vaccine financing requirements, this limits the reliability of the roadmap as a planning and budgeting tool. ***Co-financing obligations were late***: Ghana has a history of co-financing defaults prior to 2020 (in 2013, 2014, 2016, and 2018). During the current audit period, although annual co-financing obligations were eventually met, payments were consistently delayed. In 2024, only 36% of the obligation had been paid by March, rising to 60% by September and 97% by October. UNICEF requires a 3 to 6 months window from payment to delivery of vaccines to the country. This means that 2024, vaccines were delivered late, in 2025, due to late payment. requiring Gavi to advance its 2025 contribution to prevent vaccine stockouts. In 2025, 70% of obligations were met by July and full settlement achieved by September. These delays were compounded by adverse macroeconomic conditions, particularly significant depreciation of the Ghanaian cedi against the US dollar. As vaccine procurement is denominated in USD while national budgets are approved in local currency, additional budgetary approvals were required to cover exchange-rate losses, further contributing to settlement delays. ***Readiness for transition remains weak across several key pillars*:** The audit's assessment of Ghana's transition readiness across seven pillars rated governance, financing, and service delivery as red, indicating that critical systems or controls are either absent or not functioning effectively. Transition planning, financial management, and programme performance were rated orange, reflecting partial readiness with significant gaps requiring corrective action. (For this assessment, a three-point scale was applied: green—minimum readiness criteria met and systems functioning adequately; orange—partial readiness with major deficiencies; and red—low readiness where essential systems are not in place or are ineffective.) See table below:	and the proposed EPI Technical Working Group (TWG). Clearly define roles, reporting lines, and decision-making responsibilities, and avoid establishing parallel governance bodies to manage the transition. Ensure regular meetings and systematic tracking of progress against agreed milestones. • Integrate transition financing requirements into national budget planning processes to improve the timeliness and predictability of co-financing settlements. Use the updated transition roadmap to inform medium-term financing discussions and mitigate risks associated with late payments during the transition period. • Develop a focused advocacy plan to address funding gaps and sustain political commitment to immunisation during and beyond the transition period. The advocacy strategy should leverage the endorsed transition roadmap and align with broader health sector financing discussions to support increased and predictable domestic resource allocation for immunisation.

Table 8: Summary of Ghana's transition readiness assessment

Area	Score
Transition assessment and planning	🟡
Governance	🔴
Financial management and use of country systems	🟡
Programme performance	🟡
Financing	🔴
Service delivery	🔴

The detailed assessment is presented under annex 6.

***Commitments to increased health and immunisation financing have not translated into improved prioritisation*:** Although Ghana has articulated multiple commitments to increased health spending (including under the Abuja and Abidjan declarations and the Universal Health Care Roadmap), domestic allocation to immunisation remains low relative to comparable countries. While Ghana's GNI grew significantly between 2015 and 2025, immunisation expenditure remained at approximately 1.5% of health spending, compared to over 2% in peer countries.

Root Cause

- Weak government ownership and institutional continuity leading the transition agenda, resulting in delayed endorsement and limited operationalisation of the transition roadmap.
- Insufficient governance arrangements to drive execution, including an underutilised steering committee and lack of systematic monitoring of transition milestones. This was also weakened due to changes in leadership for example, within a 12-month period, the Ministry of Health experienced multiple changes in the Minister, Deputy Minister, and Chief Director, while the Ghana Health Service and the EPI also underwent changes in the Director General and EPI Manager within a six-month period. These leadership transitions resulted in repeated re-orientation, shifting priorities, and interruptions to planning and execution of transition activities, weakening continuity of advocacy and reform momentum.
- Weak integration of transition planning into national budgeting and financing processes, combined by weakening of the currency affected the predictability and timeliness of co-financing.
- Limited use of the transition roadmap as a dynamic planning instrument, with slow adjustment to changes in population and cost assumptions.

Management comments

See detailed management responses in Annex 19

Risk / Impact / Implications

If not addressed, these weaknesses increase the risk that:

- Ghana will enter full self-financing without having achieved key transition milestones;
- immunisation financing will remain unpredictable, increasing the likelihood of vaccine supply disruptions (see finding 4.5.1);
- programme performance and coverage gains may stall or regress during the transition period; and
- the remaining accelerated transition window will be insufficient to correct structural weaknesses.

Responsibility

See detailed management responses in Annex 19

Deadline / Timetable

See detailed management responses in Annex 19

4.2.2 Strategic and operational planning processes need to be improved

Context and Criteria

Effective immunisation programming requires coherent strategic planning, translated into costed annual operational plans and sub-national micro plans, with regular review of implementation progress and resourcing. As Ghana moves towards full domestic financing for immunisation, planning processes must support prioritisation, resource allocation, targeted interventions to address inequities, and timely implementation of programme activities.

To strengthen planning and coordination, Gavi and partners have adopted the National Immunisation Strategy (NIS) framework, which sets a five-year strategic direction for immunisation and should be translated into annual operational plans and monitoring arrangements.

A study on routine immunisation coverage published in 2025[6] highlights significant disparities in vaccination coverage between urban and rural areas and across regions. Targeted interventions are needed to address gaps in coverage, particularly in urban areas where full vaccination rates remain lower. Without robust planning processes there is no way to ensure targeted interventions.

Condition

***National Immunisation Strategy (NIS) 2025-2030 was not endorsed*:** The NIS development was commissioned by WHO in 2024, however, this was still work-in-progress at the time of the audit in November 2025 owing to several technical and administrative delays. As a result, it could not serve as the authoritative framework for guiding annual operational planning, prioritisation, and performance monitoring during its first year.

Operational planning at national level was weak and not consistently linked to strategic objectives and targeting: The audit noted the following weaknesses in annual work planning:

- no standard template for workplans;
- workplans did not clearly link activities to programme objectives and strategies;
- there was no evidence of quarterly review and update of annual workplan implementation status; and
- workplans did not consistently indicate budgets, funding sources, or available funding for each activity.

In addition, the EPI was unable to provide evidence of how targeting for key programme activities (such as outreach and supportive supervision) was determined and reflected in annual plans. See issue 4.2.6 in this report for detailed issue on supportive supervision.

***Microplanning at sub-national level was not done*:** The programme did not develop routine immunisation (RI) micro plans at sub-national levels during the audit period. The absence of these planning documents limited the programme's ability to systematically guide implementation, monitor performance, and tailor interventions to local coverage gaps and operational constraints.

***Annual programme reviews did not translate into a documented improvement plan, resulting in recurring unresolved issues*:** Although annual EPI reviews were conducted and generated action points, these were not followed through via a documented improvement plan with clear timelines, prioritisation, identified funding sources, and assigned responsibilities. As a result, the audit noted repeated challenges across consecutive reviews, including:

- Data coverage, equitable coverage, accurate population targets (identified in 2021,2022,2023)
- High number of Under Immunised (UI) in urban/peri-urban and hard to reach areas (identified in 2022,2023)

Recommendation 3

To strengthen programme planning and prevent recurrent implementation gaps, MoH/EPI should:

- Finalise and endorse the NIS 2025–2030, including confirmation of the implementation timeframe and planned operationalisation period, and use it as the authoritative basis for annual operational planning and monitoring.
- Standardise operational planning processes by establishing structured, comprehensive annual workplans using a standard template, with clear linkage to NIS objectives and strategies.
- Cost annual plans by developing an annual prioritised schedule of EPI activities and associated resource requirements, including budgets and funding sources for each activity. Funding for immunisation activities should be discussed at ICC and HSWG to ensure adequate resource mobilisation beyond Gavi funds.
- Institutionalise periodic review of implementation by mandating quarterly reviews of workplan progress and constraints,

[6] Routine immunisation coverage in under 24 months in Eastern Ghana

- Under reporting and delays in reporting Adverse Event Following Immunisation (AEFI) (identified in 2022,2023)
- Incomplete investigation of AEFI (identified in 2022,2023)
- Data quality audits not done (identified in 2022,2023).

This limited the programme's ability to systematically address persistent weaknesses and sustain progress toward coverage and quality targets.

***Delays in transfer of funds for campaigns to sub-national levels*:** During the period, the MoH and EPI together organised 9 vaccination campaigns for IPV, YF, Cholera, MR and Polio. The audit team noted several instances where funds to facilitate the campaign activities were transferred to the subnational level days past the end date of the campaign. For example, for YF phase II campaign that took place on 26 Feb 2022, funds were received by GHS on 22 March 2022 and the first disbursements to the regions were done on 04 April 2022.

Table 9: Delays in transfer of campaign funds to sub-national levels

Campaign	Dates of campaign	Date of first transfers to regions	Days past activity
YF - phase I	17-Dec-21	23-Dec-21	6
YF - phase II	26-Feb-22	04-Apr-22	37
		17-Mar-22	19
Polio - round II	14 - 17 Nov 2025	19-Nov-24	2
Cholera - phase I	29-Nov-24	10-Mar-25	101

led by the EPI TWG and aligned to immunisation governance arrangements.

- Strengthen targeting and microplanning by ensuring that sub-national RI micro plans are developed, reviewed, and used to guide targeted outreach and supportive supervision.
- Strengthen implementation continuity by reviewing and updating GHS/EPI job descriptions to confirm a new EPI manager, allocate clear responsibilities for planning, monitoring, and follow-up; and completing an MoH HR assessment to ensure core roles are staffed as Ghana prepares to manage immunisation fully post-transition.
- Improve timeliness of campaign fund transfers by strengthening campaign financial workflows and timelines so funds reach sub-national levels before or during campaign implementation, to avoid post-campaign disbursements.

Root Cause

- Delays in administrative and internal processes within MoH/GHS/EPI affecting endorsement, planning finalisation, and execution.
- Plans not consistently costed, limiting implementation where funding was not clearly identified at activity level. Also, the programme remains reliant on Gavi funding for immunisation activities. This means that activities not funded through Gavi grants are often delayed or postponed due to insufficient funding. For example, disbursements for campaigns noted above were delayed (between 30 and 90 days) because the funds were often received late.
- Gaps in governance and accountability mechanisms, including limited routine review of annual plans and implementation progress; and the absence of an effective governance mechanism function to perform this role. See issue on Governance and oversight 4.1.1
- Capacity and role clarity constraints, including incomplete job descriptions and lack of dedicated time for staff to undertake strategic planning, monitoring, and follow-up. At national level, the EPI manager is in an acting role and all seven staff are often engaged in field activities, leaving less room for strategic and operational planning and follow-up.
- Campaigns by nature lead to intermittent disruption of routine immunisation planning and monitoring, as the same national and sub-national personnel are required for both campaign preparation (often over 3–6 months) and routine immunisation performance monitoring.

Management comments

See detailed management responses in Annex 19

Risk / Impact / Implications	Responsibility	Deadline / Timetable
• Delays in finalising the NIS could lead to: ○ Strategic misalignment: Country-level priorities risk being misaligned with Gavi Leap's strategic vision for future Gavi funding, potentially undermining strategic planning and related operational planning during the Gavi 6.0 period. ○ Impact on performance monitoring: If the NIS is endorsed late—reaching its midpoint before approval—it will compromise timely performance monitoring and the ability to measure progress within the intended timeframe. • Delays in operational planning have several implications including: ○ Delays in critical programme activities as already experienced - including the IPV2 introduction was supposed to be done in early 2024 but was eventually concluded in February 2025, HepB vaccine application was delayed since early 2025 and was not completed at the time of the audit, delays in the EPI coverage survey from 2023 to 2025. ○ Inadequate allocation of funds to critical activities leading to delays for example the EPI coverage survey which was supposed to be done in 2023 was not done due to inadequate funding, it was thus reprioritised until Gavi funded the activity in 2025. This has created a missed opportunity to have good data for decision making see finding on data 4.4.1 for more details. ○ Weaknesses in operational planning impact mobilisation of funds – see issue on VPD surveillance 4.2.4 highlighting stock outs of lab reagents and issue 4.5.1 on vaccine shortages. ○ Failure to address known challenges in routine immunisation, for example routine measles programming leading to increase in measles incidence see finding 4.2.3 on measles.	See detailed management responses in Annex 19	See detailed management responses in Annex 19

4.2.3 National response to growing incidence of measles cases should be intensified

Context and Criteria

In 2011, Ghana as part of the 46 WHO African Region (AFRO) countries, signed on to the WHO-AFRO regional measles (and rubella) elimination goal by 2020. Based on the regional strategy, Ghana sought to achieve:

- ≥95% coverage with 2 doses of measles-containing vaccine (MCV) at national and district levels through routine and supplementary immunisation activities (SIAs).
- Confirmed measles incidence of < 1 case in 1 million population.
- No Congenital Rubella Syndrome (CRS) through endemic transmission.
- Case-based surveillance systems that meet performance indicator target.

Despite not reaching the 2020 elimination goal, the implementation of the elimination strategies substantially reduced measles morbidity and mortality.

The renewed commitment through the Measles and Rubella (MR) Strategic Framework 2021- 2030 is to see a world free from measles and rubella. The goal is to achieve and sustain the regional measles and rubella elimination goals by 2030. Based on the goal of the framework, Ghana seeks to ensure:

- No indigenous measles cases for at least 12 months within a functional surveillance system.
- No CRS cases associated with endemic transmission for at least 12 months within a functional surveillance system.

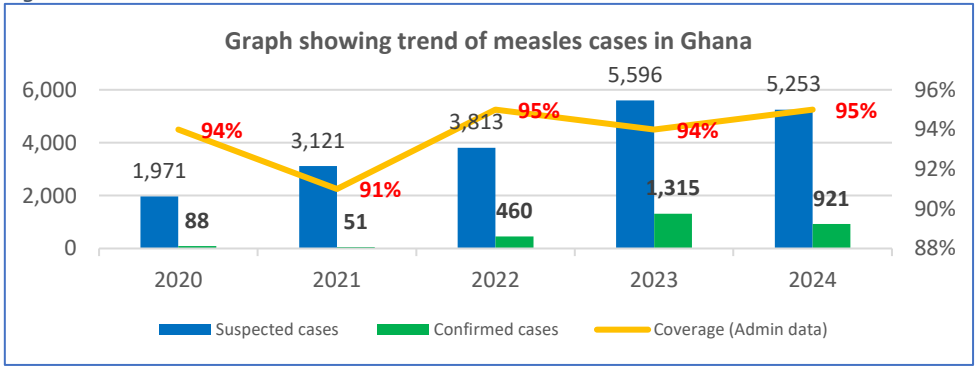
To achieve these, it is required that the country achieve less than one confirmed case per 1,000,000 population in a year. Specifically, Ghana seeks to:

1. Achieve and sustain at least 95% for measles-rubella vaccination for 1st and 2nd doses at national and district levels.
2. Achieve at least 95% MR SIAs coverage levels in all districts and nationwide.
3. Achieve the measles surveillance performance targets.
4. Achieve the CRS surveillance performance targets.

Condition

There is an increasing trend of measles cases: Though Ghana has been working towards achieving Measles and Congenital Rubella Syndrome (CRS) elimination, with no measles deaths between 2018 and 2020, confirmed cases have recorded increasing trends since 2021 after the last Supplemental Immunisation Activity (SIA) in 2018. Measles cases have had more than a tenfold increase from 88 in 2020 to over 1,300 in 2023 and 971 confirmed cases in 2024. See graph below:

Figure 2: Measles cases in Ghana



Recommendation 4

To reduce the surge in the number of measles cases in the Country, MoH/EPI should:

- Ensure routine immunisation services consistently reach children at the recommended ages (9 and 18 months) and prioritise follow-up of those who missed doses through facility-based and outreach sessions.
- Expand outreach to underserved populations, including urban poor, ethnic minorities, migrants, and border communities, by deploying mobile teams and integrating vaccination with other health services including work done by the CSOs.
- Intensify health education and community engagement, implementing targeted communication campaigns to address vaccine

***Population immunity remains insufficient to prevent transmission*:** Although administrative coverage indicates improvement in MR1 and MR2 coverage (from 94% and 84% in 2020 to 95% and 92% in 2024), the data indicates that population immunity remains insufficient to interrupt transmission, particularly where coverage gaps persist below the herd immunity threshold. The comparison between administrative coverage and WUENIC estimates further indicates uncertainty and potential overestimation in administrative coverage data.

Table 10: Immunisation coverage (2020-2024)

	2020	2021	2022	2023	2024
MR 1st dose					
WUENIC	88	94	95	90	90
Admin data	94	98	96	90	95
MR 2nd dose					
WUENIC	79	83	84	78	79
Admin data	84	88	87	84	92

***Weaknesses in surveillance testing and confirmation process*:** During the period, suspected measles cases more than doubled (from 1,971 to 5,253). Although increase in number of suspected cases could imply good sensitivity in the surveillances system, the audit identified weaknesses in testing of samples with 78% of samples in 2024 not tested.

According to the data from SORMAS, only 22% of samples collected from measles suspected cases in 2024 were tested (27% in 2023 and 33% in 2022). See table below:

Table 11: number of suspected cases versus number investigated (data from SORMAS)

	2022	2023	2024
Total suspected cases	2,877	5,365	5,149
Number investigated	948	1,437	1,131
% investigated	33%	27%	22%

The audit also identified severe delays between when samples are collected versus when investigation is done (cases of >30 days). See additional details under finding 4.2.4. This indicates that most suspected cases did not receive laboratory confirmation in a timely manner, limiting the effectiveness of outbreak detection and response

***Nation-wide MR campaign did not achieve its coverage target*:** The 2024 MR vaccination and Vitamin A Supplementation Follow-up campaign (conducted from 2nd to 6th October 2024) for children 9 to 59 months provided an opportunity for the under-immunised and missed-out populations to be reached to boost population immunity as well as provide additional protection to those already vaccinated. Measles coverage survey after MR national campaign reveals a coverage of 84%. This was well below the target of 97%.

hesitancy, reinforce the benefits of complete vaccination, and counter misinformation.

- Strengthen VPD surveillance systems (as detailed in Section 4.2.4) to ensure rapid case detection, reporting, and outbreak investigation, enabling early response and containment.
- Train health personnel in active case finding, outbreak investigation, and micro-planning to improve field response and surveillance sensitivity.

<table>
<tr><td>Root Cause
• Persistent immunity gaps, including reduced or disrupted routine immunisation services during and after the COVID-19 period, combined with incomplete catch-up, leaving pockets of unvaccinated or under-immunised children.
• Vaccine availability constraints, including reported severe stockouts of MR vaccines in Q4 2022 and Q1 2023, which likely disrupted routine vaccination and contributed to immunity gaps.
• Weaknesses in surveillance confirmation, including limited testing of collected samples, reducing timely confirmation and delaying outbreak response.
• Cross-border transmission risk, with outbreaks in neighbouring countries increasing the likelihood of importation and onward transmission, particularly where local immunity is inadequate.</td><td colspan="2">Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
• Further increases in measles transmission and associated morbidity and mortality, particularly among unvaccinated children and vulnerable populations, if herd immunity thresholds are not achieved and sustained.
• Delayed detection and response to outbreaks, as low laboratory testing rates reduce timely confirmation and may allow community transmission before response measures are activated.
• Increased reliance on repeated campaigns to manage outbreaks, which is resource-intensive and may divert funds and staff time away from strengthening routine immunisation—particularly relevant in the context of transition away from external support.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.2.4 Improvements are needed in the Vaccine preventable disease (VPD) surveillance system and processes

Context and Criteria

Surveillance for vaccine-preventable diseases (VPDs) is a core component of public health surveillance, involving the continuous and systematic collection, analysis, interpretation, and dissemination of health data to inform public health action. Effective VPD surveillance enables early detection of outbreaks, timely investigation and response, monitoring of programme performance, and optimisation of vaccine use.

The Ghana National Immunisation Strategy (NIS) 2025–2030 identifies outbreaks and emergencies as a strategic priority, with a focus on strengthening the country's capacity to detect, respond to, and manage VPD outbreaks, and to ensure continuity of immunisation services during crises. Key strategic objectives include preparedness for rapid detection and high-quality response to VPD outbreaks and establishment of coordinated emergency response systems.

WHO guidance further positions community-based surveillance (CBS) as a critical complement to facility-based surveillance, particularly for early detection of outbreaks, events in hard-to-reach populations, and conditions where individuals may not present promptly to health facilities. CBS should be integrated into the formal surveillance system and aligned with Integrated Disease Surveillance and Response (IDSR) and International Health Regulations (IHR) core capacities.

In Ghana, VPD surveillance is implemented through the IDSR system, supported by facility-based reporting, community-based volunteers, laboratory confirmation, and electronic case management through the Surveillance Outbreak Response Management and Analysis System (SORMAS). District Surveillance Officers (DSOs) are responsible for case investigation, sample collection and transport, and initial data entry, while laboratory testing is conducted at designated reference laboratories, with results entered into SORMAS and communicated to relevant levels, including EPI.

Condition

Ghana has an Integrated Disease Surveillance and Reporting (IDSR) process in place and guidelines which were available across all facilities and levels including availability of case investigation forms for recording surveillance cases. However, the audit identified weaknesses that affect the sensitivity, timeliness, and reliability of VPD surveillance:

***Weaknesses of case detection at community level*:** Case identification relied predominantly on facility-based consultations, with limited evidence of active community-based surveillance. The audit found no evidence of recent training or systematic engagement of community-based surveillance volunteers to identify and report VPD cases at community level, limiting early detection, particularly in hard-to-reach areas.

***Incomplete and inaccurate data entries in* SORMAS:** SORMAS is used nationally to capture key surveillance variables, including immunisation status, dates of case identification, investigation, sample collection, laboratory receipt, testing, and results. However, the audit identified significant data quality issues, including:

- mandatory fields (such as immunisation status) not completed as required under IDSR;
- inconsistencies where dates of investigation preceded dates of case identification;
- duplicate case identification numbers, creating confusion in result reporting; and
- missing or incomplete entries following laboratory investigation at the National Public Health Research Laboratory (NPHRL).

The auditors also noted instances of missing information/entries after investigation was concluded by the National public health research laboratory (NPHRL). Refer to table below for details

Recommendation 5

To strengthen VPD surveillance performance, timeliness, and coverage, the MoH/GHS should:

- Strengthen coordination between EPI and the Disease Surveillance Department, including routine data sharing, joint analysis of VPD trends, and establishment of a regular forum or TWG to monitor surveillance indicators and follow up on actions.
- Improve data quality and use of SORMAS by instituting routine data validation, clean-up, and review processes, and clarifying accountability for completeness, accuracy, and timely updating of case records.
- Reinforce community-based surveillance by re-orienting and supporting community-based surveillance volunteers, with clear roles, refresher training, and feedback mechanisms linked to the formal surveillance system.

Table 12: Example of data errors in SORMAS

EPID number	Disease	Case report date	Date sample was collected	Date sample was sent	Date sample received at lab	Sample report date
GHA-GAR-ADE-24-xxx	Cholera	1/29/2024	10/29/2024	11/7/2024	Not recorded	11/8/2024
GHA-GAR-ADE-24-xxx	Cholera	10/29/2024	10/29/2024	11/7/2024	11/7/2024	11/8/2024
GHA-GAR-ADE-24-xxx	Cholera	10/27/2024	10/27/2024	11/7/2024	11/7/2024	11/8/2024
GHA-GAR-ADE-24-xxx	Cholera	10/16/2024	10/16/2024	10/16/2024	10/17/2024	10/16/2024
GHA-GAR-ADE-24-xxx	Cholera	10/7/2024	10/7/2024	10/7/2024	10/11/2024	10/16/2024
GHA-GAR-ADE-24-xxx	Cholera	10/5/2024	10/5/2024	10/5/2024	10/11/2024	10/16/2024
GHA-GAR-ADE-24-xxx	Cholera	10/7/2024	10/7/2024	10/7/2024	10/11/2024	10/16/2024
GHA-GAR-ADE-24-xxx	Cholera	10/5/2024	10/5/2024	10/5/2024	10/11/2024	10/16/2024

These issues are detailed in Annex 7
Furthermore, there was no evidence that the Disease Surveillance Department conducts routine data quality checks, clean-up, or validation of SORMAS data.

***Long turnaround time for investigating suspected cases*;** Analysis of measles surveillance data at NPHRL showed extended turnaround times for investigation and confirmation of suspected cases, with delays of up to 90 days observed in several instances (see table below). These delays undermine the ability to initiate timely outbreak response and control measures.

Table 13: Extended investigation turnaround time(s)

#	Description of Lead time (Days)	Number of samples	Percentage
1	Investigation period less than 30 days	2,895	65%
2	Investigation period of 30-60 days	362	8%
3	Investigation period of 60-90 days	253	6%
4	Investigation period of more than 90 days	631	14%

***Stockouts of laboratory supplies constrained timely testing*:** The audit identified prolonged stockouts of laboratory reagents required for VPD testing at the national laboratory, including for measles testing. Documented stockout periods included:

- 21 March 2023 to 8 May 2023 (over 60 days),
- 22 January 2024 to 9 February 2024 (19 days), and
- 22 April 2025 to 15 July 2025 (over 80 days).

These stockouts hampered timely testing and investigation of suspected cases (see Annex 8).

Weaknesses in monitoring of VPD surveillance indicators: The Disease Surveillance Department, together with EPI, was unable to provide evidence of regular analysis, monitoring, or reporting of VPD surveillance indicators. There was no established coordination forum where monthly or routine reviews of VPD trends and SORMAS data were conducted. Feedback mechanisms to lower levels following completion of case investigation were unclear, and while it was assumed that DSOs would review laboratory results entered into SORMAS, there was no documented process or evidence to confirm this occurred systematically.

- Reduce investigation and laboratory turnaround times by addressing operational bottlenecks in sample transport, testing workflows, and result reporting, and monitoring turnaround time as a key performance indicator.
- Strengthen planning and advocacy for sustainable surveillance financing to ensure timely availability of laboratory reagents, sample collection materials, and transport infrastructure, aligned with operational planning processes.

<table>
<tr><td>Root Cause
Lack of a well-coordinated forum / TWG to regularly discuss VPD surveillance related issues and monitor indicators in a timely manner.
Trainings conducted between 2020 and 2023 for surveillance focal persons at lower levels have not translated into on-the-job improvements including community-based case identification and accurate data entry into SORMAS.
Funding gaps towards VPD surveillance to cover timely sourcing of testing reagents, sample collection and storage tools and, transportation infrastructure to the designated testing laboratory may undermine sustainability. See issue on weaknesses in operational planning 4.2.2</td><td colspan="2">Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
Weak community-based surveillance limits early case detection, leading to delayed investigation and response, particularly in hard-to-reach areas, and increasing the risk of undetected VPD transmission and larger outbreaks.
Incomplete, inaccurate and duplicate SORMAS entries (including missing immunisation status, inconsistent dates and missing laboratory results) undermine analysis of VPD trends, delay case classification, and can result in missed outbreaks, sub-optimal response, and misinformed programme decisions.
Prolonged investigation and laboratory turnaround times hinder timely confirmation of suspected cases, delay case management and contact tracing, and increase the likelihood of sustained or expanded transmission before control measures are implemented.
Recurrent stockouts of laboratory reagents and sample collection materials prevent timely testing and classification of suspected VPD cases, contributing to investigation backlogs, delayed public health action, and reduced confidence in the surveillance system.
Absence of routine monitoring and joint review of VPD surveillance indicators by Disease Surveillance and EPI teams weakens oversight, allows systemic data quality and timeliness issues to persist, and limits the ability of MoH/GHS to detect performance deterioration and target corrective actions.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.2.5 Improvements required to align CSO implementation for greater impact

Context and Criteria

In December 2021, the Gavi Board approved a revised Civil Society and Community Engagement (CSCE) approach, requiring countries to allocate at least 10% of combined Health System Strengthening (HSS), Equity Accelerator Fund (EAF), and Targeted Country Assistance (TCA) ceilings to CSO-led implementation when submitting new funding requests. The CSCE approach is intended to strengthen equity-focused immunisation delivery by leveraging the comparative advantages of civil society organisations (CSOs) to reach underserved and marginalised populations.

The CSCE approach emphasises:

- targeting zero-dose (ZD) and under-immunised (UI) populations, particularly in urban poor, peri-urban, minority, and hard-to-reach communities;
- structured community engagement and demand generation, including addressing vaccine hesitancy and gender-related barriers;
- use of data and evidence to prioritise geographies and populations with the highest unmet need; and
- clear government stewardship, including coordination, oversight, and monitoring of CSO performance.

According to Gavi data, approximately half of Ghana's zero-dose children are concentrated in 29 districts across eight regions, including high-burden urban and peri-urban districts. Recent evidence on routine immunisation coverage[7] further highlights persistent geographic and urban–rural disparities, underscoring the need for targeted, data-driven CSO engagement to complement government service delivery.

Condition

CSO implementation was not adequately targeted to districts with the highest zero-dose burden: The Ministry of Health (MoH) engaged the Ghana Coalition of NGOs in Health (GCNH) to manage CSO implementation under Gavi grants. GCNH is responsible for coordinating civil society engagement, supporting community mobilisation and demand creation, and channelling funding and technical support to local NGOs. During the audit period, GCNH operated in 40 districts; however, 15 of the 29 districts with the highest zero-dose burden were not included. The audit further noted that a higher number of CSOs, and a larger share of funding, were allocated to areas with comparatively lower zero-dose burden. For example, between 2021 and 2024, CSOs in the North East Region received US$63,422, while CSOs in the Eastern Region received approximately three times more (US$194,657) over the same period, despite higher zero-dose concentration in some excluded regions (see Annex 9). MoH and GCNH were unable to provide documented criteria, rationale, or evidence base for the selection of regions or CSOs engaged for immunisation activities.

Table 14: Number of CSOs engaged by GCNH per region

	Number of CSOs engaged per region		
Region	**2022-2023**	**2023-2024**	**2025**
Ashanti	6	6	13
Bono East	0	2	6
Eastern	1	4	7
Greater Accra	12	4	12
North-East	0	1	4
Northern	1	2	6
Upper East	1	2	5
Upper West	5	1	5
Volta	2	4	8

Recommendation 6

To strengthen the effectiveness and equity impact of CSO implementation, the MoH/EPI should:

- Refine the strategic approach to CSO engagement by working with GCNH to prioritise districts and populations with the highest zero-dose and under-immunised burden, using transparent, data-driven selection criteria.
- Clarify coordination and oversight arrangements by defining clear roles and reporting requirements for CSO activities at national, regional, and district levels, including integration into existing health management structures.
- Establish a performance monitoring and evaluation framework for CSO implementation, with clear objectives, indicators, milestones, and reporting requirements, and ensure that CSO results are

[7] Routine immunisation coverage in under 24 months in Eastern Ghana

There is limited evidence of CSO contribution to immunisation outcomes: One of the stated objectives of CSO engagement was to contribute to achieving at least 90% Penta3 coverage in all districts by 2025. However, review of coverage data showed that, among the 40 districts where GCNH-supported CSOs were active:

- fewer than half recorded a marked improvement in Penta3 coverage between 2022 and 2023; and
- only nine districts showed improvement between 2023 and 2024.

This suggests limited and inconsistent evidence of impact attributable to CSO-supported interventions (see table below).

Table 15: Number of districts with marked improvements in Penta3 coverage

Number of districts with marked improvement in Penta3 coverage (i.e. more than 5%age points)	
Between 2022-2023	Between 2023-2024
15	9

Number of districts achieving 90% Penta3 coverage		
2022	2023	2024
5 out of 40	6 out of 40	8 out of 40

Missed opportunity to involve CSOs during campaign planning to boost demand generation: During the period, Ghana held 9 campaigns targeting different VPDs and at varying levels (national or selected districts). The auditors noted that although TWGs are formed for the extensive planning of all campaigns, there was no evidence of engagement of GCNH / CSOs during this process.

***Coordination and oversight of CSO activities at sub-national level were weak*:** At sub-national level, all four Regional Health Directorates visited reported that CSOs operating in their regions were not required to formally report to them. In addition, the audit did not obtain evidence from GCNH of regular sub-national coordination meetings, reporting mechanisms, or structured engagement with regional or district health management teams.

periodically reviewed and validated by MoH/EPI.
- Systematically engage CSOs in campaign planning and implementation, particularly for demand generation and outreach to missed populations.
- Strengthen the evidence base for CSO engagement by improving CSO mapping and ensuring that technical assistance supporting civil society engagement is representative and aligned with equity objectives.

Root Cause

- Insufficient strategic integration of CSOs within national immunisation planning, as the NIS does not clearly articulate CSO roles, expected contributions, or priority areas aligned to zero-dose and equity objectives.
- Weak government stewardship and oversight of CSO implementation, including limited reporting on CSO activities and results at ICC level, absence of defined oversight roles at district level, and lack of verification of GCNH-reported results by MoH/EPI.
- Absence of a monitoring and evaluation framework for CSO performance, including clear indicators, milestones, and accountability mechanisms. The Memorandum of Understanding between MoH and GCNH does not specify how CSO activities and results will be monitored.
- Limitations in technical assistance supporting CSO engagement, including a CSO mapping exercise that was not representative of the national CSO landscape, reducing its usefulness for strategic targeting.

Management comments

See detailed management responses in Annex 19

Risk / Impact / Implications	Responsibility	Deadline / Timetable
• Zero-dose and under-immunised populations, particularly in high-burden urban and peri-urban districts, may not be effectively prioritised or reached. • Resources allocated to CSO implementation may not achieve intended equity outcomes, reducing value for money under Gavi-supported grants. • Opportunities to leverage CSO strengths in demand generation, trust-building, and community mobilisation (especially during campaigns) will continue to be missed. • Fragmentation between government and civil society efforts will persist, weakening accountability and coordination at sub-national level.	See detailed management responses in Annex 19	See detailed management responses in Annex 19

4.2.6 Documentation and follow up of supportive supervision needs to be enhanced

Context and Criteria

According to the WHO supportive supervision is crucial for monitoring performance towards program goals and using data for decision-making by following up regularly with staff to ensure that new tasks are being correctly implemented. The collected information should aid the supervisor in deciding on corrective action during the visit and what issues require follow-up action in the longer term.

The Ghana Health Service developed standard operating guidelines for supportive supervision (2017). The purpose of the guideline is to provide a roadmap for providers, managers, administrators and directors on how to implement supportive supervision nationwide. The guidelines provide step-by step guidance for supervisors and supervisees on how to prepare for, conduct and provide continuity in the supervision process at all levels of the health care system

Section 6.2 planning and preparing for supportive supervision sessions gives detailed steps on the planning activities that supervisors must perform at national, regional and district level including development of annual plans, review of HMIS data to inform site selection and communicate scheduling.

According to section 5.1.5, "*after the session supervisors should complete a brief report to summarise finding and make recommendations for improvement…".* The guidelines also require development of action plans.

Condition

Supportive supervision activities were implemented across levels during the audit period, with reported expenditure of approximately GH¢5 million on supervision and monitoring activities. However, the audit identified weaknesses in planning, documentation, and follow-up:

***Gaps in planning and targeting of supportive supervision at national level*:** The EPI team was unable to provide annual supportive supervision plans for the audit period. There was no documented evidence of risk-based or data-driven site selection, as required under the GHS guidelines. As a result, the distribution of supervision visits across regions appeared uneven and not clearly justified.

For example, data recorded in the WHO Open Data Kit (ODK) tool showed that Greater Accra Region received 205 supervision visits, in some cases up to four times more than other regions, without documented criteria to explain the prioritisation. See table below:

Table 16: Sample of regions and ODK recorded number of supervisions

Region	No. of supervision visits in 2023 and 2024
Bono East	30
Central	47
Eastern	46
Greater Accra	205
North East	50
Northern	67
Oti	78
Volta	20
Western	129

Recommendation 7

To enhance the effectiveness and sustainability of supportive supervision, the MoH/EPI should:

- Strengthen planning and prioritisation of supportive supervision by developing and implementing annual supervision plans informed by programme performance data and risk analysis, in line with GHS guidelines.
- Improve documentation and follow-up mechanisms by ensuring that supervision visits are systematically recorded at all levels, action points are clearly documented, and progress is tracked over time.
- Enhance feedback to supervised facilities by ensuring that supervision findings are shared in an accessible and timely manner, with feedback that is specific, actionable, and supports continuous improvement.

<table>
<tr><td colspan="2">Supportive supervision at sub-national level was ad hoc: Although all four Regional Health Directorates (RHDs) visited and six out of seven District Health Directorates (DHDs) reported receiving supportive supervision visits, these visits were described as ad hoc, with no pre-agreed schedules or guidance on expected frequency. This indicates that supervision activities were not consistently embedded within structured annual or quarterly plans at sub-national levels.

There was inadequate documentation and reporting of supportive supervision activities at sub-national level: Documentation and follow-up mechanisms for supportive supervision were weak, particularly at sub-national levels:
• All RHDs visited reported not having registers to record supportive supervision visits.
• All RHDs further reported that there was no mechanism to track or follow up on action points arising from supervision.
• Although supervision results were captured using the WHO ODK tool, health facilities did not have access to the tool or to the findings from their own assessments. This limited facilities' ability to develop action plans, track progress, or use supervision feedback for continuous improvement.</td><td></td></tr>
<tr><td>Root Cause
• Insufficient orientation and reinforcement of guidelines: Staff at national, regional, district and facility levels have not been adequately oriented on the supportive supervision guidelines, leading to inconsistent understanding and application of requirements for planning, documentation and follow-up
• Lack of clear accountability: There are no defined requirements or enforcement mechanisms to ensure that managers prepare supervision plans, document visits, and track follow-up actions.
• Weak integration into routine management processes: Supportive supervision is not fully embedded in annual or quarterly planning, budgeting, and performance review cycles, causing it to remain ad hoc rather than systematic.</td><td>Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
• Supportive supervision resources are not optimally targeted, particularly in a transition context where resources are increasingly constrained and must be prioritised to areas of greatest need.
• Identified implementation gaps are not systematically addressed, as weak documentation and lack of follow-up delay corrective actions at facility and district levels.
• Opportunities to improve service quality and programme performance are missed, reducing the effectiveness of supervision as a management and quality improvement tool.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.3 Digital immunisation information systems

4.3.1 Improvements needed in digital immunisation and vaccine logistics systems

Context and Criteria

Effective immunisation programmes rely on integrated, interoperable digital systems to ensure vaccine availability, accurate coverage reporting, and timely follow-up of missed children. Digital logistics and service-delivery systems are expected to provide end-to-end visibility from national to last mile, support forecasting and cold-chain management, and enable triangulation of supply and service data for decision-making.

In Ghana, vaccine and health commodity logistics are managed through GhiLMIS, the national logistics management information system, while individual-level immunisation service data are captured through eTracker, built on the DHIS2 Tracker architecture. Ghana's Digital Health Strategy (2023–2027) [8] sets out clear expectations for interoperable systems, strengthened data governance, and the use of national master data services, including unique client identification and alignment with national registries.

For immunisation supply chains, Gavi Target Software Standards (TSS) [9] define minimum functional and digital requirements, including reliable LMIS workflows, forecasting, cold chain and temperature monitoring, batch and stock visibility to last mile, integrated analytics dashboards, and interoperability with other health information systems. These standards are intended to ensure vaccine availability, reduce wastage, and strengthen accountability across the immunisation system

Condition

***The GhiLMIS EPI module does not adequately support core immunisation logistics functions*:** Although GhiLMIS was expanded in 2023 to include EPI workflows, the vaccine module is built on a generic commodity-management architecture rather than a vaccine-specific design. As a result:

- the system does not provide integrated EPI-specific dashboards;
- reporting functionality is limited (for example, vaccine receipt reports restricted to short time windows such as 182 days);
- weak validation controls allow data anomalies, including negative opening balances, to appear in programme reports; and
- critical immunisation logistics capabilities are absent, including cold chain equipment (CCE) inventory management, real-time temperature monitoring (RTM), Vaccine Vial Monitor (VVM) tracking, and vaccine forecasting.

***Limited integration between digital systems*:** There is no functional integration between GhiLMIS and the national health management information system (DHIMS/eTracker), resulting in data silos between supply chain and service delivery data. This limits the ability to triangulate vaccine availability, stock movements, and immunisation service outputs, constraining effective planning, monitoring, and corrective action.

GhiLMIS does not meet key Gavi Target Software Standards: Assessment against Gavi TSS benchmarks showed that only three of the nine required capabilities are currently met. Gaps remain in forecasting, CCE and RTM integration, advanced analytics, dashboards, and last-mile visibility (see table below). See table below:

Recommendation 8

To strengthen digital systems supporting immunisation and vaccine logistics, the MoH/GHS should:

- Operationalise interoperability in line with the Digital Health Strategy (2023–2027) by advancing a national health information exchange that enables integration between GhiLMIS, eTracker, and DHIMS, improving data visibility across supply and service delivery.
- Conduct a comprehensive Gavi TSS gap analysis of GhiLMIS and address identified gaps by incorporating missing immunisation-specific modules, including CCE inventory, RTM, forecasting, and integrated analytics dashboards.
- Strengthen data quality controls by implementing automated validation and

[8] Ghana's Digital Health strategy (2023-2027)
[9] Gavi TSS

Table 17: Status of GhiLMIS against Gavi TSS requirements

GAVI TSS Key features	Description	Present and used in GhiLMIS
Forecasting and planning	Configure and use calculation for ideal stock amounts (ISA) for supply planning.	No
Distribution Management	Vaccine distribution & delivery management	Yes
Early warning alerts	Stock alarms (potential expiry and potential stock out)	Yes
Requisition and issue workflows	Stock requests and issues workflows	Yes
Cold chain inventory	Track cold chain equipment inventory	No
Integration with remote temperature monitoring	Integration with RTM device (fridge tags)	No
Interoperability with other systems	Integration with other systems	No
Inventory management	Inventory data and stock movement to provide an overview of full stock availability (central store to health facility)	No
Advanced analytics	Presence of vaccine dashboards	No

Potential scalability and performance risks exist in the current eTracker configuration*:* The eTracker system stores each vaccination as an individual event. Given high monthly vaccination volumes across districts and facilities, the growing dataset poses scalability and performance risks, including slower dashboards, delayed report generation, system timeouts, and delays in synchronising data from facilities using offline functionality as data volumes increase.

Current eTracker configuration increases the risk of duplicate records: The current eTracker child identification logic generates system IDs based on registration date, facility code, and a running number, without mandatory validation fields such as caregiver names, contact details, or national identifiers. This creates a risk of duplicate child records, particularly for children attending outreach sessions without immunisation cards, or registering at multiple facilities. While Ghana has begun piloting biometric identification (Simprints), this is not yet institutionalised within the national system.

integrity rules within GhiLMIS to prevent invalid transactions and improve reliability of logistics data.

- Adopt and institutionalise a robust national unique child identifier for use within eTracker, aligned with national digital standards, to reduce duplication and improve longitudinal tracking of immunisation services.

Root Cause

- Limited last-mile digital readiness, including connectivity constraints, variable digital literacy, and high costs of devices and data, restricting effective use and expansion of systems to facility level.
- Insufficient institutional familiarity with Gavi TSS requirements, resulting in a vaccine logistics module that is not fully aligned with immunisation-specific functional standards.
- Absence of automated data integrity controls within GhiLMIS, allowing invalid or inconsistent transactions to be recorded.
- Weak national standards for unique client identification within eTracker, leading to duplication and challenges in longitudinal tracking of children.

Management comments

See detailed management responses in Annex 19

Risk / Impact / Implications

- Misalignment with Ghana's Digital Health Strategy (2023–2027), particularly in relation to interoperability, data governance, and unique client identification.

Responsibility

See detailed management

Deadline / Timetable

See detailed management responses in Annex 19

• Inaccurate or inflated immunisation coverage figures, undermining the reliability of programme monitoring and strategic decision-making. • Inability to accurately identify true defaulters, limiting effective follow-up of missed vaccinations and equity-focused interventions. • Health workers may revert to parallel paper systems, reversing digital gains.	responses in Annex 19	

4.4 Immunisation data management

4.4.1 Improvements needed in quality assurance mechanisms to reduce data inconsistencies

Context and Criteria

Under Clause 8(d) of the Partnership Framework Agreement, the Government is required to ensure that all information provided to Gavi—including applications, progress reports, and supporting operational and financial documentation—is accurate and correct at the time of submission. Annex 1, Article 16 further specifies that Gavi support is subject to strict performance monitoring, relying on government reports and existing country-level mechanisms to assess results.

Gavi application and reporting guidelines additionally require countries to strengthen data availability, data quality, and the systematic use of data for planning, programme management, and documentation of results, including through routine immunisation coverage monitoring and triangulation of multiple data sources.

Within the Ghana Health Service (GHS), guidelines and standard operating procedures exist for data verification, analysis, interpretation, and reporting at all levels of the health system. These include internal mechanisms for cross-checking and validating routine data. Immunisation coverage is primarily monitored using routine administrative data from the District Health Management Information System (DHMIS), complemented by population-based surveys such as the Ghana Demographic and Health Survey (GDHS), the Multiple Indicator Cluster Survey (MICS), and EPI coverage surveys, which provide independent estimates for validation and triangulation.

Condition

***Variations in population denominators led to challenges in monitoring and immunisation planning*:** The audit noted that coverage rates indicators at the subnational levels computed using routine data reported by health facilities often exceeded 100%. Although Ghana conducted a national population census in 2020, and a DHS in 2022, comparison of the national immunisation coverage rates for basic antigens showed 100% coverage using DHMIS data with census-based denominators, compared to just over 90% when GDHS denominators were applied.[10] This indicates gaps in the alignment and validation of denominators used for routine monitoring and planning.

Variances between doses administered and doses distributed: The audit noted significant variances between the number of children reported as vaccinated and the number of vaccine doses distributed for Pentavalent and PCV vaccines between 2020 and 2024. Reported numbers of vaccinated children consistently exceeded distributed doses by approximately 53% for Pentavalent and 58% for PCV, as illustrated in the graphs below. These discrepancies raise concerns about over-reporting, data aggregation errors, or weaknesses in stock and utilisation reconciliation. Similar issues were previously reported in the 2019 audit (see finding 4.4.1 on irregular administrative coverage).

Recommendation 9

To strengthen data quality assurance and reduce inconsistencies, the MoH/EPI should:

- Plan and conduct a comprehensive Data Quality Assessment (DQA) using a WHO-endorsed methodology, including development and resourcing of a Data Quality Improvement Plan (DQIP).
- Institutionalise routine data triangulation at national and sub-national levels, including systematic comparison of administrative coverage, vaccine distribution and utilisation data, and available survey estimates, with documented analysis and explanation of identified variances.
- Strengthen routine data verification and validation at sub-national level by ensuring that districts and regions conduct and document regular data quality checks, with clear accountability and follow-up.

[10] Increasing the accuracy of coverage for maternal and child health programs report by University of Ghana

Figure 3: Variances between vaccinated children and doses distributed at National level

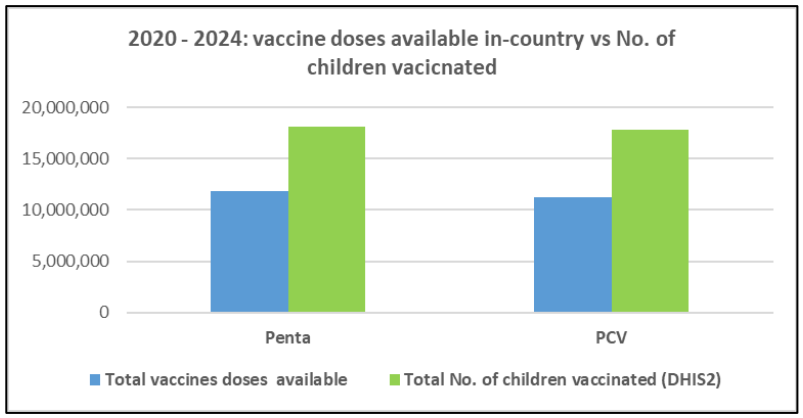
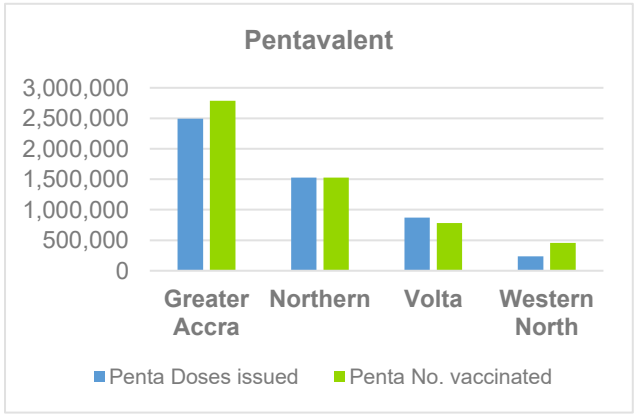
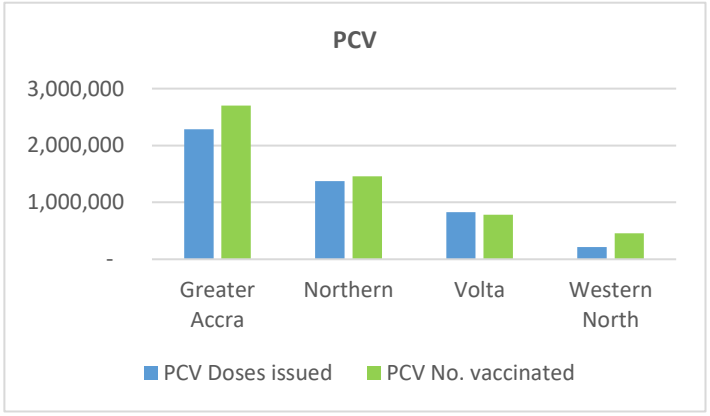


Figure 4: Variances between vaccinated children and doses distributed at Sub-national level





- Expedite completion of the ongoing EPI coverage survey to provide updated population-based estimates for validation of routine data.
- Prioritise funding to accelerate scale-up of the eTracker platform for routine immunisation, to improve individual-level data capture and reduce aggregation errors.
- Strengthen supportive supervision and follow-up on data quality issues, ensuring that findings from data reviews and supervision visits are communicated back to sub-national levels and corrective actions are tracked to completion

Disparities noted in reported coverage for co-administered vaccines: Ghana's immunisation schedule requires that certain vaccines be administered at the same visit (for example, Penta 1, PCV 1, OPV 1, and Rota 1 at six weeks; and Penta 3, PCV 3, OPV 3, and IPV at fourteen weeks). However, comparison of reported vaccinations for co-administered antigens over the five-year audit period showed significant variances, particularly between DTP1 and Rota 1, which would not be expected if immunisation practice, recording and reporting were consistent. See table below.

Table 18: Variances between vaccinations done at the same time

Year		No. of children vaccinated (as reported in DHMIS)	Variance	%Var
	DTP1	**ROTA**		
2020	1,154,865	1,132,168	22,697	2%
2021	1,225,734	1,216,093	9,641	1%
2022	1,217,279	1,157,282	59,997	5%
2023	1,197,577	886,578	**310,999**	**26%**
2024	1,207,518	1,111,156	**96,362**	**8%**

Root Cause

- The country was overdue for its next comprehensive data quality assessment as no DQA was performed in the period 2020 – 2024.
- The EPI coverage survey was last performed in 2017 and a Multiple indicator cluster survey in 2018. Although the EPI coverage survey had been planned for execution in 2023 this did not happen due to funding challenges and was still not complete at the time of the audit. See issue 4.2.2
- Delayed scale up use of the eTracker digital platform (currently deployed in 81 districts across six regions as part of the initial implementation phase) limiting improvements in individual-level data quality and consistency. See issue 4.3.1
- Supportive supervision at sub-national level was inadequate. 2 out of 4 RHDs and 3 out of 7 DHDs reported not to have received feedback previously following data reviews/checks done. See issue 4.2.6
- Inadequate routine data quality assurance at sub-national level, as only 2 of 4 Regional Health Directorates and 5 of 7 District Health Directorates provided documented evidence of regular data validation and quality checks.

Management comments

See detailed management responses in Annex 19

Risk / Impact / Implications

If not addressed, these weaknesses increase the risk that:

- Planning, forecasting, and funding decisions are based on inaccurate or inconsistent data, contributing to vaccine shortages and inefficiencies.
- Programme performance may be misrepresented, masking real coverage gaps, overstating progress or missing critical programming improvements were vaccines to be administered at the same time are missed.
- Confidence in routine data is undermined, weakening institutionalised data use for programme management and accountability.

Responsibility

See detailed management responses in Annex 19

Deadline / Timetable

See detailed management responses in Annex 19

4.5 Vaccine supply chain management

4.5.1 Stock levels are low resulting in vaccine stock outs and affecting service delivery

Context and Criteria

Ensuring uninterrupted availability of vaccines is essential for the continuity and effectiveness of routine immunisation services. Accurate demand forecasting and supply planning are critical prerequisites for estimating vaccine requirements to meet routine demand and supplementary immunisation activities, while maintaining adequate buffer and safety stock at all levels of the supply chain.

In Ghana, vaccine forecasting and supply planning is conducted annually, typically in September, using UNICEF forecasting templates. The process is led collaboratively by the Ministry of Health (MoH), Ghana Health Service (GHS)/EPI, and UNICEF Supply Division, which acts as Gavi's procurement agent. The forecasting process captures key inputs, including target population estimates, WHO-established wastage rates, expected coverage levels, buffer stock (typically 25% of forecasted quantities per antigen), and stock on hand at the national cold room at the time of forecasting. The resulting forecast informs UNICEF Supply Division's proposed shipment plan, which is reviewed and endorsed by Ghana prior to procurement.

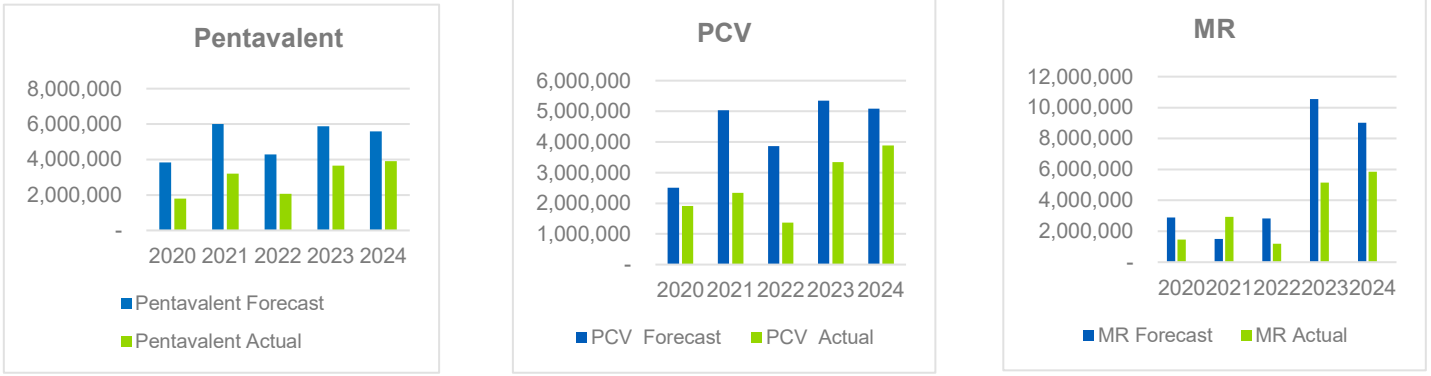
Good practice requires that forecasts be periodically reviewed and adjusted to reflect changes in assumptions (for example, population estimates, coverage trends, or financing constraints) and that stock levels be monitored across national and sub-national levels to prevent stockouts.

National guidance relevant to vaccine logistics, including the EPI Field Guide (2023), provides operational direction for Effective Vaccine Management (EVM) activities. However, the guide does not define minimum and maximum stock levels to be maintained at national, regional, district, or health facility levels.

Condition

***Vaccine forecast assumptions were not periodically reviewed*:** The audit observed significant variances between forecasted vaccine quantities and doses actually received during the audit period. There was no evidence of periodic review of forecast assumptions to assess forecast accuracy or recalibrate future forecasts based on observed deviations. As a result, substantial variances were noted between forecasted doses and doses received, including approximately 43% for Pentavalent, 41% for PCV, and 38% for MR.

Figure 5: Variances between forecasted and received quantities



Recommendation 10

To ensure availability of adequate supply of vaccines and related supplies, MoH/GHS management should:

- Strengthen advocacy and coordination with the Ministry of Finance to support the timely release of funds for co-financed vaccines, improving predictability of procurement and supply planning (see finding on transition financing and co-financing delays).
- Develop and implement country-specific forecasting and quantification SOPs, including explicit definition of minimum and maximum stock levels at each tier of the supply chain, documentation of planning assumptions, review timelines, and approval processes, and expedite the development of Terms of Reference for a

***Vaccine stock levels were below operational benchmarks at national and sub-national levels*:** Although national guidelines do not formally define minimum and maximum stock levels, discussions with the national logistics team indicated that the programme operates using agreed operational planning benchmarks for months of stock, namely:

- National Cold Room (NCR): minimum 3 months, maximum 6 months
- Regional Vaccine Stores (RVS): minimum 2 months, maximum 4 months
- District Vaccine Stores (DVS): minimum 1 month, maximum 2 months
- Health Facilities: minimum 1 month, maximum 1.5 months

These thresholds are not formally documented in national guidelines but are used in practice to guide supply planning and issuance decisions.

At the time of the audit, vaccine stock balances at the national cold room for several antigens, notably PCV, Rotavirus, and BCG, were below the minimum operational benchmarks. Further analysis of the projected supply pipeline showed that expected deliveries toward the end of 2025 and into the first quarter of 2026 were insufficient to restore stock levels above minimum requirements, including safety stock (see table below).

Table 19: Stock balances at National Cold Room on date of audit visit (25 Nov 25)

					PHASE I		PHASE II			
#	Antigen	Monthly Requirement (Doses)	Stock On Hand 4. Nov.25	MoS	Expected Pipeline (2025)-Go GHA (Doses)	Scheduled Pipeline ETA	Expected Pipeline (1st Qtr-2026)-Go GHA (Doses)	Scheduled Pipeline ETA	Stock on Hand (SoH)-Post-Pipeline	MoS
1	Pentavalent	229,563	1,738,470	7.6	1,738,000	30.Nov.25	No Pipeline		3,476,470	15.1
2	PCV-13	242,317	751,800	3.1	605,600	20.Nov.25	No Pipeline		1,357,400	5.6
3	Yellow Fever	117,417	479,500	4.1	No Pipeline		No Pipeline		479,500	4.1
4	IPV	106,750	542,900	5.1	No Pipeline		818,000	25.Jan.26	1,360,900	12.7
5	MR	239,000	1,189,180	5	No Pipeline		No Pipeline		1,189,180	5
6	BCG	140,500	494,000	3.5	No Pipeline		No Pipeline		494,000	3.5
7	Rotavirus	260,990	279,175	1.1	1,125,375	11.Dec.25	No Pipeline		1,404,550	5.4

Similarly, all four regional stores visited had low vaccine stocks for pentavalent and yellow fever as detailed in the table below:

Table 20: Stock balances at all four regional vaccine stores on the audit visit day

Antigen	Greater Accra Region	Northern Region	Volta Region	Western North Region
	MoS	MoS	MoS	MoS
Pentavalent	1.9	1.7	3.3	2.6
PCV-13	4.5	4	5.6	5.2
Yellow Fever	3.9	2.8	2.9	4.1
IPV	5.4	4.6	6.1	3.8
MR	4.6	8.4	7.9	5.1
BCG	4.3	3.0	5.2	3.6

logistics Technical Working Group (TWG) to strengthen stakeholder engagement.

- Institutionalise periodic stock and forecast reviews, including regular assessment of stock levels across national and sub-national levels and structured review of forecast assumptions with UNICEF and Gavi to improve accuracy in subsequent forecasting cycles.

<table>
<tr><td colspan="2">Vaccine stock outs at Sub-national level: All four Regional Vaccine Stores and all seven District Vaccine Stores visited reported having experienced stockouts of one or more vaccines during the audit period. Details of these stockouts are provided in Annex 10.</td><td></td></tr>
<tr><td colspan="2">Root Cause
Delayed settlement of government co-financing obligations, which reduced the predictability of vaccine procurement and constrained the supply pipeline, contributing to sustained low stock levels and stockouts. See issue 4.2.1
Absence of country-tailored forecasting and quantification standard operating procedures (SOPs) to guide the forecasting process, document assumptions, define stock thresholds, and support consistent review and recalibration of forecasts
Lack of formally documented minimum and maximum stock thresholds to clearly define planning benchmarks for months of stock (MoS) at national, regional, district, and health facility levels, resulting in reliance on undocumented operational practices and weakening accountability for stock management decisions.</td><td>Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
Missed vaccination opportunities due to vaccine stockouts at national and sub-national levels, undermining coverage and equity.
Inconsistent forecasting practices, where undocumented assumptions increase the likelihood of errors and reduce accountability in supply planning.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.5.2 Gaps in end-to-end supply chain visibility have weakened accountability across the vaccine supply chain

Context and Criteria

Successful immunisation programmes rely on functional, end-to-end supply chain and distribution systems that ensure vaccines and related supplies are available at service delivery points when needed. These systems should enable coordinated storage, distribution, handling, and accountability across vaccines, injection supplies, and last-mile delivery arrangements to prevent missed vaccination opportunities. Gavi's Immunisation Supply Chain (iSC) Strategy 2025–2030 emphasises the adoption of systems that enable dynamic inventory management, real-time or near-real-time visibility, and data use for operational and strategic decision-making.

Effective inventory management requires that vaccine receipts, issuances, adjustments, and stock on hand (SoH) are accurately recorded, timely, and verifiable at all levels of the supply chain. Reliable stock data are essential to inform replenishment decisions, prevent stockouts and overstocking, and support accountability for vaccine use.

At national level, Ghana uses a mix of systems to manage vaccine inventory, including an offline Stock Management Tool (SMT), manual vaccine stock ledgers, and partial deployment of the Ghana Integrated Logistics Management Information System (GhiLMIS) at some sub-national stores. Section 3.6 of the EPI Field Guide requires monthly physical stock counts at district, sub-district, and facility levels prior to order placement, with discrepancies recorded as surplus or missing doses and corresponding adjustments made to stock balances.

Vaccines are distributed quarterly from the National Cold Room (NCR) to Regional Vaccine Stores (RVS) and monthly from regional to sub-national levels. Distribution is supported by two refrigerated trucks at the NCR and one truck per region for last-mile delivery. In addition, a third-party logistics provider (3PL), Zipline, is used to support emergency distributions and deliveries to hard-to-reach areas.

Condition

***Limited visibility of stock balances below regional level*:** The National Cold Room (NCR) primarily uses the SMT for vaccine stock management. However, during the audit period, the SMT had not been rolled out to District Vaccine Stores (DVS) or Health Facilities (HFs). Most DVS and HFs visited relied on manual stock ledgers, similar to those used at facility level. Regional Vaccine Stores (RVS) aggregated district-level data manually and populated SMT files, which were shared with the NCR on a monthly basis. As a result, the NCR had no direct or real-time visibility of stock balances at district or facility levels, relying instead on periodic, manually consolidated reports. To partially address these gaps, a partner-owned system (Thrive 360) was used to enhance visibility at lower levels, however, this creates a parallel system that undermines sustainability and national ownership

Misalignment between vaccine and dry-supply distribution disrupted bundling at service delivery level: Due to inadequate storage capacity at the National Cold Room, dry supplies (including syringes, needles, and safety boxes) were stored and distributed through the Central Medical Store (CMS), while vaccines continued to be distributed through the NCR. As a result:

- vaccines were distributed quarterly to Regional Vaccine Stores by the NCR; while
- corresponding dry supplies intended for concurrent use were distributed bi-annually by CMS or collected on an ad hoc basis by regions.

This misalignment disrupted the bundling of vaccines and injection supplies at lower levels. During the audit period, 3 of 7 District Vaccine Stores and 4 of 14 Health Facilities reported previous stockouts of BCG needles and syringes due to untimely receipt of dry supplies, despite vaccine availability.

Recommendation 11

To enhance vaccine stock visibility and close accountability gaps identified, MoH/GHS should:

- Develop and disseminate comprehensive vaccine inventory management SOPs, clearly defining procedures for stock recording, reconciliation, investigation of discrepancies, documentation standards, and accountability at each level, and train staff on their practical application.
- Accelerate the rollout and adoption of a reliable electronic LMIS (GhiLMIS) across all vaccine storage points, ensuring that it meets immunisation-specific requirements and enables timely, ideally near-real-time, visibility of stock balances down to district and facility levels.
- Strengthen reconciliation and oversight mechanisms by requiring routine comparison of physical stock counts with system records,

Limited visibility and performance management of third-party logistics (3PL) distributions: Zipline was engaged to support emergency and hard-to-reach distributions; however, the audit noted that there was no real-time visibility at national level of deliveries completed by the 3PL at sub-national level. Verification and reconciliation of deliveries were conducted retrospectively, based on monthly reports submitted by the service provider.
In addition, there were no defined Key Performance Indicators (KPIs) in place to systematically monitor and manage 3PL performance, such as On-Time-In-Full (OTIF) delivery, order cycle time, or rate of returns. This limited the ability of MoH/GHS to proactively manage last-mile distribution performance and ensure accountability.

Unexplained variances between physical stock counts and stock records: Significant discrepancies were observed between physical stock counts conducted during audit visits and recorded stock balances;

- National cold room: Comparison of physical counts with SMT records for 2025 showed variances for all eleven (11) sampled antigens. See details in Annex 11
- Regional vaccine stores; Variances were observed at 2 of the 4 RVS when comparing physical counts with SMT files and vaccine stock ledgers. See Annex 12 for details
- District vaccine stores; Variances were observed at 3 of the 7 DVS when comparing physical counts with vaccine stock ledgers. Find details in Annex 13

***Inconsistencies in reconciled stock balances at regional level*:** The audit team conducted stock reconciliations using SMT files for 2025 maintained at sampled RVS over a ten-month period (1 January to 31 October 2025), comparing opening balances plus receipts from NCR against issuances and adjustments. Discrepancies were identified between expected balances and actual stock on hand at two out of four regional vaccine stores.

Table 21: Stock reconciliation variances at Volta and Greater Accra RVS

REGION NAME	VACCINES	UoM (Doses per Vial)	CLOSING BALANCE as of 31st Dec 2024	OPENING BALANCE as of 1st Jan 2025	TOTAL RECEIPTS (FROM SMT)	TOTAL ISSUES (FROM SMT)	EXPECTED BALANCE	SMT BALANCE	VARIANCE
Volta Region RVS	Pentavalent	10	23,800	23,800	135,720	123,280	36,240	36,000	240
	PCV	4	34,540	34,540	151,200	127,688	58,052	58,680	(628)
	Yellow Fever	10	3,200	3,200	90,000	74,400	18,800	18,390	410
	IPV	10	10,900	10,900	151,800	107,800	54,900	54,300	600
	MR	10	17,810	17,810	179,490	118,810	78,490	77,800	690
	BCG	20	360	360	144,000	101,400	42,960	42,840	120
Greater Accra RVS	Pentavalent	10	122,420	122,420	377,260	423,996	75,684	97,820	(22,136)
	PCV	4	128,000	128,000	460,000	416,400	171,600	242,400	(70,800)
	Yellow Fever	10	11,300	11,300	285,000	236,250	60,050	135,220	(75,170)
	IPV	10	84,600	84,600	321,000	195,200	210,400	139,840	70,560
	MR	10	119,500	119,500	404,500	383,900	140,100	207,470	(67,370)
	BCG	20	53,000	53,000	383,000	293,300	142,700	134,055	8,645

formal investigation and documentation of variances, and independent cross-checks by designated staff not involved in day-to-day stock handling.

- Integrate on-the-job mentorship into supportive supervision, focusing on practical application of inventory management procedures, timely data entry, and follow-up of identified gaps to improve consistency and accountability.

Recommendation 12

To strengthen vaccine distribution and last-mile accountability across the supply chain, MoH/GHS should:

- Expedite the development and operationalisation of Logistics TWG Terms of Reference, and ensure regular engagement of NCR, CMS, and relevant partners to align distribution schedules for vaccines and related dry supplies.
- Strengthen governance and performance management of third-party logistics arrangements by defining and enforcing Key Performance Indicators (including OTIF delivery, order cycle time, and exception management), and improving visibility of last-mile distributions to enable timely monitoring and corrective action.

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Root Cause

- Absence of comprehensive vaccine inventory management SOPs providing detailed, step-by-step guidance on stock recording, reconciliation, investigation of discrepancies, and accountability at each level. The existing EPI Field Guide is general and does not provide sufficient operational detail.
- Fragmented and non-real-time inventory systems, with reliance on offline tools (SMT), manual ledgers, and monthly aggregated reporting, limiting timely visibility and corrective action.
- Inconsistent physical stock-taking practices, with the last confirmed annual stock count at the NCR conducted in December 2023 and limited evidence of routine stock counts at sub-national levels.
- Delayed and non-real-time data entry, contrary to the Field Guide requirement that stock transactions be recorded within one working day.
- Weak documentation and record-keeping, including missing, incomplete, or illegible requisition and issue vouchers and stock ledgers at lower levels.
- Inconsistent supportive supervision and limited follow-up, with classroom-based training not translating into sustained improvements in day-to-day stock management practices. Irregular engagement and coordination between logistics stakeholders, including the Logistics Technical Working Group (TWG) comprising NCR and CMS personnel, which contributed to misalignment of distribution schedules for vaccines and dry supplies.
- Absence of clearly articulated performance measures in the contractual arrangements with the 3PL, limiting accountability, efficiency, and timely completion of distributions on behalf of MoH/GHS.

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Management comments

See detailed management responses in Annex 19

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Risk / Impact / Implications

- Inaccurate stock data informing replenishment and forecasting decisions, contributing to stockouts or overstocking.
- Reduced accountability for vaccine stocks, increasing the risk of wastage, losses, or misreporting.
- Delayed detection of emerging supply risks, as monthly or retrospective visibility is insufficient to support timely corrective action.
- Continued reliance on parallel partner-supported systems, undermining sustainability as the country transitions towards greater domestic ownership. Disruptions to immunisation service delivery, where vaccines or essential injection supplies are unavailable at the point of service despite availability elsewhere in the supply chain.
- Reduced ability of national level to provide timely remedial action, as limited real-time visibility of last-mile distributions constrains proactive management and escalation of delivery issues

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Responsibility

See detailed management responses in Annex 19

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Deadline / Timetable

See detailed management responses in Annex 19

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4.5.3 Cold chain management practices need to be improved

Context and Criteria

Cold chain management is a critical component of the national immunisation programme, ensuring that vaccines are stored, transported, and handled within recommended temperature ranges throughout the supply chain to maintain their potency and effectiveness. WHO Effective Vaccine Management (EVM) standards require countries to implement robust cold chain systems, including routine preventive maintenance, temperature monitoring, and temperature mapping of cold rooms and freezer rooms at least every two years.

In Ghana, a national cold chain inventory assessment conducted in March 2023 led to the development of a Cold Chain Equipment (CCE) inventory and gap analysis tool aimed at improving availability and functionality of CCE across all supply chain levels. Through support from the Gavi Cold Chain Equipment Optimisation Platform (CCEOP), more than 2,342 CCE were deployed to districts and health facilities, with an additional 1,339 units added in 2021–2022. Currently, approximately 38% of health facilities are equipped with CCE; about 92% have electricity availability exceeding eight hours per day, while 8% have limited or no reliable power supply.

Section 7.11 of the Immunisation Programme Field Guide further requires that immunisation records, including vaccine ledgers and cold chain maintenance records, be maintained at all levels—electronically or in hard copy—for at least three years to support programme monitoring and review.

Condition

***Temperature mapping of WICRs was overdue*:** Temperature mapping of WICRs at the National Cold Room and Regional Vaccine Stores was last conducted in 2022, exceeding the WHO-recommended two-year interval. The absence of recent temperature mapping increases the risk that temperature variations within cold rooms may go undetected, potentially compromising vaccine potency.

***Preventive maintenance planning and documentation were inadequate*:** There were no comprehensive preventive maintenance plans or service logs at the National Cold Room to demonstrate routine maintenance activities for CCE, including the four WICRs installed in 2022, which were outside their warranty period at the time of the audit. Similarly, at sub-national level: 3 of 4 Regional Vaccine Stores, 5 of 7 District Vaccine Stores, and 7 of 14 Health Facilities were not maintaining documented preventive maintenance plans or service logs for their CCE.

***Redundant and non-functional CCE were observed across levels*:** Prolonged non-use (redundancy) and lack of servicing of CCE increase the risk of blocked vents, temperature instability, and potential vaccine spoilage, while also constraining storage capacity. At the time of the audit: Six ultra-cold chain (UCC) units at the National Cold Room and Two WICRs at Volta Regional Vaccine Store were found to be redundant due to delayed servicing.
In addition, non-functional CCE (including UCC units and refrigerators) were observed at: 2 of 4 RVS, 2 of 7 DVS, and 7 of 14 HFs visited.

***Power backup arrangements at sub-national level were insufficient*:** The audit noted that 5 of 7 DVS and 10 of 14 HFs visited did not have power backup systems for CCE. In addition, contingency plans for managing vaccines during prolonged power outages were either unclear or not disseminated at sub-national levels.

Recommendation 13

To strengthen its cold chain management operations, MoH/EPI with support from partners should:

- Develop and implement comprehensive cold chain management SOPs, detailing standard procedures for operations, preventive and corrective maintenance, calibration, and procurement timelines for CCE spare parts and replacements.
- Introduce and enforce routine use of maintenance plans, service logs, and checklists at national and sub-national levels to ensure systematic documentation and follow-up of CCE maintenance activities.
- Provide targeted training for cold chain managers, technicians, and biomedical engineers on the application of maintenance tools, SOPs, and troubleshooting procedures.
- Prioritise completion of ongoing infrastructure works and conduct temperature mapping of all national and regional cold rooms in line with WHO requirements.

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- Strengthen power contingency arrangements at sub-national level by disseminating clear guidance on vaccine handling during power outages and advocating for dedicated budgets to support installation and maintenance of power backup systems.

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Root Cause

- Limited oversight of cold chain operations, including delays in procuring replacement parts and toolkits, irregular calibration of equipment, and incomplete documentation of maintenance activities.
- Absence of detailed cold chain management SOPs or operational manuals, resulting in inconsistent application of standardised procedures for preventive and corrective maintenance.
- Operational disruptions caused by ongoing infrastructure works, including reconstruction at the National Cold Room and installation of new cold rooms at Volta and Western North Regional Stores, which delayed completion of temperature mapping exercises.
- Inadequate funding for sub-national cold chain resilience, particularly for acquisition and maintenance of power backup systems.

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Management comments

See detailed management responses in Annex 19

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Risk / Impact / Implications

- Exposure of vaccines to fluctuating or inappropriate temperatures, leading to reduced shelf life, loss of potency, and potential wastage.
- Increased frequency of equipment breakdowns, reducing the service life of CCE and increasing reliance on emergency repairs or replacement.

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Responsibility

See detailed management responses in Annex 19

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Deadline / Timetable

See detailed management responses in Annex 19

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4.5.4 Delays in implementation of EVM assessment recommendations

Context and Criteria

Effective Vaccine Management (EVM) is a global framework designed to strengthen immunisation supply chains by ensuring that potent vaccines are available when and where needed across the life course. EVM assessments systematically evaluate the performance of key components of the immunisation supply chain, identify risks and weaknesses, and inform prioritised improvement actions.

Findings from EVM assessments are translated into an immunisation supply chain Continuous Improvement Plan (cIP), which is intended to guide investment, sequencing, and implementation of corrective actions over time. For Gavi-supported countries, an overall EVM score of at least 80% is considered indicative of an adequately functioning supply chain.

Ghana conducted an EVM assessment in 2014 using the EVM 1.0 tool, which assessed nine criteria (E1–E9), and achieved an overall score of 87%. In 2021, Ghana adopted the updated EVM 2.0 tool, which expanded the assessment to thirteen criteria (E1–M4) to reflect evolving supply chain requirements and good practice.

Condition

***Overall EVM performance declined between assessments*:** The 2021 EVM assessment recorded an overall score of 73%, representing a decline from the 87% achieved in 2014. Of the nine criteria that were comparable between the two assessments, seven showed regression, indicating deterioration in key areas of vaccine management rather than sustained improvement (see table below).

Table 22: Performance evaluation across two nationwide EVMA

Evaluation Criteria		Nationwide EVMA results in %	
		2014	2021
Vaccine arrivals	E1	94	73
Temperature management	E2	67	73
Storage and transportation capacity	E3	81	68
Facility infrastructure and equipment	E4	92	74
Maintenance and repair	E5	100	70
Stock management	E6	88	71
Distribution of vaccines and dry goods	E7	87	67
Vaccine management	E8	96	89
Waste management	E9	81	74
Annual needs forecasting	M1		74
Annual work planning	M2		69
Supportive supervision	M3		79
ISC performance monitoring	M4		70
All criteria		**87%**	**73%**

Recommendation 14

To strengthen immunisation supply chain performance and ensure effective follow-through on EVM assessments, the MoH/GHS should:

- Undertake a comprehensive review of the current implementation status of the Continuous Improvement Plan, identifying completed, ongoing, delayed, and unimplemented actions.
- Develop a prioritised and fully costed action plan, informed by risk, impact, and feasibility, and aligned with available financial and human resource capacity.
- Integrate systematic monitoring and reporting of cIP implementation into existing supply chain governance structures, with regular progress reviews and escalation of bottlenecks to senior management.
- Align future supply chain investments and partner support to the prioritised cIP to ensure coordinated, sustained improvements rather than fragmented interventions.

<table>
<tr><td colspan="2">Limited costing, prioritisation, and tracking of the Continuous Improvement Plan: Following the 2021 EVM assessment, Ghana developed a Continuous Improvement Plan (cIP) covering the period 2021–2025, outlining 87 recommended activities to address identified supply chain gaps. However:
• only 38% (33 out of 87) of the activities had been costed; and
• at the time of the audit, only these costed activities were ongoing, largely funded through Gavi support.

In addition, there was no systematic mechanism in place to track, monitor, and report on progress against the cIP, either through routine reporting or existing governance structures. As a result, implementation status, delays, and bottlenecks were not consistently visible to decision-makers.</td><td></td></tr>
<tr><td>Root Cause
• Insufficient oversight and accountability for cIP implementation, with progress not systematically monitored or reviewed through existing immunisation supply chain governance structures. See shortcomings in governance structures in issue 4.1.1
• Challenges in prioritisation and resourcing of cIP activities, including limited costing of recommendations and lack of a comprehensive financing and human resource plan to support full implementation beyond activities funded by Gavi.</td><td colspan="2">Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
• Identified supply chain risks and weaknesses persist or worsen, undermining vaccine availability, stock management, cold chain performance, and last-mile delivery.
• Investments in assessments do not translate into measurable system improvements, reducing value for money and weakening accountability.
• Supply chain performance continues to fall below expected standards, as evidenced by the declining EVM score, with implications for programme performance and equity—particularly as Ghana prepares for transition and greater reliance on domestic systems and financing.

The supply chain challenges highlighted on 4.5.2 and 4.5.3 are, in part, manifestations of the delayed and incomplete implementation of EVM recommendations.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.6 Budget and financial management

4.6.1 Weaknesses in financial controls and documentation led to questioned expenditures

Context and Criteria

The signed PFA (under Paragraph 19 of annex 2) required that "*in respect of all Gavi provided funds, the Government shall comply with Gavi requirements on the use and management of cash, including the following: (a) the Government shall use the cash solely to fund Programme Activities; (b) the Government shall ensure that the funds are prudently managed in accordance with the Transparency and Accountability Policy (TAP) and Financial Management Requirements; (c) in the case of cash in lieu of supplies, funds shall be used to purchase the vaccines in accordance with the self-procurement mechanism set out in the Country's application as reviewed and approved by Gavi and managed in accordance with all guidelines, procedures, standards, reporting requirements and recommendations (if any) on self-procurement mechanisms and in accordance with this Agreement and the relevant Decision Letter(s); and (d) the Government shall not apply any cash received from Gavi to satisfy its cofinancing obligations".*

Annex 2, paragraph 23 of the PFA requires that *"the Government shall maintain accurate and separate accounts and records of each of the Programmes prepared in accordance with internationally recognised standards that are sufficient to establish and verify accurately the costs and expenditures under the Programmes. The Government shall maintain such accounts and records and any other supporting documents evidencing expenses made with Gavi's funds according to the Country's fiscal requirements for a minimum of five (5) years after the completion of a Programme. In the event where Gavi provided funds are pooled with other sources of funding, accounts and records will equally be maintained for the pooled funds."*

The signed PFA, (under clause 15) requires that *"the Gavi funds provided under this Agreement shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies. The Government shall use its reasonable efforts to set up appropriate mechanism to exempt from duties and taxes all purchases made locally and internationally with Gavi funds."*

Annex 2, paragraph 20 of the PFA also defines misuse of funds and supplies. Sub paragraph 20.1 states that: *"in respect of all funds and vaccines and related supplies provided to the Government under the Programme(s), the Government shall comply with obligations and requirements on the use of such funds and supplies, including the following:*

- *the Government shall use the funds and vaccines, and related supplies received from GAVI under a programme for the sole purpose of carrying out the programme activities of such programme;*
- *the Government shall ensure that there is no misuse or waste of, or corrupt, illegal, or fraudulent activities involving the funds and vaccines and related supplies; and*
- *the Government shall ensure that all expenses relating to the use or application of funds are properly evidenced with supporting documentation sufficient to permit Gavi to verify such expenses.*

If the Government fails to comply with any of the above, such event shall be a "Misuse" (and "Misused" shall be construed accordingly)".

GHS developed Financial Management Standard Operating Procedures (FMSOPs) (dated August 2023) that were disseminated across its departments. Some of the stipulations in the FMSOPs that cover fuel and allowances are:

Section 5.3.2 (iv) of the FMSOPs state that *the finance office shall maintain activity/ledgers to track each program/activity fuel coupons to ensure appropriate usage and accountability*.

Section 4.3.4 (v) of the FMSOPs also state that *drivers' activities shall be monitored by the verification of daily logbooks.*

Section *4.3.2 (v and vi) of the FMSOPs state that each team shall have a supervisor and shall produce a report that will clearly state; the activities conducted, where the activities took place, when the activities took place, the persons who undertook the activity, outputs of the activity and any recommendations.*

GHS based per diem rates on a United Nations (UN) memorandum (dated 4 November 2022). The UN memo specifies a per diem rate of GH¢ 902 for regional capitals and GH¢ 638 for other locations and explicitly prohibits differentiated rates for categories of staff.

Condition

The audit team reviewed a sample of expenditures totalling USD 2,997,317 (GH¢ 26,487,097) incurred between 1 January 2020 and 31 December 2024, covering expenditures at GHS EPI, GHS Headquarters, MoH, selected Regional Health Directorates (RHDs), and District Health Directorates (DHDs). The sample also included funds disbursed to GHS EPI by partners (WHO and UNICEF).

Based on the documentation available, the audit team questioned expenditures totalling USD 706,381 (23% of sample) categorised as follows.

Table 23: Summary of questioned costs in USD

	Inadequate	Irregular	Unsupported	Ineligible	Total
GHS EPI	177,319	59,001	9,217	-	245,538
GHS HQ	4,321				4,321
MoH	82,797	1,080	-	-	83,877
WHO funds to GHS EPI	154,532	29,275	2,791	-	186,599
UNICEF funds to GHS EPI	32,782	2,408	9,903	-	45,092
Sub-national level	90,854	50,094	-	6	140,954
	542,606	**141,858**	**21,911**	**6**	**706,381**

*Excluded from the table above is **USD 24,944** related to VAT. While excluded from the questioned expenditure, MoH and GHS should recover these amounts from treasury and return to the programme.* A more detailed summary is provided under Annex 14a).

Inadequately supported expenditures (USD 542,606/GH¢ 4,407,054) – These comprised transactions where supporting documentation was incomplete or insufficient to verify the expenditure, including:

- missing or unsigned attendance sheets, meeting minutes, activity reports, and third-party invoices or receipts;
- reliance on photocopied documents without originals;
- fuel expenditures supported only by fuel coupons, without vehicle request forms, activity registers, completed vehicle logbooks, or documented allocation methodology.

In particular, fuel payment vouchers lacked key information required under the FMSOPs, including vehicle registration numbers, destinations, distances to be covered, fuel consumption estimates, and completed logbooks.

Irregular expenditures (USD 141,858/GH¢ 1,611,175) – These included transactions where applicable procurement and payment procedures were not followed, such as:

- failure to obtain the required number of supplier quotations;
- per diem payments supported only by mobile money transfer records, without documentation of activity duration, applicable rates, or confirmation of participant attendance.

The audit also noted application of unapproved and non-standardised per diem rates. Rates applied by GHS (GH¢ 900 for officers and GH¢ 500 for drivers) were inconsistent with the UN memorandum, which prohibits differentiated rates by staff category and requires lower rates for non-regional capital locations. The practice applied creates inequity, a practice discouraged for Gavi funding. At sub-national level, RHDs applied significantly lower rates (GH¢ 350 and GH¢ 250), further highlighting inconsistency and lack of standardisation.

Recommendation 15

To ensure that funds are properly and adequately accounted for, MoH and GHS management should ensure that:

- Ensure all expenditures are fully supported by appropriate documentation, including signed attendance sheets, meeting minutes, activity reports, detailed per diem and allowance schedules, third-party invoices and receipts, acknowledgement forms, and completed vehicle logbooks.
- Develop, approve, and disseminate a standardised per diem policy applicable across MoH and GHS, aligned with approved benchmarks and applied consistently at all levels.
- Ensure that Gavi funds are not used to pay VAT or other ineligible taxes and establish controls to prevent such charges.
- Strengthen internal review and validation processes, including routine verification of supporting documents at accounts offices and enhanced financial oversight during supportive supervision visits.
- Strengthen review of sub-national expenditures, including regular validation of statements of expenditure from RHDs and DHDs.
- Strengthen review of sub-national expenditures, including regular validation of statements of expenditure from RHDs and DHDs.
- Liaise with WHO and UNICEF to strengthen financial reviews of reports submitted by MoH and GHS to include detailed inspection of supporting documentation, rather than reliance on summary expenditure reports.

<table>
<tr><td colspan="3">Unsupported expenditures (USD 21,911/GH¢ 150,041) – These comprised expenditures for which no supporting documentation was provided, or where the value per the supporting documents was less than the amount recorded in expenditure listings.

Ineligible expenditures (USD 6/GH¢ 90) – The audit identified expenditures that were not related to approved Gavi programme activities, including use of grant funds for activities outside approved budgets and without evidence of prior approval from Gavi.

Similar weaknesses were previously reported in the 2019 Gavi programme audit (see finding 4.1.3 in the Ghana November 2020), indicating that these issues are recurrent.</td><td></td></tr>
<tr><td colspan="3">Root Cause
While Gavi has put in place TA to support the design of controls for finance, some SOPs require improvement for example, the SoP remains silent on detailed requirements for accountability of DSA. Also, the finance team has not ensured consistent implementation of the SoP for fuel acquittals.
Non-adherence to laws and regulations including FMSOPs requirements.
Financial reviews by the partners (WHO and UNICEF) did not include detailed reviews of supporting documents for the reported expenditures.
Absence of an approved per diem policy for MoH and GHS.
Poor document retention and archiving practices mean that the required documents for expense liquidation are not filed together for reference and review.</td><td>Management comments

See detailed management responses in Annex 19</td></tr>
<tr><td colspan="3">Risk / Impact / Implications
Non-compliance with the PFA and grant agreement, which led to ineffective financial procedures and resulted in questioned costs. This may indicate that Gavi funds are not being utilised effectively and efficiently, as well as the potential risk of financial mismanagement, or fraud.
Poor health outcomes of the targeted population, as the funds intended for the vaccination programme may not be utilised optimally, due to inadequate financial procedures and controls.
Incurring VAT expenses reduces the amount of funds available for the implementation of programme activities.</td><td>Responsibility

See detailed management responses in Annex 19</td><td>Deadline / Timetable

See detailed management responses in Annex 19</td></tr>
</table>

4.6.2 Traceability and accountability of Gavi Funds at GHS and MoH needs to be improved

Context and Criteria

The Accounting, Treasury and Financial (ATF) Reporting Rules and instructions, 2016 state that *"As a final check of the integrity of financial information contained in Departmental Cash Books, Accounts Staff should prepare a Bank Reconciliation for each Bank account maintained by the Budget Management Centres (BMC). In the case where one BMC is managing Account on behalf of others, a supporting schedule should be attached to the Bank Reconciliation showing each BMC of Record's respective share of the "book" balance. (Section M, sub-section M2, page 118)"*
The PFA (Article 23) states the Government shall maintain accurate and separate accounts and records of each of the Programmes prepared in accordance with internationally recognised standards that are sufficient to establish and verify accurately the costs and expenditures.

Section 6.4 (i) of the FMSOPs states that *'where a commingled bank account is being used by a BMC, account managers/accounts staff shall prepare and submit monthly fund balances reports of their respective cashbooks to the Head of Finance not later than 15 days within the ensuing month.'*

Condition

Gavi cash grants disbursed to the Republic of Ghana are maintained in commingled accounts (also referred to as 'donor pooled accounts') at GHS and MoH. Gavi funds are first disbursed to the GHS HQ USD account (no. 2441000851448) held at Eco Bank Limited. The funds are then transferred to other local currency (GHS and MoH) accounts as below:

Table 24: Bank accounts that hold Gavi funds at GHS and MoH

Entity	Bank Name	Account number	Purpose
GHS HQ	Consolidated Bank of Ghana (CBG) account	0272018100005	Funds for HSS grant
GHS EPI	Consolidated Bank of Ghana (CBG) account	0272018100003	Campaign funds from GHS HQ
MoH	Bank of Ghana (Central)	1018631527237	Transfers from GHS HQ or EPI for various activities

NB: *The same accounts also receive any cash transfers from WHO and UNICEF.*

GHS uses the SAGE ACCPAC accounting system in all its departments. Receipts and expenses related to Gavi funding are posted in specific ledger accounts created in the system. The accountants at GHS HQ and EPI also maintain separate excel-based expenditure listings from which they prepare financial reports submitted to Gavi. The accountants are expected to reconcile transactions in the expenditure listings with the SAGE system. The accountants also prepare cash book balances reconciliations for various donors or programmes. On the other hand, MoH uses a transactional tool for donor funds. This is a reporting tool that manages the transactions from commitment to reporting level.
The audit team noted the following differences/variances in the reconciliations prepared at GHS and MoH:

At MoH as at 31 December 2024

There was a variance of **USD 160,425 (GH¢ 1,551,313)** between the expected Gavi fund balance and the bank reconciliation balance as shown in the table below:

Recommendation 16

- GHS EPI team should immediately make available for use the amount of GH¢ 2,189,569 (USD 226,429) held in the Gavi refund account ledger.
- GHS (HQ and EPI) should reconcile monthly the external expenditure listings/financial reports to the SAGE system/cash book balances. Any variances noted should be investigated and resolved. Reconciliations should be signed off by the preparer and reviewer to maintain transparency of process and accountability for review.
- At both GHS and MoH, where Gavi funds are used to fund other projects/programmes, journal vouchers should be maintained and followed up periodically to ensure that Gavi provided funds are returned to the designated Gavi account as required by the grant management requirements; and
- Bank reconciliation statements and relevant journal vouchers (with corresponding schedule of balances per funding source) should be reviewed and signed off by senior management within MoH and GHS management team to

Table 25: MoH: Reconciliation of balances of Gavi funds as at 31 December 2024

	Grant	Amount GH¢	Amount USD
Total transfers to MoH	HSS	5,008,460	517,938
	CDS 3	540,048	55,848
Total (a)		**5,548,508**	**573,786**
Reported expenditure	HSS	2,891,352	299,002
	CDS 3	531,892	55,005
Total (b)		**3,423,244**	**354,007**
Expected fund balance *(a-b)*		**2,125,264**	**219,779**
Available bank balance at 31 Dec 2024		573,950	59,354
Difference		***1,551,314***	***160,425***

*The difference represents Gavi funds that were not in the bank account at the close of the audit period. The audit team noted that on 13 December 2023, there was an instruction from the Chief Director sent to the Bank of Ghana to transfer **GH¢ 6,852,953** from the MoH Central Account to the Health Training institution's account. As of 31 December 2024, the outstanding unpaid balance on this inter borrowing was **GH¢ 5,652,953**.

At GHS EPI as at 31 December 2024

There was a variance of **USD 751,342 (GH¢ 7,265,479**) between the expenditure listings and the SAGE system/cash book balances as shown in the subsequent table:

Table 26: GHS EPI: Reconciliation of balances of Gavi funds as at 31 December 2024

	Expected balances as per expenditure listings provided	
	GH¢	USD
CDS3	11,495,968	1,188,828
IPV	-	-
MVIP	209,693	21,685
MR	998,445	103,252
Total expenditure listing balances (a)	**12,704,106**	**1,313,765**
GAVI balance as per cash book (SAGE) reconciliation **(b)	19,969,585	2,065,107
Variance (a - b)	**(7,265,479)**	**(751,342)**

The SAGE balances of **GH¢ 19,969,585 included:

- **GH¢ 17,780,016 (USD 1,838,678)** balances in the main GAVI ledger account; and
- **GH¢ 2,189,569 (USD 226,429)** balances in a ledger account named "GAVI Refund". This ledger account held VAT refunds that were questioned during the previous audit carried out in 2019. At the time of this audit, the funds had not been released to the programme since 2022 when the refunds were deposited in the GHS EPI Cedi account.

At GHS EPI as at 30 June 2025

The audit team also reviewed the reconciliation of Gavi balances as at 30 June 2025 that was prepared by GHS EPI. The reconciliation is provided under annex 13.

The following were noted from the reconciliation:

- The ledger account named 'GAVI refunds' still had the balance of **GH¢ 2,189,569 (USD 226,429)**.

ensure transparency, accuracy and completeness.

<table>
<tr><td>

- The expected recomputed Gavi fund balance (from expenditure listings provided) was **GH¢ 64,557,354 (USD 6,676,045)** while the actual bank balance was **GHS 44,189,320 (USD 4,569,733).** The was thus a difference of **GH¢ 20,368,034 (USD 2,106,312)** that represented Gavi funds not in the bank account.
- The expected recomputed Gavi fund balance (from expenditure listings provided) was **GH¢ 64,557,354 (USD 6,676,045)** while the SAGE system/cash book balances as per the reconciliation provided by GHS EPI was **GH¢ 56,287,691 (USD 5,820,857)**. There was thus a difference of **GH¢ 8,269,663 (USD 855,187).**
- GHS EPI provided a separate reconciliation from the expenditure listings which from which the following was noted:
- A reversal of **GH¢ 10,371,200 (USD 1,072,513)** was included which reduced the balances from **GH¢ 64,548,954 (USD 6,675,176)** to **GH¢ 54,177,755 (USD 5,602,663).** The GHS EPI team explained that the amount was transfer to GCNH that was entered twice in the SAGE system but reversed in August 2025. This had led to a lower SAGE system/cash book balance as at 30 June 2025.
- The balance for MVIP grant was reported as **GH¢ 193,625 (USD 20,023)** instead of the expected **GH¢ 202,025 (USD 20,892)**. The variance of **GH¢ 8,400 (USD 869)** was due to a transaction that was not included in the expenditure listings provided to the audit team.

NB: *The exchange rate used for conversion is GHS 9.67 to USD 1.*

Further, this issue was raised in the 2019 Gavi programme audit, see finding 4.1.2 published in November 2020.

</td><td></td></tr>
<tr><td>

Root Cause

- Lack of regular reconciliations of Gavi expenditure listings and the SAGE ACCPAC accounting system/cash book balances which led to differences that were not corrected in time.
- While GHS and MoH noted that bank reconciliations are completed on a quarterly basis, the audit found no evidence of completed and signed off bank reconciliations, a recommendation made in the 2019 programme audit report.
- Interproject borrowing in the comingled bank accounts without proper tracking and timely reimbursement of funds. The accounts at GHS and MoH that hold Gavi funds also hold other donor funds. The audit team noted that funds in the accounts were at times utilised for other donor activities or transferred from the bank accounts to other entities or accounts.
- Journal vouchers are not maintained for proper traceability of interproject borrowing within the comingled bank account.

</td><td>

Management comments

See detailed management responses in Annex 19

</td></tr>
<tr><td>

Risk / Impact / Implications

- Lack of traceability of Gavi provided funds contravenes the requirements of the PFA.
- The interproject borrowing without timely reimbursements impacted implementation of Gavi funded activities due to unavailability of funds.
- Lack of regular reconciliations between the Gavi expenditure listings and SAGE ACCPAC accounting system resulted in undetected errors in financial reports submitted to Gavi.

</td><td>

Responsibility

See detailed management responses in Annex 19

</td><td>

Deadline / Timetable

See detailed management responses in Annex 19

</td></tr>
</table>

4.6.3 *Improvements required in advances management at national level*

Context and Criteria

The Accounting, Treasury and Financial (ATF) Reporting Rules and instructions, 2016, require that *funds received and transferred to BMCs are treated as advances by the transferring BMC (Transferor) and as Funds held in trust by the receiving BMC. (Section F, sub-section F.1, page 74) and that National BMC recognise expenses only upon receipt of a retirement from the RHD (page 85)*.

Section 1.3.4 of the FMSOPs state that *(iii) An implementing level BMC, upon receipt of funds into its bank account, has a maximum 90 calendar days to use the funds as per activity implementation guidelines. (iv) Funds not utilised after the implementation timeline shall be returned to the source with a report from the Principal Spending Officer giving the reason for non-utilisation.*

Condition

***Advances to sub-national levels were expensed before verification**:* All disbursements made from central level (GHS Headquarters and EPI) to Regional and District Health Directorates (RHDs and DHDs) were recorded as expenditure in the SAGE accounting system and included in expenditure listings and financial reports submitted to Gavi. These disbursements were not recorded as advances, contrary to the ATF and FMSOPs requirements.

RHDs are required to submit Statements of Expenditure (SoEs) every 90 days to retire advances. However, there was no evidence that:

- SoEs submitted by RHDs were systematically reviewed and validated; or
- accounting adjustments were made to previously expensed amounts where variances between advances issued and actual expenditures were identified.

As a result, advances were recognised as final expenditure without confirmation that the underlying activities had been implemented.

Delays in utilisation and retirement of advances at sub-national level: The audit identified multiple instances where advances provided to RHDs were utilised and expensed well beyond the 90-day limit prescribed in the FMSOPs. For example, advances issued to the Volta Region were expensed more than 500 days after disbursement from central level. Consequently, quarterly financial reports submitted to Gavi may have included amounts recorded as expenditure for activities that had not yet been carried out at the time of reporting. Examples of advances expensed after the 90-day threshold are detailed in Annex 16**.**

Further, this issue was raised in the 2019 Gavi programme audit, see finding 4.1.1

Recommendation 17

To strengthen advances management and improve the accuracy of financial reporting, it is recommended that:

- GHS Headquarters and EPI fully implement the ATF (2016) and FMSOP requirements for Gavi-funded activities. Specifically:
  - all disbursements to sub-national levels should be recorded as advances, not as expenditure; and
  - expenditure should only be recognised upon receipt, review, and validation of SoEs evidencing actual costs incurred.
- Accounting adjustments should be systematically made in the SAGE system to reverse unretired advances and to recognise only verified expenditures. Any unutilised funds should be recovered or returned in line with FMSOP requirements.
- The 90-day utilisation and retirement requirement for advances should be reiterated and enforced at sub-national levels, supported by regular monitoring and escalation of non-compliance to senior management.

<table>
<tr><td>Root Cause
Non-adherence to ATF and FMSOP requirements, particularly regarding the treatment of advances and timing of expense recognition.
Incomplete operationalisation of the FMSOPs, despite their issuance in August 2023 to address known gaps in advances management.
Insufficient oversight and monitoring mechanisms at central level to ensure that advances issued to sub-national units are utilised and retired within prescribed timelines.</td><td colspan="2">Management comments
See detailed management responses in Annex 19</td></tr>
<tr><td>Risk / Impact / Implications
Financial reports submitted to Gavi are misstated, compromising their accuracy, credibility, and compliance with the Partnership Framework Agreement.
Accountability for advances is weakened, as unutilised or delayed funds are not readily identified, recovered, or reprogrammed.
Programme implementation is adversely affected, where delays in fund utilisation reduce the timeliness and effectiveness of planned activities.</td><td>Responsibility
See detailed management responses in Annex 19</td><td>Deadline / Timetable
See detailed management responses in Annex 19</td></tr>
</table>

Annexes

Annex 1 : Acronyms

AEFI	Adverse Event Following Immunisation
BCG	Bacillus Calmette–Guérin
BMC	Budget Management Centre
CCE	Cold Chain Equipment
CSO	Civil Society Organisation
CVS	Central Vaccine Store
cMYP	Comprehensive Multi-Year Planning
DHD	District Health Directorate
DHIS	District Health Information System
DHMT	District Health Management Team
DQIP	Data Quality Improvement Plan
DSA	Daily Subsistence Allowance
DVS	District Vaccine Store
EPI	Expanded Programme of Immunisation
FMSOPs	Financial Management Standard Operating Procedures
GCNH	Ghana Coalition of NGOs in Health
GH¢	Ghanaian Cedi
GHS	Ghana Health Service
GNI	Gross National Income
GSS	Ghana Statistical Services
HF	Health Facility
HQ	Headquarters
HISP	Health Information System Program
HR	Human Resource
HSS	Health Systems Strengthening
HSWG	Health Sector Working Group
ICC	Interagency Coordinating Committee
ID	Identification
IPM	Internal Procedures Manual
IPV	Inactivated Polio Vaccine
ISS	Integrated Supportive Supervision
JSI	John Snow, Inc
LMIS	Logistics Management Information System
MoH	Ministry of Health
MR	Measles Rubella
MVIP	Malaria Vaccine Implementation Programme
NGO	Non-Governmental Organisation
NIS	National Immunisation Strategy
NITAG	National Immunisation Technical Advisory Group
ODK	Open Data Kit
PCV	Pneumococcal Conjugated Vaccine
PFA	Partnership Framework Agreement
RHD	Regional Health Directorate
RVS	Regional Vaccine Store
SIA	Supplementary Immunisation Activities
SMT	Stock Management Tool
SoE	Statement of Expenditure
SOP	Standard Operating Procedure
SORMAS	Surveillance Outbreak Response Management and Analysis System
TCA	Targeted Country Assistance
ToR	Terms of Reference
TWG	Technical Working Group
UCC	Ultra Cold Chain
UI	Under-Immunised
UNICEF	United Nations Children's Fund
USD	United States Dollar
VAT	Value Added Tax
VIG	Vaccine Introduction Grant
VVM	Vaccines Vial Monitor
WHO	World Health Organisation
WICR	Walk In Cold Room
ZD	Zero Dose
3PL	Third Party Logistics

Annex 2 : Methodology

Gavi's Audit and Investigations (A&I) audits are conducted in conformance with the Global Internal Audit Standards of the Institute of Internal Auditors. These Standards constitute the fundamental requirements for the professional practice of internal auditing and for evaluating the effectiveness of the audit activity's performance. The Institute of Internal Auditors' Global Guidance is also adhered to as applicable to guide operations. In addition, A&I staff adhere to A&I's Audit Manual.

The principles and details of the A&I's audit approach are described in its Board-approved Terms of Reference and Audit Manual and specific terms of reference for each engagement. These documents help our auditors to provide high quality professional work, and to operate efficiently and effectively. They help safeguard the independence of the A&I's auditors and the integrity of their work. The A&I's Audit Manual contains detailed instructions for carrying out its audits, in line with the appropriate standards and expected quality.

In general, the scope of A&I's work extends not only to the Gavi Secretariat but also to the programmes and activities carried out by Gavi's grant recipients and partners. More specifically, its scope encompasses the examination and evaluation of the adequacy and effectiveness of Gavi's governance, risk management processes, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve Stated goals and objectives.

Annex 3 : Definitions – audit opinion, audit rating and prioritisation

A. Overall Audit Opinion

The audit team ascribes an audit rating for each area/section reviewed, and the summation of these audit ratings underpins the overall audit opinion. The audit ratings and overall opinion are ranked according to the following scale:

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

B. Issue Rating

For ease of follow up and to enable management to focus effectively in addressing the issues in our report, we have classified the issues arising from our review in order of significance: High, Medium and Low. In ranking the issues between 'High,' 'Medium' and 'Low,' we have considered the relative importance of each matter, taken in the context of both quantitative and qualitative factors, such as the relative magnitude and the nature and effect on the subject matter. This is in accordance with the Committee of Sponsoring Organisations of the Treadway Committee (COSO) guidance and the Institute of Internal Auditors standards.

Rating	Implication
High	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating high inherent risks or strategic business risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a major impact on delivery of organisational objectives; major reputation damage; or major financial consequences. • The risk has either materialised or the probability of it occurring is very likely and the mitigations put in place do not mitigate the risk. • Fraud and unethical behaviour including management override of key controls. Management attention is required as a matter of priority.
Medium	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating medium inherent risks are either inadequate or ineffective. • The issues identified may result in a risk materialising that could either have: a moderate impact on delivery of organisational objectives; moderate reputation damage; or moderate financial consequences. • The probability of the risk occurring is possible and the mitigations put in place moderately reduce the risk. Management action is required within a reasonable time period.
Low	At least one instance of the criteria described below is applicable to the finding raised: • Controls mitigating low inherent risks are either inadequate or ineffective. • The Issues identified could have a minor negative impact on the risk and control environment. • The probability of the risk occurring is unlikely to happen. Corrective action is required as appropriate.

Annex 4 : List of sites visited

Regions (4)	Operational Districts (7)	Health Centers (14)
Greater Accra	Ashaiman District	Niima CHPS
		Ashaiman Municipal Hospital
Volta	Ho	Ho Polyclinic
		Council Hall
	Ketu South	Central Aflao
		Denu Health Centre
Northern	Tamale Metropolitan	Bilpeila Health Centre
		Kpanvo Health Centre
	Yendi Municipal	Yendi Central Health Centre
		Adibo Health Centre
Western North	Sefwi Akontombra	Kofikrom CHPS
		Futa CHPS
	Sefwi Wiawso	Punikrom CHPS
		Edewakrom CHPS

Annex 5a) : Ghana's immunisation schedule

Antigen	Period
BCG	At birth
OPV0	
OPV1	At 6 weeks
PCV1	
DTP HepB-Hib (Penta) 1	
Rota1	
OPV 2	At 10 weeks.
PCV 2	
DTP HepB-Hib (Penta) 2	
Rota 2	
OPV 3	At 14 weeks.
PCV 3	
DTP HepB-Hib (Penta) 3	
Rota 3	
IPV 1	
Malaria Vaccine 1	At 6 months
Malaria Vaccine 2	At 7 months
MR 1	At 9 months
YF	
Malaria Vaccine 3	
MR 2	At 18 months
Meningococal A	
Malaria Vaccine 4	At 24 months
HPV	Between 9 to 14 years for girls

Annex 6b) : Disbursements of funds to partners

Partner	2020	2021	2022	2023	2024
BUCKLE				38,100	64,500
CDC	150,000	73,000			
IBRD				431,173	
JSI		109,794	176,573	3,493	193,102
MAHA	140,433				
MMGH			42,772	12,944	
NOG					121,413
PATH	186,686	158,868	98,213	40,706	97,378
PWC	12,786		293,410	421,380	
UNI OF OSLO	18,018	544	69,081		
UNICEF	336,231	465,047	815,631	656,962	73,200
WHO	286,814	248,987	491,108	623,968	160,150
Grand Total	**1,130,968**	**1,056,240**	**1,986,788**	**2,228,727**	**709,743**

Annex 6: Assessment of Ghana's readiness for transition

Area	Audit Assessment	Score
Transition assessment and planning	The country has a documented Transition Roadmap to act as a guide and a tool for both advocacy and strategy. Our assessment revealed slow progress on implementation of the roadmap.	
Governance	Although governance and oversight mechanisms are in place, these have not been effective. *(See governance and oversight finding for details)*	
Financial management and use of country systems (PFM).	We reviewed this along 7 key components including Budgetary, treasury, accounts, systems, people, audit, procurement. We observed recent improvements in budget visibility at national level, ongoing transition to use of GIFMIS at all levels, Supreme Audit Institution used to perform grant audits, use of Supplies, Stores and drugs Management Division (SSMD) for all procurement. Grants being managed by use of country treasury guidelines and manuals.	
Programme performance	While the country experienced a 6% decline in child immunisations during the COVID-19 lockdown in April 2020, it implemented catch-up vaccination programs, leading to a recovery to pre-pandemic growth levels by 2021. Additionally, the number of zero dose is reported to have decreased by 17,000 between 2019 and 2022. However, there remain issues with the population denominator used – which leaves questions around the actual programme performance. See finding 4.4.1	
Financing	The roadmap includes / captures all immunisation related costs both operational costs (warehousing, distribution and SC) plus vaccine costs. The country has prepared investment case for optimisation of vaccine portfolio including PCV switch. However, country has had challenges with adequacy and timeliness of meeting co-financing payments in the audit period and remain reliant on Gavi for funding operational costs for immunisation beyond salaries for government employees. See finding 4.2.2	
Service delivery	Successful introduction of malaria vaccine with new plans to scale up and switch, recent introduction of HPV, Hep B birth dose, second dose of inactivated polio vaccine, planning for PCV switch. However, there remain gaps in ensuring availability of services in hard-to-reach and marginalised communities. Additionally, the country still struggles with serious supply chain issues. *See finding 4.2.5 for gaps in reaching marginalised communities and finding 4.5.1 for vaccine stock outs noted due to supply chain challenges*	

Annex 7: Data errors in SORMAS

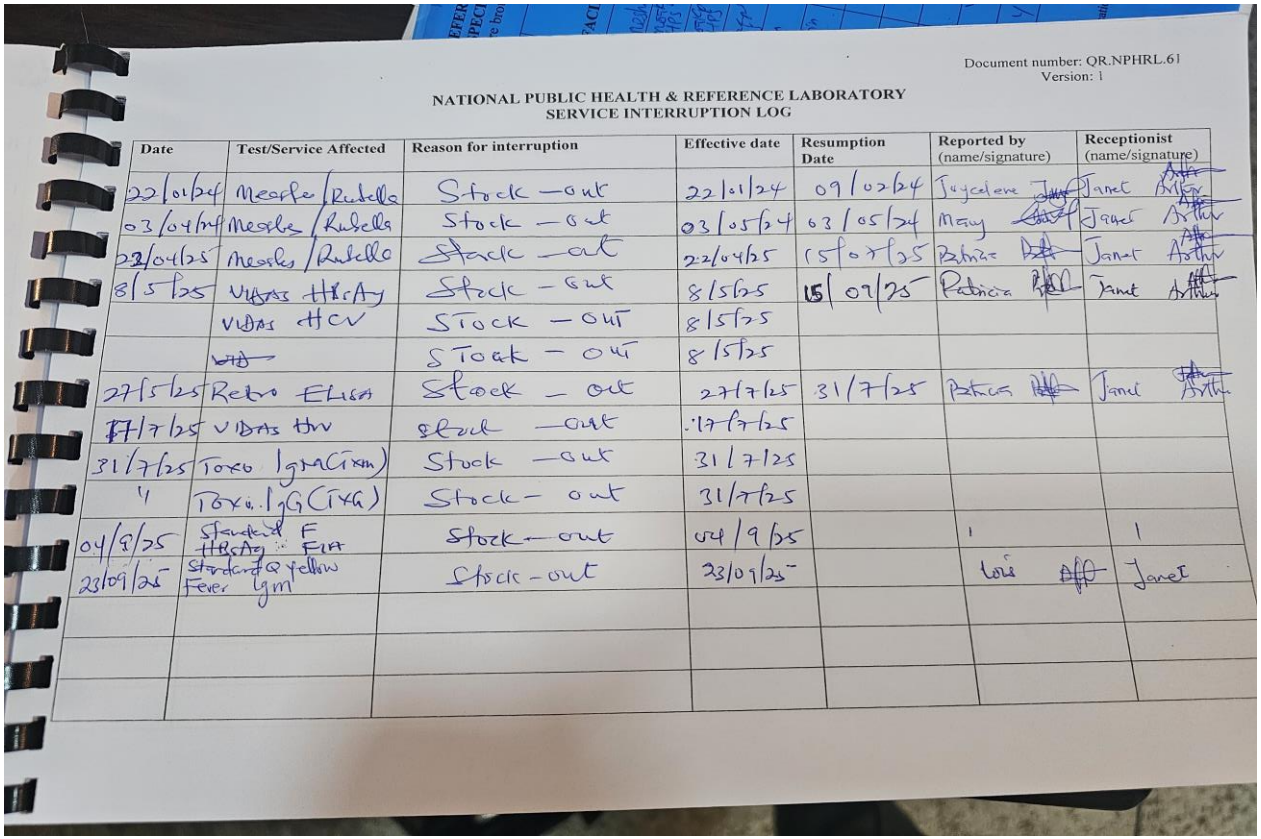
Duplicated case IDs in SORAMS

Countr	Case Sf	Case ID	EPID number	Sex	Pregna
GHA	8403609	UB	S-20-008	Female	
GHA	8402277	VN	S-20-008	Male	
GHA	1.2E+07	XX	S-21-005	Male	
GHA	8307920	UW	S-21-005	Female	
GHA	2E+07	TU	S-23-017	Female	
GHA	2E+07	T2F	S-23-017	Female	No
GHA	8365879	XAE	S-21-001	Male	
GHA	4384888	XLP	S-21-001	Male	
GHA	1.7E+07	XE3	S-22-001	Male	
GHA	2E+07	SRK	S-22-001	Male	
GHA	1.7E+07	RR(	S-22-002	Female	No
GHA	2E+07	QF	S-22-007	Female	No
GHA	2E+07	SGF	S-22-007	Female	No
GHA	1.1E+07	QB	S-21-002	Male	
GHA	1.1E+07	V4T	S-21-002	Male	
GHA	2E+07	RRE	W-22-007	Female	
GHA	2E+07	W3	W-22-007	Male	
GHA	2E+07	R3S	S-22-007	Female	
GHA	2E+07	UV	S-22-007	Female	
GHA	2E+07	WV	S-23-005	Female	No
GHA	2E+07	WD	S-23-005	Male	
GHA	2.1E+07	UZ	S-24-014	Male	No
GHA	2.1E+07	WS	S-24-014	Female	
GHA	2E+07	QX	N-23-011	Female	No

Date of Investigation is before date of reporting

Date of report (dd/MM/yyyy)	Case classification	Investigation status	Date of investigation (dd/MM/yyyy)	Outcome of case	No. of days btwn report and investigation	Date
17/05/2024	Suspect case	Investigation done	18/03/2024	No Outcome Yet	-60	
20/02/2021	Suspect case	Investigation done	20/01/2021	No Outcome Yet	-31	
20/07/2022	Suspect case	Investigation done	24/06/2022	No Outcome Yet	-26	
23/02/2023	Not a case	Investigation done	23/03/2023	No Outcome Yet	-702	
03/05/2023	Confirmed case	Investigation done	05/03/2023	No Outcome Yet	-59	
24/09/2024	Suspect case	Investigation done	24/09/2023	No Outcome Yet	-366	
26/12/2022	Confirmed case	Investigation done	26/11/2022	No Outcome Yet	-30	
02/03/2022	Confirmed case	Investigation done	02/02/2022	Recovered	-28	
17/10/2024	Suspect case	Investigation done	01/07/2024	Recovered	-108	
10/10/2024	Not a case	Investigation done	12/05/2024	Recovered	-151	
16/03/2023	Not a case	Investigation done	21/02/2023	Recovered	-23	
09/12/2022	Not a case	Investigation done	30/03/2022	Recovered	-254	
31/05/2021	Suspect case	Investigation done	10/02/2021	No Outcome Yet	-110	
31/05/2021	Suspect case	Investigation done	10/03/2021	No Outcome Yet	-82	
31/05/2021	Suspect case	Investigation done	06/04/2021	No Outcome Yet	-55	
31/05/2021	Suspect case	Investigation done	06/04/2021	No Outcome Yet	-55	
31/05/2021	Suspect case	Investigation done	08/04/2021	No Outcome Yet	-53	
31/05/2021	Suspect case	Investigation done	08/04/2021	No Outcome Yet	-53	
31/05/2021	Suspect case	Investigation done	13/04/2021	No Outcome Yet	-48	
07/02/2022	Suspect case	Investigation done	09/08/2021	No Outcome Yet	-182	
07/02/2022	Suspect case	Investigation done	28/09/2021	No Outcome Yet	-132	
07/02/2022	Suspect case	Investigation done	18/10/2021	No Outcome Yet	-112	
07/02/2022	Suspect case	Investigation done	29/10/2021	No Outcome Yet	-101	
06/10/2023	Suspect case	Investigation done	31/07/2023	No Outcome Yet	-67	
31/08/2021	Not yet classified	Investigation done	31/08/2020	No Outcome Yet	-365	
24/09/2021	Suspect case	Investigation done	29/08/2021	No Outcome Yet	-26	
03/09/2024	Suspect case	Investigation done	08/04/2024	No Outcome Yet	-148	
12/01/2022	Suspect case	Investigation done	11/01/2021	Recovered	-366	

Annex 8: Stock register showing outs of laboratory reagents



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NATIONAL PUBLIC HEALTH & REFERENCE LABORATORY
SERVICE INTERRUPTION LOG

Date	Test/Service Affected	Reason for interruption	Effective date	Resumption Date	Reported by (name/signature)	Receptionist (name/signature)
22/01/24	Measles/Rubella	Stock – out	22/01/24	09/02/24	Jaycelene	Janet
03/04/24	Measles/Rubella	Stock – out	03/05/24	03/05/24	Mary	Janet
22/04/25	Measles/Rubella	Stock – out	22/04/25	15/07/25	Patricia	Janet
8/5/25	VIDAS HBsAg	Stock – out	8/5/25	15/09/25	Patricia	Janet
	VIDAS HCV	STOCK – OUT	8/5/25			
	~~VIDAS~~	STOCK – OUT	8/5/25			
27/5/25	Retro ELISA	Stock – out	27/7/25	31/7/25	Patricia	Janet
27/7/25	VIDAS HIV	Stock – out	27/7/25			
31/7/25	Toxo IgM(Vidas)	Stock – out	31/7/25			
"	Toxo IgG(Vidas)	Stock – out	31/7/25			
04/8/25	Standard F HBsAg	Stock – out	04/9/25		"	"
23/09/25	Standard Q yellow Fever IgM	Stock – out	23/09/25		Lois	Janet

Annex 9: Total funds allocated to CSOs engaged per region by GCNH

	Total funds allocated to CSOs engaged per region		
	2021 & 2022	2022 & 2023	2023 &2024
Ashanti	85,000	139,611	130,869
Bono East	-	88,611	45,223
Eastern	18,000	88,611	88,046
Greater Accra	158,000	88,611	88,046
North-East	2,000	37,611	23,811
Northern	14,000	54,611	45,223
UPPER EAST	68,000	37,611	45,223
UPPER WEST	31,000	37,611	23,811
Volta	84,000	139,611	88,046

Annex 10: Vaccine stock outs

10a) Stock outs at regional level

Name of RVS	Name of Vaccine	Stockout 1		Stockout 2		Stockout 3		Stockout 1 Days	Stockout 2 Days	Stockout 3 Days
		Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	[Diff btn start & end date]	[Diff btn start & end date]	[Diff btn start & end date]
Volta Region Vaccine Store	Pentavalent	10/4/2022	10/14/2022	10/14/2024	10/22/2024	10/22/2024	10/26/2024	10	8	4
	PCV	5/5/2022	5/12/2022	10/22/2024	10/26/2024			7	4	0
	Yellow Fever (YF)	1/10/2022	1/25/2022	4/28/2022	5/12/2022	2/3/2023	2/6/2023	15	14	3
	IPV	10/13/2021	10/26/2021	10/8/2024	10/26/2024			13	18	0
	Measles Rubella (MR)	11/13/2020	12/16/2020	12/30/2020	1/16/2021	6/7/2022	6/21/2022	33	17	14
	BCG	4/29/2020	6/17/2020	9/25/2020	9/28/2020	5/5/2022	6/21/2022	49	3	47
	Rotavirus (RV)	2/16/2023	3/10/2023	3/15/2023	4/17/2023	5/22/2023	6/1/2023	22	33	10
Western North Regional Vaccine Store	Pentavalent	5/25/2022	7/2/2022	7/2/2022	8/4/2022	8/9/2022	9/6/2022	33	28	10
	PCV	8/9/2022	9/6/2022	9/7/2022	11/3/2022	1/11/2023	2/7/2023	57	27	4
	Yellow Fever (YF)	5/25/2022	7/2/2022	8/9/2022	9/6/2022	9/7/2022	11/3/2022	28	57	62
	IPV	5/25/2022	7/2/2022	7/2/2022	8/4/2022	8/9/2022	9/6/2022	33	28	27
	Measles Rubella (MR)	7/12/2022	8/4/2022	8/9/2022	9/6/2022	9/7/2022	11/3/2022	28	57	60
	BCG	7/2/2022	8/4/2022	8/9/2022	9/6/2022	9/7/2022	10/20/2022	28	43	60
	Rotavirus (RV)	5/25/2022	7/2/2022	7/2/2022	8/4/2022	8/9/2022	9/6/2022	33	28	57
Northern Regional Vaccine Store	Pentavalent	9/24/2022	11/4/2022	12/22/2022	2/8/2023			48	0	0
	PCV	9/24/2022	11/4/2022					0	0	0
	Yellow Fever (YF)	2/7/2024	2/21/2024	8/13/2024	12/3/2024			112	0	0
	Measles Rubella (MR)	10/20/2020	12/1/2020	6/20/2023	7/12/2023			22	0	0
	BCG	6/10/2020	7/1/2020	9/5/2020	10/15/2020	4/27/2021	5/7/2021	40	10	11
	Rotavirus (RV)	1/13/2021	1/20/2021	9/24/2022	11/4/2022	1/17/2023	3/9/2023	41	51	32
Greater Accra RVS	PCV	1/12/2022	1/18/2022	10/4/2022	11/3/2024	1/12/2023	2/9/2023	761	28	0
	Yellow Fever (YF)	4/22/2020	5/4/2020	8/13/2021	9/23/2021	8/18/2022	8/22/2022	41	4	44
	Measles Rubella (MR)	7/6/2020	7/7/2020	10/14/2020	10/23/2020	1/12/2021	1/14/2021	9	2	7
	BCG	9/30/2021	10/11/2021	4/26/2022	6/23/2022	2/10/2023	3/12/2023	58	30	43
	Rotavirus (RV)	9/14/2022	11/3/2022	1/12/2023	3/9/2023	3/30/2023	4/3/2023	56	4	14

10b) Stock outs at district level

District Vaccine store	Name of Vaccine	Stockout 1		Stockout 2		Stockout 3		Stockout 1 Days	Stockout 2 Days	Stockout 3 Days
		Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	Starting (date when the stock balance is NIL)	Ending (Stock being replenished)	[Diff btn start & end date]	[Diff btn start & end date]	[Diff btn start & end date]
Ashaiman DVS	Pentavalent	1/6/2020	1/10/2020	1/6/2022	1/12/2022	3/3/2023	3/9/2023	4	6	6
Ashaiman DVS	PCV	9/7/2020	9/18/2020	10/15/2020	10/19/2020	5/4/2021	5/5/2021	11	4	1
Ashaiman DVS	Yellow Fever (YF)	7/30/2020	7/30/2020	11/2/2020	11/3/2020	3/1/2021	3/9/2021	0	1	8
Ashaiman DVS	IPV	5/31/2021	6/7/2021	11/1/2022	11/4/2022	2/1/2023	2/10/2023	7	3	9
Ashaiman DVS	Measles Rubella (MR)	2/17/2020	3/11/2020	6/3/2021	6/7/2021	2/28/2022	3/9/2022	23	4	9
Ashaiman DVS	BCG	3/3/2023	3/13/2023	4/14/2023	4/26/2023	5/26/2023	7/18/2023	10	12	53
Ashaiman DVS	Rotavirus (RV)	3/3/2020	3/11/2020	9/23/2020	9/18/2020	1/4/2021	1/18/2021	8	-5	14
Sefwi Wiawso	Pentavalent	6/30/2022	7/6/2022					6	0	0
Sefwi Wiawso	Yellow Fever (YF)	2/8/2022	2/10/2022	4/28/2022	5/2/2022	9/30/2022	10/31/2022	2	4	31
Sefwi Wiawso	IPV	6/28/2022	7/6/2022					8	0	0
Sefwi Wiawso	Measles Rubella (MR)	10/27/2022	11/7/2022					11	0	0
Sefwi Wiawso	BCG	6/16/2020	6/30/2020	8/14/2020	8/28/2020	3/3/2022	3/8/2022	14	14	5
Sefwi Wiawso	Rotavirus (RV)	12/2/2020	12/16/2020	1/21/2021	1/27/2021	5/3/2022	5/25/2022	14	6	22
Sefwi Akontombra DVS	Yellow Fever (YF)	11/5/2020	1/6/2021	2/2/2023	2/14/2023	3/2/2023	3/13/2023	62	12	11
Sefwi Akontombra DVS	BCG	6/13/2022	7/8/2022	7/9/2022	7/10/2022	3/1/2023	3/13/2023	25	1	12
Sefwi Akontombra **DVS**	Rotavirus (RV)	9/12/2022	9/13/2022	6/29/2023	7/16/2023	8/21/2023	9/5/2023	1	17	15
Ho District	Pentavalent	8/14/2020	8/18/2020					4	0	0
Ho District	Yellow Fever (YF)	11/19/2020	11/26/2020	12/2/2020	12/21/2020	5/16/2022	5/26/2022	7	19	10
Ho District	Measles Rubella (MR)	4/30/2020	5/4/2020	1/6/2021	1/21/2021	3/11/2021	5/4/2021	4	15	54
Ketu South	Pentavalent	12/13/2021	1/6/2022	1/10/2022	2/1/2022	11/6/2024	11/11/2024	24	22	5
Ketu South	PCV	10/20/2021	11/4/2021	11/10/2021	12/6/2021	1/11/2022	2/1/2022	15	26	21
Ketu South	Yellow Fever (YF)	11/5/2021	11/30/2021	1/11/2022	2/1/2022	2/11/2022	3/1/2022	25	21	18
Ketu South	IPV	10/30/2024	11/11/2024					12	0	0

District Vaccine store	Name of Vaccine	Stockout 1		Stockout 2		Stockout 3		Stockout 1	Stockout 2	Stockout 3
		Starting	Ending	Starting	Ending	Starting	Ending	Days	Days	Days
		(date when the stock balance is NIL)	(Stock being replenished)	(date when the stock balance is NIL)	(Stock being replenished)	(date when the stock balance is NIL)	(Stock being replenished)	[Diff btn start & end date]	[Diff btn start & end date]	[Diff btn start & end date]
Ketu South	Measles Rubella (MR)	12/9/2020	12/18/2020	6/6/2022	6/17/2022	7/5/2022	7/13/2022	9	11	8
Ketu South	BCG	5/20/2020	6/19/2020	6/21/2021	7/6/2021	3/30/2023	5/9/2023	30	15	40
Tamale Metro	Pentavalent	10/16/2020	10/16/2020	3/31/2021	4/16/2021	8/25/2021	9/14/2021	0	16	20
Tamale Metro	PCV	1/24/2020	2/24/2020	6/5/2020	7/8/2020	7/14/2020	7/15/2020	31	33	1
Tamale Metro	Yellow Fever (YF)	1/14/2020	1/23/2020	2/10/2020	2/14/2020	3/18/2020	4/28/2020	9	4	41
Tamale Metro	IPV	11/26/2020	12/10/2020	12/30/2020	1/8/2021	1/25/2021	2/2/2021	14	9	8
Tamale Metro	Measles Rubella (MR)	6/13/2022	6/22/2022	10/14/2022	11/4/2022	11/7/2022	3/3/2023	9	21	116
Tamale Metro	BCG	2/5/2020	2/24/2020	6/5/2020	7/8/2020	7/14/2020	7/15/2020	19	33	1
Tamale Metro	Rotavirus (RV)	5/7/2020	5/12/2020	7/14/2020	7/15/2020	9/16/2020	9/17/2020	5	1	1
Yendi Municipal	BCG	6/8/2020	6/10/2020	9/15/2020	10/21/2020	10/29/2020	11/27/2020	2	36	29

Annex 11: Unexplained stock variances between SMT and stock count at NCR

Name of Vaccine	UoM (Doses per vial)	Batch No.	Expiry Date	Quantity counted (A)	Quantity recorded in SMT (B)	Variance (A-B)
IPV	10	43C461V	27-Mar	2,000	0	2,000
		Y3C641V	27-Mar	220,300	217,300	3,000
		Y1C84D1	27-Aug	91,100	37,500	53,600
		Y3C651V	27-Mar	45,000	45,300	-300
		Y1B191V	27-Mar	3,000	0	3,000
		X1D111V	26-Oct	900	0	900
		Y3C461V	27-Mar	2,000	58,700	-56,700
HPV	1	Z005624	27-Oct	990	17,540	-16,550
		Z007647	27-Oct	128,880	128,160	720
		Z007899	27-Dec	92,160	0	92,160
		Z005622	27-Oct	500	0	500
		Z006114	27-Nov	570	0	570
		Z007646	27-Oct	970	79,450	-78,480
		Z007124	27-Dec	1,000	0	1,000
		Z005634	27-Oct	80	0	80

Name of Vaccine	UoM (Doses per vial)	Batch No.	Expiry Date	Quantity counted (A)	Quantity recorded in SMT (B)	Variance (A-B)
Rotavirus	5	61Q25011A	27-Apr	3,925	0	3,925
		61Q25022A	27-May	72,000	1,375	70,625
		61Q25024A	27-Jun	203,250	280,175	(76,925)
BCG	20	0374MA083	27-Jan	294,000	291,560	2,440
		0374MA081	27-Jan	195,000	267,400	(72,400)
		0373MA104	26-Apr	5,000	0	5,000
PCV	4	MA5055	27-Dec	136,800	0	136,800
		MA5053	27-Nov	222,200	0	222,200
		MA5057	27-Nov	356,800	0	356,800
		MA5058	27-Dec	3,600	342,000	(338,400)
		LL3928	27-May	6,800	0	6,800
		MA5059	28-Jan	18,000	0	18,000
		LL9332	27-Jun	200	0	200
		LN8507	27-May	1,000	0	1,000
		HC8581	26-Mar	200	0	200
		MA2763	27-Nov	1,200	0	1,200
		MA5055	27-Dec	5,000	410,600	-405,600
Td	10	222600425A	28-Jan	125,380	154,390	(29,010)
Yellow Fever	10	Y3H58D2	27-Sep	124,900	0	124,900
		Y3H85D1	27-Sep	135,000	70,400	64,600
		Y3H84D1	27-Sep	217,200	0	217,200
		Y3J01D1	27-Sep	2,400	242,400	(240,000)
Men A	10	1784M030	27-May	330,000	328,000	2,000
		1784M029	27-May	500	0	500
Oral Cholera	1	EF924058H	26-Oct	55	0	55
		EF924082H	26-Nov	10	0	10
		EF924057H	26-Oct	10	0	10

Annex 12: Unexplained stock variances between stock records and stock counts at regional stores

Name of facility	Name of Vaccine	Batch No.	Quantity counted (A)	Quantity in stock ledger book (B)	Quantity recorded in SMT (C)	Variance (A-B)	Variance (A-C)
Northern Regional Vaccine Store	Pentavalent	2865x010A	37,400	37,400	0	0	37,400
	PCV	MA5058	84,360	84,360	0	0	84,360
	Yellow Fever (YF)	MA5055	32,700	32,700	0	0	32,700
	IPV	Y1C84D1	51,000	75,000	0	-24,000	51,000
		Y1B191V	21,000	0	0	21,000	21,000
		Y1C34D1	3,000	0	0	3,000	3,000
	Measles Rubella (MR)	420600525A	73,500	142,670	0	-69,170	73,500
		420600625A	13,500	0	0	13,500	13,500
		0124W07	55,670	0	0	55,670	55,670
	BCG	0374MA081	52,680	52,680	0	0	52,680
Greater Accra RVS	Pentavalent	2865X010B	66,500	79,920	79,920	-13,420	-13,420
	Measles Rubella (MR)	0124W069/420600625A	170,650	170,500	170,500	150	150
	Rotavirus (RV)	61Q25024A	163,750	163,500	163,500	250	250

Annex 13: Unexplained stock variances between stock records at regional stores

District Name	Name of Vaccine	UoM (Doses per vial)	Batch No.	Quantity counted (A)	Quantity in stock ledger book (B)	Variance (A-B)
Ketu South	Yellow Fever (YF)	10	Y3C841V	380	390	-10
	IPV	10	Y1B191V	1,960	2,260	-300
	BCG	20	0374MA081	1,160	1,140	20
Sefwi Akontambara	Pentavalent	10	2865X010A/2865X004B/220111124A	2,330	2,350	-20
	PCV	4	MA2763/MA5053	2,200	2,220	-20
	IPV	10	Y3C461V/Y1B191V/Y1C841V	920	960	-40
	Measles Rubella (MR)	10	0124W039/0124W068/0124W069	3,640	3,660	-20
	BCG	20	0374MA081	880	940	-60
Sefwi Wiawosa	Pentavalent	10	2865X004B/2865X010A	2,830	3,540	-710
	PCV	4	MA2763/MA5053	2,892	3,544	-652
	Yellow Fever (YF)	10	Y3C841V	980	1,250	-270
	IPV	10	Y3C461V/X1C501V/Y1B191VX1D111V	2,740	3,040	-300
	Measles Rubella (MR)	10	0124W069/0124W070/0124W068	4,130	4,510	-380
	BCG	20	0374MA081	1,720	2,360	-640
	Rota	5	61Q25022A	1,580	2,840	-1,260

Annex 14a): Detailed summary of questioned costs per level

Level	Total sampled and tested GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Total questioned GH¢	*USD equivalent
GHS EPI	4,173,315	2,546,818	1,007,174	566,760	52,563	-	1,626,497	245,538
GHS HQ	3,610,993	3,549,593	61,400	-	-	-	61,400	4,321
MoH	3,464,207	2,337,901	1,111,806	14,500	-	-	1,126,306	83,877
WHO funds to GHS EPI	3,506,898	1,978,936	1,083,216	415,996	28,750	-	1,527,962	186,599
UNICEF funds to GHS EPI	895,572	607,619	204,225	15,000	68,728	-	287,953	45,092
Sub-national level (see details in Annex 17)	10,836,112	9,297,870	939,233	598,919	-	6	1,538,242	140,954
	26,487,097	**20,318,737**	**4,407,054**	**1,611,175**	**150,041**	**6**	**6,168,360**	**706,381**

Annex 14b): Summary of VAT

	Amount in GH¢	Amount in USD
GHS EPI	28,925	2,808
GHS HQ	52,574	5,104
MoH	91,025	8,837
WHO funds to GHS EPI	21,460	2,083
UNICEF funds to GHS EPI	51,302	4,980
Sub-national level	11,641	1,130
Total	**256,927**	**24,944**

Annex 15: GHS EPI reconciliation of Gavi fund balances at 30 June 2025

	Balances as per GHS EPI reconciliation GH¢	Expected balances as per expenditure listings provided GH¢	Expected balances as per financial reports provided USD	Comments/ explanations
CDS3	63,809,666	63,809,665	6,598,724	
IPV	13,242	13,242	1,369	
MVIP	193,625	202,025	20,892	The variance of **GHS 8,400** was due to a transaction in the SAGE system that had been omitted in the expenditure listings provided to the audit team.
MR	532,422	532,422	55,059	
Reversed In August 2025	(10,371,200)		-	The reversal was made in the SAGE beyond the cut-off period ending 30 June 2025. The GHS EPI accountant put this in the reconciliation provided to show that the cash book balance should have been higher. This does not affect the reconciled Gavi balance of **GHS 64,557,354.** The cash book balance as at 30 June 2025 was **GHS 30,888,054.**
Total (a)	**54,177,755**	**64,557,354**	**6,676,045**	
Balance as per the bank statement as at 30 June 2025 (b)		**44,189,320**	**4,569,733**	
Variance (a - b)		**20,368,034**	**2,106,312**	The funds were not in the GHS EPI GHS account as at 30 June 2025
GAVI balance as per SAGE system/cash book reconciliation (d)		56,287,691	5,820,857	This Includes: • Gavi ledger account balance of **GHS 54,098,132** as per the cash book balances reconciliation provided by GHS EPI; and • Refunds recorded in a ledger account named "GAVI refunds" amounting to **GHS 2,189,569.** This was also noted in the reconciliation for 31 December 2024.
Variance ((a - d)		**8,269,663**	**855,187**	The balances in the financial reports were higher than what was in the SAGE accounting system.

Annex 16: Examples of advances from RHDs to DHDs that were expensed beyond 90 days

Grant	Amount GH¢	Transferred from	Date transferred from RHD	Date expensed at DHD	DHD	Number of days taken
HSS	7,957	Greater Accra	16 April 2024	28 July 2025	Ashaiman	468
HSS	7,070	Volta	27 April 2024	20 October 2025	Ketu South	541
HSS	5,620	Volta	27 April 2024	3 November 2025	Ho	555

Annex 17: Details of questioned expenditure

Annex 17 a: Questioned expenditure at GHS EPI

					Classification of expenditure in local currency					
Grant	Date	Cheque No.	Description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CDS3	06/10/2024	1786	Cash - support vaccine accountability	270,000	-	270,000		-	-	-
CDS3	06/10/2027	1787	Cash - support vaccine accountability	270,000			270,000			
CDS2	16/08/2023	001385	National review meeting of the roll out of Covid 19	357,500	76,000	-	281,360	-	-	140
CDS2	17/04/2023	001156	Supportive supervision visits to regions and districts	331,500	204,967	-	214,533	-	-	-
CDS2	03/05/2023	TRO2305099	Supportive supervision visits to regions and districts-GOIL	88,000				-	-	-
CDS2	24/06/2022	000687	National level activities on 2nd national	192,100	237,008	-	233,372	-	-	570
CDS2	24/06/2022	000698	National level activities on 2nd national	279,250						
CDS2	02/02/2022	10280	National level activities on Covid 19	32,513	32,300	-		213	-	-
CDS2	02/02/2022	10281	National level activities on Covid 19	82,221	80,132	-	-	-	-	2,089
IPV1	14/11/2019	TRANSFER/CASH	Funds for IPV planning and training for regional teams for IPV catchup campaign	161,330	133,804	20,000	-	6,393	-	1,133
IPV1	26/03/2020	9243	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	39,825	282,527	52,700	-	444	-	229
IPV1	26/03/2020	9244	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	39,825						
IPV1	26/03/2020	9245	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	57,750						
IPV1	26/03/2020	9246	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	49,050						
IPV1	26/03/2020	9248	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	49,050						
IPV1	26/03/2020	9249	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	49,050						

					Classification of expenditure in local currency					
Grant	Date	Cheque No.	Description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
IPV1	26/03/2020	9247	Cash - funds for national level monitoring and supervision of the nationwide IPV campaign	51,350						
IPV1	26/03/2020	TRO203018	Goil - fuel for national level monitoring and supervision of the nationwide IPV campaign	52,700	-	52,600	-	100	-	-
ROTA		9459	Cash - funds for Rotavac switch activities-national level	56,905	129,521	-	-	25,186	-	56
ROTA		9465	Cash - funds for Rotavac Switch activities-national level	56,905						
ROTA		TRO208049	Cash - funds for Rotavac switch activities-national level	40,953						
YF	17/03/2020	Cash /transfer	Funds for Phase B Yellow Fever preventive mass training and planning national /region	208,000	168,083	28,000	-	-	-	11,917
YF	11/03/2020	Cash /transfer	Release of communication funds for Phase B Yellow Fever-national level	206,288	139,650	32,000	15,400	14,382	-	4,856
YF	11/12/2020	Cash /fuel	Funds for Phase B Yellow Fever mass vaccination campaign national level	974,850	800,320	103,000	-	5,845	-	7,935
			Total	**3,996,914**	**1,953,167**	**1,007,174**	**566,760**	**52,563**	**-**	**28,925**
			Total questioned costs		**1,626,497**					

Annex 17 b: Questioned expenditure at GHS HQ

					Classification of expenditure in local currency					
Grant	Date	Cheque no.	Description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
HSS 3.1	10/08/2022	003635	DSA to collaborate with Local Governments to identify Urban and Peri Urban slums	168,280	162,635	-	-	5,558	-	87
HSS 3.1	10/08/2022	003637	DSA, communication, VPD Outbreak investigation and response	215,178	213,213	-	-	1,965	-	-
HSS 3.1	29/02/2024	003998	DSA, refreshment for Monitoring and Evaluation of trained Creche and Kindergarten tutors	61,400	-	-	61,400	-	-	-
HSS 3.1	13/09/2022	070	Erata Hotel - Conference Package training of Queen Mothers	9,796	8,564	-	-	-	-	1,232
HSS 3.2	10/05/2023	0065	True Vine Hotel - Conference package orientation of Crèche tutors Middle Zone	273,157	232,935	-	-	-	-	40,222

					Classification of expenditure in local currency					
Grant	Date	Cheque no.	Description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
HSS 3.2	16/02/2024	003982	Cash - Dinner refund, stationary for officers and Drivers EPI National level reviews	85,860	85,760	-	-	100	-	-
HSS 3.2	16/02/2024	003983	Cash - DSA, stationery and communication for VPD outbreak investigations and response	78,600	76,600	-	-	2,000	-	-
HSS 3.2	16/02/2024	003984	Cash - Snack and lunch, T&T for planning and Coordination of VPD outbreak investigations	56,000	55,947	-	-	53	-	-
HSS 3.2	16/02/2024	003985	Cash - Dinner refund to participants - Capacity Building of training institutions tutors on revised EPI Preservice training	105,000	103,900	-	-	1,100	-	-
HSS 3.2	16/02/2024	003987	Cash - DSA, Stationery for officers and drivers on capacity building for training institutions on revised curriculum	93,157	92,900	-	-	257	-	-
			Total	**1,146,428**	**1,032,454**	**-**	**61,400**	**11,033**	**-**	**41,541**
			Total questioned costs			**61,400**				

Annex 17 c: Questioned expenditure at MoH

						Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Activity Code	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
HSS 2.4_5	FMS MoH CENTRAL-PV-23-042	09/10/2023	05/01/1900	Being refund of funds to chief director's account to cater for cost of venue for the 2023 health summit	466,900	406,496		-	-	-	60,404
HSS 2.4_5	FMS MoH Central-PV-23-062	09/10/2023	05/01/1900	Kempinski hotel-gold coast city-request for funds for stakeholder conference on draft national transition plan/ roadmap (fiscal sustainability of immunisation services)-conference package	153,600	133,728	-	-	-	-	19,872

Grant	Voucher n°	Voucher Date	Activity Code	Transaction description	Amount GH¢	Classification of expenditure in local currency					
						Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
HSS 2.4_5	FMS MoH Central-PV-23-064	24-10-2023	05/01/1900	Request for funds for stakeholder conference on draft national transition plan/ roadmap (fiscal sustainability of immunisation services)-fuel	90,600	-	90,600	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-040	04/07/2024	4.7.1	Funds for steering committee meeting for the implementation of Ghana's transition roadmap towards self-financing of immunisation services	16,900	13,000	3,900	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-062	15/07/2024	4.7.1	Funds for three (3) day retreat of steering committee meeting for the implementation of Ghana's transition roadmap towards self-financing of immunisation services	86,497	65,497	21,000	-	-	-	-
HSS 2.4 - PSR2	FMSMoHCENTRAL PV-24-065	25/07/2024	3.7.2 (21,303.45) & 3.7.3 (26,696.55)	Funds for Gavi chief executive officer's visit to Ghana	48,000	33,500		14,500	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-067	02/08/2024	3.7.3	Funds to purchase fuel for Gavi mission (15th- 19th July 2024)	8,000		8,000	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-064	14/08/2024	4.7.1	City escape hotels: being release of funds for payment of conference package for three-day retreat of steering committee meetings for Ghana's transition roadmap towards self-financing of immunisation services	83,080	72,332	-	-	-	-	10,748
HSS 2.4 - PSR2	HQ ACCTS-CDPV-24-395	31/12/2024	5.10.1	Being release of funds for fuel for ministerial monitoring on measles rubella and polio campaigns	376,000	-	376,000	-	-	-	-
HSS 2.4 - PSR2	FMS MoH Central-PV-23-063	24/10/2023	3.1.1	Request of funds to discuss a draft national transition/roadmap	24,000	-	24,000	-	-	-	-

Grant	Voucher n°	Voucher Date	Activity Code	Transaction description	Amount GH¢	Classification of expenditure in local currency					
						Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-23-075	02/11/2023	3.1.1	Funds for five-day writing retreat conference package	295,840	252,640	43,200	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-030	04/03/2024	3.11.2 (39,630.49) & 3.8.1b (24,011.72) & 3.7.2 (6,607.79)	Funds to facilitate the Gavi audit process	70,250		70,250		-		
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-051	25/06/2024	3.7.2	Goil company ltd. Funds for fuel for purchase of fuel for the Gavi technical working group meeting	27,000	-	27,000	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL- PV-24-018	03/12/2024	3.8.1b	Funds for the Gavi programme routine administrative activities	45,427	-	45,427	-	-	-	-
HSS 2.4 - PSR2	FMS MoH CENTRAL PV-24-019	03/12/2024	3.8.1b	Goil (fuel component): Funds for the Gavi programme routine administrative activities	48,000	-	48,000	-	-	-	-
CDS 3	BOG DOLLARPV-24-020	31-12-2024		Being release of funds for ministerial monitoring on measles rubella and polio campaigns	531,892	177,400	354,429	-	-	-	-
				Total	**2,371,987**	**1,154,593**	**1,111,806**	**14,500**	**-**	**-**	**91,025**
				Total question costs			**1,126,306**				

Annex 17 d: Questioned expenditure WHO and UNICEF funds to GHS EPI

							Classification of expenditure in local currency					
Source	Grant	Voucher n°	Voucher Date	Cheque/ Transfer	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
WHO	CDS	DC-2101131320	13/01/2021	Transfer	Funds for context covid 19-GOIL - being fuel for national monitoring of epi activities in selected districts in six new regions.	13,287	-	13,287	-	-	-	-
WHO	HSS	DC-2112012492	12/01/2021		Funds for implementation of EVM activities	185,216	-	185,216				
WHO	HSS	DC-2210104062	10/10/2022	Transfer	Funds for implementation of EVM activities -conference pack	45,695	40,660	-	-	-	-	5,035
WHO	HSS	DC-2205123287	10/12/2022	Transfer	Funds for implementation of EVM activities -conference pack	35,714	31,779	-	-	-	-	3,935
WHO	HSS	DC-2205063236	05/06/2022	Transfer	Funds for implementation of EVM activities -conference pack	42,965	38,231	-	-	-	-	4,734
WHO	HSS	DC-2112012491	12/01/2021	Transfer	Funds for implementation of EVM activities - fuel	56,600	-	56,600	-	-	-	-
WHO	HSS	DC-2303164843	16/03/2023	Transfer	Training of drivers on cold vans for transportation of vaccines (CP)	31,500	27,425	-	-	-	-	4,075
WHO	Yellow fever	DC-2204063101	14/04/2022	Transfer	Transfer for YF phase 2 vaccination campaign - copy print	9,828	9,450	-	-	-	-	378
WHO	Yellow fever	DC2204063103	04/06/2022	Transfer	Transfer for YF phase 2 vaccination campaign - copy print (yellow fever reactive campaign national level activities) printing of form four	4,493	4,320	-	-	-	-	173
WHO	Yellow fever	DC-2203163000	14/04/2022	9962	Yellow fever phase 2 campaign-cash	236,800	-	208,050	-	28,750		
WHO	Yellow fever	DC-2205183327	25/05/2022	645	Yellow fever phase 2 campaign-coverage survey	395,020	395,020	-	-	-		
WHO	Yellow fever	DC-2209233944	28/09/2022	839	Yellow fever phase 2 campaign-coverage survey-	5,250	-	5,250	-	-	-	-

							Classification of expenditure in local currency					
Source	Grant	Voucher n°	Voucher Date	Cheque/ Transfer	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
					supplemental (funds for post campaign coverage)							
WHO	Yellow fever	DC-2209023857	09/08/2022	-	Yellow fever phase 2 campaign-coverage survey-supplemental - YF reactive vaccination campaign	245,080	-	245,080	-	-	-	-
WHO	Yellow fever	DC-2209123894	15/09/2022	822	Yellow fever phase 2 campaign-coverage survey-supplemental (YF campaign activities) funds for data analysis and report writing for post campaign coverage	8,750	8,750	-	-	-	-	-
WHO	Chorela	DC-2412207852		2618	Oral cholera vaccination campaign	329,000	223,667	105,333		-	-	-
WHO	Chorela	DC-2412207849	23/12/2024	2612	Oral cholera vaccination campaign	490,000	313,600	-	176,400	-	-	-
WHO	Chorela	DC-2412207851	23/12/2024	2613	Oral cholera vaccination campaign	387,600	255,804	-	131,796	-	-	-
WHO	Chorela	DC-2511099147	23/12/2024	Transfer	Oral cholera vaccination campaign-fuel	97,500	-	97,500		-	-	-
WHO	Chorela	DC-2412207860	23/12/2024	2610	Oral cholera vaccination campaign-LQAS	279,950	-	172,150	107,800	-	-	-
WHO	Chorela	DC-2501318003	23/12/2024	Transfer	Oral cholera vaccination campaign-YB links	24,000	20,870	-		-	-	3,130
					Sub Total-WHO	**2,924,248**	**980,290**	**1,527,962**	**415,996**	**-**	**-**	**21,460**
UNICEF	HSS	DC-2107121779	16/07/2021	1930	Support activities to strengthen cold chain	169,050	84,525	84,525	-	-	-	-
UNICEF	HSS	DC-2107121778	16/07/2021	Transfer	Support activities to strengthen cold chain - (fuel to support activities)	111,600		96,600	15,000	-	-	-
UNICEF	HSS	DC-2111172413	16/07/2021	Transfer	Support activities to strengthen cold chain -Deng Limited - conference package to support activities meant to strengthen immunisation cold chain system	57,502	57,502		-	-	-	-

							Classification of expenditure in local currency					
Source	Grant	Voucher n°	Voucher Date	Cheque/ Transfer	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
			16/07/2022	Transfer	Support activities to strengthen cold chain-oceanic	68,728	-	-	-	68,728	-	-
UNICEF	HSS	22/0007864	15/12/2023		Being purchase of fuel for covid-19 routine vaccine management running and supportive supervision	23,100	-	23,100	-	-	-	-
					Sub Total-UNICEF	**429,980**	**142,027**	**204,225**	**15,000**	**68,728**	**-**	**-**
					Total question costs - WHO			**1,527,962**				
					Total question costs - UNICEF			**287,953**				

Annex 17 e: Questioned expenditure UNICEF funds to Greater Accra RHD

						Classification of expenditure in local currency					
Source	Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
UNICEF	HSS	20/0613712	15-Aug-22	Being release of funds for Lunch and Snack for conference participants-UNICEF/GHS project to improve EPI indicators in the low performing districts	13,600	12,754	-	-	-	-	846
UNICEF	HSS	20/0613712	11-Mar-24	Release of funds for demand generation and vaccine delivery service, covering conference package and accommodation costs	390,000	339,544	-	-	-	-	50,456
				Total	**403,600**	**352,298**	**-**	**-**	**-**	**-**	**51,302**
				Total question costs			**-**				

Annex 17 f: Questioned expenditure at Northern Region RHD

					Classification of expenditure in local currency					
Voucher n°	Voucher Date	Grant	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation Campaign - Region										
PV472/24	01/10/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Being funds released for regional level training of supervisors and support district level training of teams for the Measle Rubelle campaign	33,540	-	-	33,540	-	-	-
PV531/24	21/10/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Being payment for hospitality services for the training of Measles Rubella and Vitamin A campaign in the region.	20,400	20,408	-	-	-	-	3,665
PV444/24	17/09/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Funds released for regional level for preparatory and implementation activities for Measles Rubella and vitamin A campaign.	109,624	109,624	-	-	-	-	-
PV479/24	03/10/24	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Being funds released for regional level monitoring during the preparatory and implementation activities towards measles and Vitamin A campaign from 2nd to 6th October.	381,554	-	381,554	-	-	-	-
PV634/24	13/12/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Being funds released for conference package foe a post review campaign on Measles Rubella.	21,966	18,014	-	-	-	-	3,952
PV657/24	20/12/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation	Being funds released for payment of conference package for post review campaign on Measles Rubella and nOPV2 round 1	22,000	18,048	-	-	-	-	3,952
Funds for 9th round of national covid-19 vaccination days (NACVADS) campaign										

					Classification of expenditure in local currency					
Voucher n°	Voucher Date	Grant	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
PV18724	02/05/2024	Funds for 9th round of national covid-19 vaccination days (NACVADS) campaign	Being funds released for regional level preparation and implementation activities towards the national covid 19 vaccination campaign	426,804	426,732	-	-	-	-	72
Funds for 2nd round of national covid-19 vaccination days (NACVADS) campaign										
PV134/222	26/04/2022	Funds for 2nd round of national covid-19 vaccination days (NACVADS) campaign	Being funds regional level implementation activities towards covid 19	284,935	-	284,935	-	-	-	-
Funds for 10th round of national covid-19 vaccination days (NACVADS) campaign										
PV187/24	02/05/2024	Funds for 10th round of national covid-19 vaccination days (NACVADS) campaign	Being funds released for regional level preparation and implementation activities towards the national Covid 19 vaccination campaign R10	426,804	-	426,804	426,804	-	-	-
			Total	**1,727,627**	**589,153**	**666,489**	**460,344**	**-**	**-**	**11,641**
			Total question costs			**1,126,833**				

Annex 17 g: Questioned expenditure at Northern Region – Tamale DHD

					Classification of expenditure in local currency					
Voucher n°	Voucher Date	Grant	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
Funds for Rotavac switch activities-to regions										
0617039	10/09/20220	Rotavac	Being funds released to train facility staff and sensitise the care givers on the switch from Rotanix to Rotavac.	1,928	1,928		-	-	-	-
Funds for 10th round of national covid-19 vaccination days (NACVADS) campaign										

					Classification of expenditure in local currency					
Voucher n°	Voucher Date	Grant	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
22/0199537	13/05/2024	Funds for 10th round of national covid-19 vaccination days (NACVADS) campaign	Being cost released for Covid 19 mobilisation round 10 internet data and others	7,182	7,092	-	-	-	90	-
			Total	**9,110**	**9,020**	**-**	**-**	**-**	**90**	**-**
			Total question costs			**90**				

Annex 17 h: Questioned expenditure at Northern Region – Yendi DHD

					Classification of expenditure in local currency					
Voucher n°	Voucher Date	Grant	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
Funds for ROTAVAC switch activities										
1338118	19/0/2020	Funds for Rotavac switch activities-to regions	Being funds released to cater for training expenses on switch Rotavac.	1,248	-	1,248	-	-	-	-
Funds for Measles Rubella										
22/0601579	03/10/2024	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation Campaign	Being funds released for measle vaccination training	24,900	24,410	-	490	-	-	-
Funds for 9th round of national covid-19 vaccination days (NACVADS) campaign										
22/0422430	21/12/2023	Funds for 9th round of national covid-19 vaccination days (NACVADS) campaign	Being funds released to cater for the payment of Covid 19 round 9 exercise	51,202	-	51,202	-	-	-	-
			Total	**77,350**	**24,410**	**52,450**	**490**	**-**	**-**	**-**
			Total question costs			**52,940**				

Annex 17 i: Questioned expenditure at Greater Accra RHD

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
MR	24/0119290	15-Oct-24	Being funds released for measles Rubella & Vitamin A Supplement (Micro Planning campaign meeting)	52,080	-	52,080	-	-	-	-
IPV1	DPV/0984931	20-Feb-20	Being release of funds for training of regional and district supervision for IPV catch up campaign	4,600	-	4,600	-	-	-	-
IPV1	DPV/0984956	2-Mar-20	Being purchase of snacks and lunch for post review meeting for regional and district teams for IPV Catch up campaign	4,000	4,000	-	-	-	-	-
IPV1	DPV/0984955	10-Mar-20	Funds released for post review meeting for regional and district team catch up campaign	4,000	-	4,000	-	-	-	-
IPV1	DPV/0984940	25-Feb-20	Being release of funds for social & behaviour change communicate activities for inactivated polio vaccine campaign.	3,000	-	3,000	-	-	-	-
CDS2	20/0613834	14-Jul-22	Being funds released for the payment of T & T and lunch for microplanning	7,000	-	-	7,000	-	-	-
CDS2	20/0613833	14-Jul-22	Being funds released for the payment of T & T for post exercise data validation and review meeting	7,000	-	-	7,000	-	-	-
CDS2	20/0613836	14-Jul-22	Being funds released for the conduct of 3rd Gavi Covid-19 vaccination exercise pre-implementation orientation	1,600	-	-	1,600	-	-	-
CDS2	20/0613838	12-Jul-22	GOIL-being funds released to purchase fuel for team coordinator and supervisors	12,800	-	12,800	-	-	-	-
CDS2	20/0613837	25-Jul-22	Being release of funds for the conduct of the 3rd Gavi Covid-19 vaccination exercise per diem and T & T for drivers, team and coordinators.	106,510	-	106,510	-	-	-	-
			Total	**202,590**	**4,000**	**182,990**	**15,600**	**-**	**-**	**-**
			Total question costs			**198,590**				

Annex 17 j: Questioned expenditure at Greater Accra – Ashaiman DHD

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CDS2	0913900	29-Jun-22	Being release of funds for microplanning	6,910			6,910	-	-	-
CDS2	0913931	18-Jul-22	Being release of funds for SBCC activities for Covid 19 NID round 2 Vaccination Campaign 22	3,000	3,000		3,000	-	-	-
CDS2	0913938	18-Jul-22	Being release of funds for High Demand Generation activities for Covid-19 NID round 2.	5,000	5,000		-	-	-	-
CDS2	0913901	28-Jun-22	Being release of funds for implementation Covid -19	40,795	-		40,795	-	-	-
CDS2	0913902	29-Jun-22	Being release of funds for safety surveillance.	200		200	-	-	-	-
IPV1	0899568	25-Feb-20	Being release of funds for the payment for review meeting of the national IPV Campaign	840		-	840	-	-	-
IPV1	0899567	27-Feb-20	Being release of funds for the payment for training on Polio outbreak Reactive in High-Risk Districts	3,318	3,318		-	-	-	-
IPV1	0899566	25-Feb-20	Being release of funds for the payment for Polio Microplanning	840	840		-	-	-	-
IPV1	0899563	25-Feb-20	Being release of funds for the payment for polio campaign per diem	20,725		-	20,725	-	-	-
IPV1	0899565	25-Feb-20	Being release of funds for the payment for collection and disposal of waste for the IPV Campaign	436		436	-	-	-	-
IPV1	0899569	2-Mar-20	Being release of funds for the payment for social mobilisation on IPV mass campaign	1,507	1,507		-	-	-	-
			Sub Total	**83,571**	**10,665**	**636**	**72,270**	-	-	-
			Total question costs			**72,906**				

Annex 17 k: Questioned expenditure at Western North RHD

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
MR	327608	9/27/2024	Payment for measles rubella campaign	183,610	183,310	-	300	-	-	-
CD3	327530	05/07/2024	Funds for 10th round national Covid 19 Vaccination days campaign	125,790	103,400	-	22,390	-	-	-

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CD3	327560	07/09/2024	Funds for 11th round national Covid 19 Vaccination days campaign	125,790	119,190	6,600	-	-	-	-
CDS2	604592	4/22/2022	Funds for 2nd round covid 19 national immunisation	74,145	66,270	7,250	625	-	-	-
			Total	**509,335**	**472,170**	**13,850**	**23,315**	-	-	-
			Total question costs			**37,165**				

Annex 17 l: Questioned expenditure at Western North – Sefwi Akontombra DHD

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CDS2	"0677331 0677328"	12/13/2022	Payment for Covid-19 National Immunisation Day (NID) activities Round 2	61,710	52,940	8,770	-	-	-	-
			Total	**61,710**	**52,940**	**8,770**	-	-	-	-
			Total question costs			**8,770**				

Annex 17 m: Questioned expenditure at Western North – Sefwi Waiwso DHD

					Classification of expenditure in local currency					
Grant	Voucher n°	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CD3	59365	07/10/2024	payment for covid 19 NaCVaDS Round 11	53,110	48,460		4,650	-	-	-
CD3	653441	4/29/2022	Payment for Covid-19 NID activities round 2	84,645	73,485	1,360	9,800	-	-	-
CDS2	844540	12/22/2023	Payment for Covid 19 vaccination activities_ Round 9	53,485	52,485	1,000	-	-	-	-
CD3	644987	05/09/2024	Funds for Covid 19 Round 10	53,110	47,100	1,360	4,650	-	-	
			Total	**244,350**	**221,530**	**3,720**	**19,100**	-	-	-
			Total question costs			**22,820**				

Annex 17 n: Questioned expenditure at Volta RHD

				Classification of expenditure in local currency					
Grant	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
MR	10-Sep-24	Transfer of funds integrated Measles Rubella Vaccination and Vitamin A supplementation Campaign	1,448,560	1,486,370	160	-	-	-	-
CD3	24-Apr-24	Funds for 10th round of national covid-19 vaccination days (NACVADS) campaign	917,570	917,483	87	-	-	-	-
CDS2	14-Apr-22	Funds for 2nd round of national covid-19 vaccination days (NACVADS) campaign	737,140	737,049	91	-	-	-	-
CDS2-District	24-Apr-22	Funds for COVID-19 campaign	58,065	55,265	2,800	-	-	-	-
CDS2	11-Dec-23	Funds for 9th round of national covid-19 vaccination days (NACVADS) campaign	915,070	914,960	110	-	-	-	-
		Total	**4,076,405**	**4,111,127**	**3,248**	**-**	**-**	**-**	**-**
		Total question costs			**3,248**				

Annex 17 o: Questioned expenditure at Volta – Ketu South DHD

				Classification of expenditure in local currency					
Grant	Voucher Date	Transaction description	Amount GH¢	Adequate GH¢	Inadequate GH¢	Irregular GH¢	Unsupported GH¢	Ineligible GH¢	Ineligible Tax GH¢
CDS2-District	27-Dec-23	Release of funds for COVID-19 National vaccination activities	88,770	88,770	-	5,000	-	-	-
HSS - District	20-Oct-25	Release of funds for the payment of routine Immunisation campaign activities carried out in the municipality	7,080	-	7,080	-	-	-	-
		Total	**95,850**	**88,770**	**7,080**	**5,000**	**-**	**-**	**-**
		Total question costs			**12,080**				

Annex 18: Progress on previous audit recommendations

No.	Issue	Recommendation	Status	Comments on status
1	Weaknesses in advance management at national level	We recommend that the MoH ensure that GHS and EPI implement the ATF, 2016 and the SOPs for Gavi provided funds. This will ensure that: • advances are recorded accurately and expensed only when retirement reports are submitted and reviewed; • all funds disbursed have supporting memos describing the activities to be implemented; and • monthly and quarterly reports are submitted by regions and districts as required by the ATF.	**Partially - Implemented**	In addition to the ATF, which was updated in 2023, the GHS has now developed and implemented SOPs for Programme (Donor) funds. These SOPs provide: • Timelines for transfer of funds at each implementation level. • A requirement to refund monies that remain un-utilised for more than 90 days. • Minimum support documents for each type of expenditure. • Templates of programmatic and financial reports from sub-national levels. • Template for programmatic reports that form part of accountability of expenditure. • The GHS has implemented a digital platform with which sub-national levels are informed of funds transfers. This timely information has improved transparency of funds transfers especially from regional to district level. Gaps were still noted in advance management in the current audit. Disbursements to sub-national level were still recorded as expenses. Although Statements of Expenditure were received from the Regional Health Directorates (RHDs), there was no evidence of review and revision of the expensed advances. Superseded by recommendation 17 in this report
2	Traceability of Gavi Funds within EPI Bank Accounts	We recommend that MoH ensure that: • EPI and GHS prepare and reconcile programme activities to bank balances to ensure traceability and accountability for all Gavi provided funds; • Where Gavi provided, funds are used to fund other projects/programmes, journal vouchers are maintained and followed up periodically to ensure that Gavi provided funds are returned to the designated Gavi account as required by the grant management requirements; and • Bank reconciliation statements and relevant journal vouchers (with corresponding schedule of balances per funding source) are reviewed and signed off by senior management within the EPI and GHS management team to ensure accuracy and completeness.	**Partially - Implemented**	Gavi funds sent to the country are held at commingled accounts at GHS and MoH. Variances were noted in the cash book reconciliations prepared by the GHS and MoH accountants as at 31 December 2024. The variances were due to interproject borrowing of funds which had not yet been refunded to the account at the close of the period. Superseded by recommendation 16 in this report

No.	Issue	Recommendation	Status	Comments on status
3	Questioned costs	The Audit Team recommends that MoH and GHS ensure that: • All expenditures are adequately supported using documents including signed and dated minutes of meetings, attendance sheets, payment schedules for allowances and per diems, third party receipts and invoices, acknowledgement forms and activity reports; and • Gavi's funds should not be used to pay taxes, since these are not eligible.	**Partially - Implemented**	The country reimbursed to Gavi the amounts questioned in the 2019 programme audit. GHS developed Financial Management Standard Operating Procedures. These were disseminated in August 2023 and subsequent trainings were carried out. However, the current audit still had questioned costs amounting to USD 706,381. Some of the questioned costs related to inadequate support for fuel acquittals (coupons) and DSA issued through use of mobile money. These were recurring findings on similar transactions. Superseded by recommendation 15 in this report
4	Prior programme audit recommendations not implemented	For the programme is made whole with respect to these historic matters, the MoH should ensure that GHS: • Submits periodic requests for VAT exemptions based on consignments due. This will ensure that Gavi funded procurements receive exemption locally and internationally. • Implements the cost allocation policy developed. • Replace the two vehicles and also ensure that proceeds from the disposal of vehicles from Ashanti and Upper West and deposited back to the grant. • Refund the funds related to purchase of air conditioners to the grant as agreed in the previous audit.	**Partially - Implemented**	a) The questioned amount of USD 134,716 used to pay taxes was not yet refunded into the programme bank account, at the time of the current audit b) The process of obtaining VAT refunds was protracted and with significant delays, and so the MoH sought parliament to grant exception to donor programmes. c) The GHS shared a revised cost allocation policy for Gavi approval. Once approved, the policy will be presented to GHS Senior Management and formally circulated to users. d) The GHS is yet to replace the vehicles that were disposed off after being damaged in accidents and refund the monies used to purchase air conditioners. This recommendation will be retained for follow-up.
5	Documents missing in procurement files	We recommend that MoH ensure that: • All procurements are fully compliant with the 2016 National procurement Act and the MoH procurement manual; and • The procurement files and associated processes are checked for completeness by ensuring that the relevant documents including but not limited to: approved tender evaluation panel makeup, tender opening minutes, completed, dated and signed tender evaluation reports and approved purchase requisitions (including budgets and bid submission registers) are prepared and put on the file. Procurement files could include a checklist, which is reviewed and signed off by the management team.	**Implemented**	Significant procurements are mainly undertaken via UNICEF. The GHS takes significant caution for procurement processes, with review done by internal audit. Recent audits by Ghana Audit Service (GAS) have not raised concerns around procurement or expenditure support documentation. This recommendation is now closed.

No.	Issue	Recommendation	Status	Comments on status
6	Gaps in accountability for vaccines (a)	We recommend that the MoH, GHS and EPI ensure that all staff responsible for managing and handling vaccines should comply with the established SOPs, which stipulate the necessary management guidelines and procedures for vaccines. Specifically, the EPI should ensure that: • All vaccine stores are equipped with Vaccine Ledgers. • Monthly stock counts are carried out at each of the regional, district and health facility vaccine stores. • Quarterly stock counts are carried out at the central vaccine stores. • Distribution and receipt records are reconciled at all subnational levels and any variances investigated and explained in writing.	**Partially - Implemented**	The GHS Leadership commissioned the Internal Audit team to review the vaccine records in response to the audit. Efforts were made to reconcile the vaccine balances however weaknesses remained. The external audit also pays attention to vaccine records and some improvement has been noted, however weaknesses still remain, mainly because of inconsistencies in recording, i.e. the use of vials versus doses at different levels / facilities. Superseded by recommendation 11 in this report
7	Gaps in accountability for vaccines (b)	MoH should inform Gavi of any incidents which lead to loss of any Gavi funded commodities and assets. As the PFA stipulates that vaccines should be insured, the loss at the Tamale district store should be made whole at the Government's cost.	**Partially - Implemented**	With the COVID-19 vaccines, there are reported weaknesses in accountability of vaccines including a failure to account for and dispose expired doses. Superseded by recommendation 11 in this report
8	Gaps in accountability for vaccines (c)	The EPI should also: • Conduct refresher training on the SOPs for its EPI officers; • Provide job aids as reference documentation, including booklets and procedural wall posters – for ease of reference; and • Ensure that supportive supervision activities are planned and documented at the national and subnational levels, and that proper follow up actions are conducted.	**Partially - Implemented**	The GHS trained officers responsible for immunisation and vaccines with funding available in HSS 3. The GHS, Regional and District officers conduct supervision of sub-national level implementation. The 2022 EVMA report shows that SOPs were in place at regional and district levels, with gaps noted at service delivery level. Specifically: • SOPs/guidelines for vaccine management were in place (score 100%). • At District level - The immunisation supply chain SOPs/guidance materials were in place, written in English and updated (score 94%). • At service delivery level - 64% of facilities had SOPs for using VVMs and managing vaccine stock transactions. Superseded by recommendation 11 in this report

No.	Issue	Recommendation	Status	Comments on status
9	Other vaccine management weaknesses	The EPI should ensure that all staff responsible for managing and handling vaccines should comply with the established SOPs, that outline the necessary vaccine management guidelines and procedures. The EPI should also ensure that the storekeepers: • Record batch numbers, expiry dates and VVM status in the vaccine ledgers; and • Review the consumption patterns at the corresponding subsidiary level before re-supplying their direct reports with further vaccines.	**Partially - Implemented**	The GHS has revised and deployed vaccine ledger books that have provisions (space) to record expiry dates and batch numbers. The HSS 3 grant includes funds for training vaccine managers which was conducted. This recommendation is now closed.
10	Irregular administrative data	We recommend that the MoH and EPI programme: • Routinely triangulates available data, including an assessment of administrative coverage data and vaccine availability / utilisation as a check for accuracy of data reported. Such analyses should be completed at national and subnational levels. Data anomalies noted should be included in the review of accuracy of vaccine stock and utilisation data and coverage data; • Ensure that health facilities have adequate stock of registers, tally sheets and other primary data collection tools; • Consistently complete data verification and validation exercises at the health facility and district levels as required by the guidelines; • Conduct the required surveys and use the results to review the administrative coverage.	**Partially - Implemented**	The EPI recognises data inconsistencies especially at the peripheral levels as observed in the previous data quality assessment for which a data improvement plan (DQIP) has been developed to address the gaps. The programme also targets the weaknesses through: • Suppling data tools and registers, with the support of partners • Coaching and on-job training through supportive supervision. Superseded by recommendation 9 in this report.
11	Weaknesses noted in target population data	The MoH is recommended to: • Review the results of the 2020 national population census and adjust the target population as necessary. • Review methodology on calculation of the target population of live births and surviving infants, compare it with existing reliable external projections to ensure accuracy and completeness.	**Implemented**	The target population figures were based on numbers provided by the Ghana Statistical Service, which vary significantly from those which the programme observes during routine immunisation. Country undertook a census in 2021, the results of which were published in 2022. In 2024, Ghana Health Service revised the target administrative data figures and shared the same with Gavi and Ministry of Finance for revision of co-finance vaccine doses. Superseded by recommendation 9 in this report.

No.	Issue	Recommendation	Status	Comments on status
12	Slow Implementation of Data Quality Improvement Plan and Insufficient evidence of the use of immunisation data	The MoH is recommended to: • to source funds from the Alliance Partners to accelerate the implementation of the activities in the DQIP. • formalise the process of providing performance feedback and follow-up on recommended actions at all levels using standardised templates to ensure consistency.	**Partially - Implemented**	The progress of programme implementation is discussed at the immunisation TWG which meets about three times a year. Prior to the TWG implementers present programmatic and financial reports, and funding prioritisation discussions are held and approved at the ICC. Still the GHS does not have sufficient funding to fully implement activities in the DQIP. Immunisation performance is discussed during review sessions at the sub-national and national levels. The programme is yet to formalise a performance feedback process. Superseded by recommendation 9 in this report

Annex 19: Detailed management responses

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
Governance and oversight mechanisms over the immunisation programme need strengthening	**Recommendation 1** To strengthen governance and oversight over programme management, MoH and GHS management should: • Develop country-specific ToRs for ICC, HSWG, and Gavi TWG. These can be aligned with WHO guidelines but tailored to local systems. The ToRs should be endorsed and disseminated to all members. • Reconfirm the ICC leadership structure per WHO guidance. The Minister or Chief Director should be the chair, with designated alternates at MoH director level. The ToRs developed should include expectations of MoH leadership attendance. • Reconstitute the NITAG Immediately by accelerating the formal selection/renewal process as prescribed by the IPM. The distinction between NITAG and ICC roles should also be reinforced by the Secretariat. • Develop and enforce structured agendas for the ICC and HSWG meetings that include updates on grant performance, transition roadmap, NITAG recommendations and routine immunisation performance. • Introduce a standing agenda item for reviewing decisions from previous meetings. The responsibility for tracking action points should be assigned to a designated secretariat officer.	**Action 1** The Health Sector Working Group (HSWG) serves as a platform for coordinating development partner support and addressing cross-cutting programmatic issues within the health sector. Although immunisation is not always explicitly listed as a standalone agenda item at HSWG meetings, discussions on health systems strengthening, data systems and issues of Health financing are regularly held and these discussions directly support and benefit immunisation programmes. However, with the Inter-Agency Coordinating Committee (ICC) now fully functional, the HSWG has redirected its focus away from immunisation-related discussions to enable the ICC to exercise effective oversight of immunisation activities in Ghana. The Terms of Reference (ToRs) for the ICC has been developed in line with World Health Organisation (WHO) guidelines and has been adopted for use by the ICC. This was discussed at the last ICC meeting held in December 2025. The ToRs incorporate a standard agenda for ICC meetings, including transition planning and grant performance monitoring. The new TOR is attached. Regarding the National Immunisation Technical Advisory Group (NITAG), the new members were inaugurated on 2nd December 2025 and are expected to commence full operations in 2026. Report on the inauguration of new NITAG is attached. NITAG does not perform the functions of the ICC. Its's core mandate is to provide technical recommendations on immunisation and its related technologies which it had performed actively over the period. The Group provided eight technical guidance/recommendations to the MoH to guide immunisation policy in Ghana since 2020. These include technical recommendations on nOPV2 introduction, IPV2 introduction, introduction and scale up of malaria vaccines use in Ghana, etc. The periodic programme updates, operational briefings, etc., to NITAG remain critical to keep members up to date on programme operations, so their technical recommendations are appropriately situated within the current national immunisation landscape. The team is unable to reconcile how these periodic updates provided to the NITAG compromise its independence. We have taken note and acknowledge the gaps identified and will take the	MoH	30 June 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		necessary steps to strengthen the Governance structure of the NITAG as recommended **Audit note:** **The audit did note some operational and non-technical discussions at NITAG level, mainly as the ICC was non-functional and the NITAG during the audit period comprised of committed professionals who did their best to support the immunisation programme. Going forward, with the reconstitution of ICC and NITAG, including revamping of the ToRs, all governance bodies should operate within their mandate and the independence of NITAG will be maintained.**		
Operationalisation of the transition roadmap has been delayed	**Recommendation 2** To adequately prepare for transition, the Ministry of Health should: • Review and update the transition roadmap to reflect current realities, including revised population estimates, feasibility-based costing, and prioritisation of activities aligned to the remaining accelerated transition period. Ensure that the updated roadmap is aligned with the National Immunisation Strategy. • Formally endorse the revised transition roadmap to establish clear government ownership and accountability. • Operationalise governance arrangements for the transition by strengthening oversight through existing structures, including the Health Sector Working Group (HSWG), ICC, and the proposed EPI Technical Working Group (TWG). Clearly define roles, reporting lines, and decision-making responsibilities, and avoid establishing parallel governance bodies to manage the transition. Ensure regular meetings and systematic tracking of progress against agreed milestones. • Integrate transition financing requirements into national budget planning processes to improve the timeliness and predictability of co-financing settlements. Use the updated transition roadmap to inform medium-term financing discussions and mitigate risks associated with late payments during the transition period. • Develop a focused advocacy plan to address funding gaps and sustain political commitment to immunisation during and beyond the transition period. The advocacy strategy should leverage the endorsed transition roadmap and align with	**Action 2** Management agrees with the recommendation of the audit • Transition roadmap will be reviewed to reflect the recommendations from the Gavi audit and the December 2025 Steering Committee meeting • The updated transition roadmap will be aligned with the NIS • The transition roadmap, when updated will be endorsed by government, development partners and NGOs • The HSWG meetings will be held as planned and a schedule of actions and responsible entities will be updated and shared • A document defining the roles and responsibilities of all governing bodies for the transition will be developed and implemented • Advocacy plan was developed in 2025 and will be implemented. • Advocacy and political commitment will be sustained. • Advocacy plan will be updated to align with updated transition roadmap	MoH, GHS, DPs Coalition	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	broader health sector financing discussions to support increased and predictable domestic resource allocation for immunisation.			
Strategic and operational planning processes need to be improved	**Recommendation 3** To strengthen programme planning and prevent recurrent implementation gaps, MoH/EPI should: • Finalise and endorse the NIS 2026–2030, including confirmation of the implementation timeframe and planned operationalisation period, and use it as the authoritative basis for annual operational planning and monitoring. • Standardise operational planning processes by establishing structured, comprehensive annual workplans using a standard template, with clear linkage to NIS objectives and strategies. • Cost annual plans by developing an annual prioritised schedule of EPI activities and associated resource requirements, including budgets and funding sources for each activity. Funding for immunisation activities should be discussed at ICC and HSWG to ensure adequate resource mobilisation beyond Gavi funds. • Institutionalise periodic review of implementation by mandating quarterly reviews of workplan progress and constraints, led by the EPI TWG and aligned to immunisation governance arrangements. • Strengthen targeting and microplanning by ensuring that sub-national RI micro plans are developed, reviewed, and used to guide targeted outreach and supportive supervision. • Strengthen implementation continuity by reviewing and updating GHS/EPI job descriptions to confirm a new EPI manager, allocate clear responsibilities for planning, monitoring, and follow-up; and completing an MoH HR assessment to ensure core roles are staffed as Ghana prepares to manage immunisation fully post-transition. • Improve timeliness of campaign fund transfers by strengthening campaign financial workflows and timelines so funds reach sub-national levels before or during campaign implementation, to avoid post-campaign disbursements.	**Action 3** Management Response: Agreed. Continuous improvement is the bedrock of any successful and sustainable Immunisation Programme and Ghana has made some progress. Strategic and operational planning for Ghana's Expanded Programme on Immunisation (EPI) has seen improvements over the past years, moving from a "top-down" approach to a more integrated, data-driven cycle that connects the Comprehensive Multi-Year Plan (cMYP) [which has now transitioned into the National Immunisation Strategy (NIS)], directly to the frontline health workers. Operational success occurs at the district and sub-district levels, as evidenced by the high overall EPI coverage rates. In Ghana, Microplanning has been a "bottom-up" process, albeit with some gaps. The Programme has used three main strategies to improve coverage. • The Reaching Every Child (REC) approach. Districts develop micro plans that identify specific "hard-to-reach" communities, marketplaces, and peri-urban slums. Although this has worked well for campaigns, the country acknowledges deficiencies in microplanning for routine immunisation and the resulting equity gaps. • Human-Centred Design (HCD): As seen in recent pilots in Ga South, involving local health workers and community leaders in the design of the micro plan has increased ownership and accuracy. • Digitalisation: The country has been transitioning from paper-based maps to digital microplanning tools that use GIS data to pinpoint unreached households. 1. Endorsement of the National Immunisation Strategy (NIS) 2025–2030 Action Taken: The NIS 2025–2030 is currently undergoing final ministerial sign-off. • Mitigation: To ensure the NIS serves as the authoritative framework going forward, the 2026 Annual Work Plan (AWP) will be explicitly aligned with NIS strategic priorities. 2. Strengthening National Operational Planning Management Response: Agreed. The lack of standardised templates and weak linkages between activities and budgets hindered oversight. • Improvement Plan: o Standardisation: A new Harmonised Annual Workplan Template has been developed by the Ghana Health Service. This is being adapted to ensure every activity is linked to a specific NIS strategic objective	MoH/GHS	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		o Financial Integration: The template now includes mandatory columns for estimated budgets, specific funding sources (Government, Gavi, WHO, UNICEF, Other Partners, etc.), and funding status. o Quarterly Reviews: Starting in Q1 2026, the EPI will revive the Quarterly Performance Review (QPR) mechanism to track implementation status and dynamically update workplans. o Improving staff strength at EPI: The Director General of GHS has constituted a team to review and update job descriptions within the Service to improve staffing norms, streamline operations and maximise efficiency. The team has commenced work, and their output will help identify existing gaps for redress. 3. Sub-national Microplanning (Routine Immunisation) Management Response: Partially agreed. As previously stated, in Ghana, microplanning has been a "bottom-up" process, albeit with some gaps. We recognise that the absence of structured micro plans at many district and sub-district levels limits our ability to address local coverage gaps, particularly in difficult to reach communities. The Programme has used three main strategies – REC, HCD, Digitalisation - that have worked to improve on coverage as aforementioned. Ghana conducted a nationwide Middle Level Managers' and Immunisation in Practice training across all levels of the immunisation service delivery space in November 2025. Participants were given hands-on practice on the development of micro plans for routine immunisation (RI). We expect all districts to improve on micro plan development and use, subsequently. Sub-national level supportive supervision will emphasise and prioritise use of the micro plans with on-site support to ensure sub-districts develop and use micro plans to guide immunisation service delivery. • Action Plan: o The EPI will roll out a Microplanning Toolkit to all regions/districts. o District Health Management Teams (DHMTs) will be required to submit validated micro plans to the regional level as a performance-monitoring tool and, where appropriate, as a prerequisite for the release of RI operational funds. o These plans will specifically focus on identifying "Zero-Dose" or under-immunised children and hard-to-reach populations. 4. Translating Reviews into Actionable Improvement Plans Management Response: Agreed. While reviews were conducted, the "closing of the loop" via a tracked Improvement Plan was inconsistent. • Remediation:		

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		o Consolidated Action Tracker: We are developing a type of harmonised digital Tracker to monitor recurring issues (AEFI reporting, data quality, etc.). o Accountability: Each recurring issue identified (e.g., Data Quality Audits) has now been assigned a specific Technical Officer lead with a fixed deadline for resolution. o Prioritisation: The 2026 planning cycle will prioritise the "Zero-Dose" and "Under-Immunised" populations in urban/peri-urban areas as a core KPI to break the cycle of recurring findings. 5. Financial Disbursement for Campaigns Management Response: Agreed. We acknowledge that there have been challenges with fund release including retrospective funding of campaigns (e.g., the YF phase II campaign). This poses significant operational risks. • Corrective Measures: o Advance Planning: The Programme and high-level management of GHS (and where appropriate, MoH), working with the Finance Division of the GHS will establish a "Campaign Readiness Checklist" that includes a financial trigger 30 days prior to launch. o Bottleneck Analysis: The Programme will conduct a joint review with Partners to identify the specific causes of the disbursement delays for immunisation campaigns, e.g., as noted in 2022, to advise high-level management on the approval workflow.		
National response to growing incidence of measles cases should be intensified	**Recommendation 4** To reduce the surge in the number of measles cases in the Country, MoH/EPI should: · Ensure routine immunisation services consistently reach children at the recommended ages (9 and 18 months) and prioritise follow-up of those who missed doses through facility-based and outreach sessions. · Expand outreach to underserved populations, including urban poor, ethnic minorities, migrants, and border communities, by deploying mobile teams and integrating vaccination with other health services including work done by the CSOs. · Intensify health education and community engagement, implementing targeted communication campaigns to address vaccine hesitancy, reinforce the benefits of complete vaccination, and counter misinformation. · Strengthen VPD surveillance systems (as detailed in Section 4.2.4) to ensure rapid case detection, reporting, and	**Action 4** Data from the national public health reference lab shows that for 2024, 5,253 suspected Measles cases were recorded out of which (19.2%) were not tested. The 19% not tested is as a result on reagent stockout. The data is attached. The country commits to ensuring that the funds or waivers needed to clear reagents at the port are cleared in time to avoid stock outs. i & ii. EPI continues to deliver routine immunisation services with high immunisation coverage levels. The administrative coverage levels for MR1 and MR2 in 2024 were 95% and 92% respectively. To ensure marginalised and underserved communities/ populations are reached, the Program has prioritised special targeted vaccinations such as weekend vaccinations and evening vaccination sessions. Defaulter tracing and tracking will be emphasised at the sub-national level to identify all those who have missed doses. The use and scale up of container clinics in busy markets in urban districts is also being pursued. To improve vaccine uptake in the routine immunisation sessions, 45 districts have been prioritised with specific	MoH / GHS	30 June 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	outbreak investigation, enabling early response and containment. · Train health personnel in active case finding, outbreak investigation, and micro-planning to improve field response and surveillance sensitivity.	interventions to reach zero dose and under immunised children. Differentiated/ targeted services including weekend and late evening vaccination sessions, camp-out sessions in overbank communities, container clinics at strategic locations, etc. Specialised support will be provided to facilities to establish additional outreach points guided by data. iii. Management will prioritise the following to ensure effective communication on immunisation to minimise hesitancy and improve uptake: a. The EPI Communication sub-committee will be reconstituted to include individuals with specialty/expertise in infordemic and use of new media management b. Periodic Training/ orientation of journalists to champion immunisation/ vaccination c. Review the EPI Communication strategy to reflect current effective modern approaches and channels iv. & v. The recommendation to step up training on active case search and outbreak management for VPDs is welcome and indeed the country has undertaken some actions in that regard. Notably, between 2022 and 2023, there was support from the WHO to train surveillance staff from 130 districts, and these refresher trainings focused on regions and districts with a large burden of VPDs, especially Measles. These workshops focused on IDSR Functions such as Detection, Reporting and Response, including a refresher on outbreak investigations. Similarly, in 2023 and in 2025, supervisory visits targeted regions and districts with VPD outbreaks, with the aim to provide further support. Continued support to extend cover capacity building efforts and supportive supervision is welcome considering the significant turnover of staff and attrition rates. **Audit note:** **The audit team reviewed the new data set provided by the national public health reference lab at the time of finalising this report, however it varies significantly with what was provided to the team during the fieldwork. As such, we maintain the recommendation.** **While the routine immunisation has high coverage for both MR1 and MR2, the coverage survey highlighted weaknesses in data accuracy. It is therefore imperative that the country pays particular attention to accuracy of surveillance data.**		

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
Improvements are needed in the Vaccine preventable disease (VPD) surveillance system and processes	**Recommendation 5** To strengthen VPD surveillance performance, timeliness, and coverage, the MoH/GHS should: • Strengthen coordination between EPI and the Disease Surveillance Department, including routine data sharing, joint analysis of VPD trends, and establishment of a regular forum or TWG to monitor surveillance indicators and follow up on actions. • Improve data quality and use of SORMAS by instituting routine data validation, clean-up, and review processes, and clarifying accountability for completeness, accuracy, and timely updating of case records. • Reinforce community-based surveillance by re-orienting and supporting community-based surveillance volunteers, with clear roles, refresher training, and feedback mechanisms linked to the formal surveillance system. • Reduce investigation and laboratory turnaround times by addressing operational bottlenecks in sample transport, testing workflows, and result reporting, and monitoring turnaround time as a key performance indicator. • Strengthen planning and advocacy for sustainable surveillance financing to ensure timely availability of laboratory reagents, sample collection materials, and transport infrastructure, aligned with operational planning processes.	**Action 5** There is a schedule officers for specific VPDs to do routine data quality review and clean up through engagements with regions and districts. These are usually via phone calls or WhatsApp messages and hence means of verification was a challenge. Moving forward officers have been tasked to record these activities and include in their weekly activity reports to be submitted to the head of the department. Data validation encompassing the Disease Surveillance Department, EPI and NPHRL done on an ad hoc basis. The Disease Surveillance Department has scheduled meeting on priority PH diseases under surveillance where analysis, monitoring and review of indicators are undertaken. Based on the feedback from the team, EPI and NPHRL will be included in these meetings. The challenge of community involvement in VPD surveillance is currently being addressed with the roll-out of event-based surveillance, which has expanded community involvement beyond traditional community-based surveillance volunteers (CBSVs). The use of CBSVs has been limited by funding challenges and the increasing reluctance of community members to volunteer for such activities without remuneration. Event-based surveillance has been established in 25% of the 261 districts and plans are underway to expand to particularly rural areas. The use of eIDSR (SORMAS) has meant that direct communication with regions, districts and health facilities when results are ready is not necessary. In cases of outbreaks or other diseases requiring prompt action, the department liaises with the appropriate region to generate appropriate response. All districts have been trained and have access to the platform and are able to access information on all cases. Evidence of whether officers have accessed laboratory results can also be generated by the IT team when required. " iv. Management plans to prioritise immunisation and surveillance financing through: a. Engagement with Parliamentarians to champion financing immunisation and surveillance as a priority budget item annually	Surveillance Department / GHS / EPI	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		b. Continuous engagement of a consultant to ensure advocacy and improved planning processes are prioritised and outlined interventions pursued c. The NIS has captured surveillance operations as a key strategic priority of the immunisation programme and adequately plans for interventions to prevent, promptly detect and respond to VPDs		
Improvements required to align CSO implementation for greater impact	**Recommendation 6** To strengthen the effectiveness and equity impact of CSO implementation, the MoH/EPI should: • Refine the strategic approach to CSO engagement by working with GCNH to prioritise districts and populations with the highest zero-dose and under-immunised burden, using transparent, data-driven selection criteria. • Clarify coordination and oversight arrangements by defining clear roles and reporting requirements for CSO activities at national, regional, and district levels, including integration into existing health management structures. • Establish a performance monitoring and evaluation framework for CSO implementation, with clear objectives, indicators, milestones, and reporting requirements, and ensure that CSO results are periodically reviewed and validated by MoH/EPI. • Systematically engage CSOs in campaign planning and implementation, particularly for demand generation and outreach to missed populations. • Strengthen the evidence base for CSO engagement by improving CSO mapping and ensuring that technical assistance supporting civil society engagement is representative and aligned with equity objectives.	**Action 6** Management Response Management acknowledges the audit finding relating to the intervention areas targeted by the Ghana Coalition of NGOs on behalf of the Civil Society Organisation (CSO) implementation under the Gavi Civil Society and Community Engagement (CSCE) approach. We appreciate the observations aimed at strengthening equity-focused immunisation delivery. Management will ensure that district selection is guided by zero-dose data and that clear reporting lines are established to enable regular feedback on CSO activities to the Ministry of Health and the Expanded Programme on Immunisation (EPI). Corrective Actions To address the issues identified, Management commits to the following actions: 1. Development of a documented CSO targeted framework: GCNH in collaboration with MoH and GHS-EPI and relevant stakeholders, will develop and approve a clear, data-driven framework for CSO district selection. This framework will prioritise districts with high zero-dose, under-immunised burden and the marginalised, using updated routine immunisation data, urban–rural disparities, and equity indicators. 2. Re-prioritisation of CSOs engagement: Future CSO implementation under Gavi-supported grants will be re-aligned to ensure greater coverage of high-burden zero-dose districts, particularly urban poor, peri-urban, minority, and hard-to-reach communities, in line with the CSCE approach. 3. Work Closely with MoH/PPME and GHS-PPMD for assigned stewardship and oversight duties: GCNH in collaboration with PPMD, PHD will enhance oversight of CSO implementation by establishing clear roles for coordination, performance	GCNH / EPI	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		monitoring, and reporting, including periodic reviews of CSO geographic coverage and funding allocations. 4. Coordination and Oversight at Sub-National Level: • Establish formal reporting and coordination mechanisms between CSOs and Regional/District Health Directorates. • Advocate for participation slots in GHS review meeting within the sub-national level • Require CSOs to submit periodic activity and performance reports to both GCNH and relevant health authorities. • Strengthen supervision and documentation of CSO engagement at sub-national levels. 5. Engagement of CSOs in Campaign Planning: • Engage the Ghana Health Service (GHS) to formalise CSO participation in relevant TWGs especially at sub-national levels. • Develop standard operating procedures outlining CSO roles in campaign planning, implementation, and post-campaign review. • Ensure CSO inclusion in future campaign preparedness and demand generation strategies. 6. Improved documentation and accountability: All decisions related to CSO selection, district prioritisation, and funding allocation will be formally documented and retained to support transparency, accountability, and future audits. 7.Monitoring and Evaluation: • Management agreed to the need for a performance framework to monitor the results of CSOs. • CSOs will be mapped out to look at the spread and align with the available TA • Strengthen the CSO monitoring and evaluation framework to better capture contribution pathways between demand-side interventions and immunisation outcomes. • Continue district-level contribution analysis and qualitative evidence (e.g. community feedback, defaulter tracking outcomes). • Review district and respective community selection and intensity of CSO engagement to ensure alignment with high-priority, low-coverage areas within the selected area of implementation. • Refine CSO workplans to focus on clearly defined immunisation performance gaps.		

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		• Improve alignment between CSO activities and district micro plans. • Use routine data more systematically to adjust CSO strategies mid-implementation.		
Documentation and follow up of supportive supervision need to be enhanced	**Recommendation 7** To enhance the effectiveness and sustainability of supportive supervision, the MoH/EPI should: • Strengthen planning and prioritisation of supportive supervision by developing and implementing annual supervision plans informed by programme performance data and risk analysis, in line with GHS guidelines. • Improve documentation and follow-up mechanisms by ensuring that supervision visits are systematically recorded at all levels, action points are clearly documented, and progress is tracked over time. • Enhance feedback to supervised facilities by ensuring that supervision findings are shared in an accessible and timely manner, with feedback that is specific, actionable, and supports continuous improvement.	**Action 7** EPI supportive supervision to subnational levels is guided by data. Routine immunisation data is analysed and districts with sub-optimal performance/gaps are prioritised for visits. The Recommendation to improve on documentation of the processes involved in the activity implementation ranging from planning, field visits to feedback provision is well noted and will be implemented	EPI	30 June 2026
Improvements needed in digital immunisation and vaccine logistics systems	**Recommendation 8** To strengthen digital systems supporting immunisation and vaccine logistics, the MoH/GHS should: • Operationalise interoperability in line with the Digital Health Strategy (2023–2027) by advancing a national health information exchange that enables integration between GhiLMIS, eTracker, and DHIMS, improving data visibility across supply and service delivery. • Conduct a comprehensive Gavi TSS gap analysis of GhiLMIS and address identified gaps by incorporating missing immunisation-specific modules, including CCE inventory, RTM, forecasting, and integrated analytics dashboards. • Strengthen data quality controls by implementing automated validation and integrity rules within GhiLMIS to prevent invalid transactions and improve reliability of logistics data. • Adopt and institutionalise a robust national unique child identifier for use within eTracker, aligned with national	**Action 8** The GHS will take steps to ensure data exchange between the e-tracker, DHIMS2, and GhILMIS to improve data quality and enable prompt decision-making. As of now, the EPI, with the support of SSDM, has organised a refresher training for National and Regional officers (EPI Coordinators and Cold Chain Managers) on the GhiLMIS to improve its utilisation across the supply levels. The regional teams will support the district teams to fully utilise the GhIMIS for vaccine logistics management. The National level with adequate knowledge on the GhiLMIS utilisation would monitor its utilisation across the supply chain. Current Mitigation Measures • The system architecture has so far supported nationwide immunisation data capture without critical service interruptions. • Offline functionality has enabled continuity of service delivery in low-connectivity settings, with synchronisation occurring once connectivity is restored. • Routine monitoring of system uptime and performance is conducted by the team.	GHS	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	digital standards, to reduce duplication and improve longitudinal tracking of immunisation services.	Ongoing and Planned Improvements • Conduct a national Immunisation Information System (IIS) technical review to assess database growth, system performance, and optimisation needs. • Implement data aggregation and archiving strategies for historical records to reduce system load. • Optimise dashboards, reports, and offline data synchronisation processes, especially for high-volume facilities. • Integrate scalability requirements into the next phase of eTracker system upgrades and partner-supported investments. 2. Risk of Duplicate Records Due to Identification Logic a. Current Controls • Health workers are trained to search existing records before creating new registrations. • Data quality reviews at district and regional levels include checks for potential duplicates. • For now, immunisation cards (with unique IDs) remain the primary reference for continuity of records where available. b. Ongoing and Planned Improvements • Ghana has initiated biometric identification pilots (Simprints) within immunisation services to strengthen unique identification, particularly in outreach and mobile populations. • Lessons from the pilot will inform national-scale integration of biometric or alternative unique identifiers into eTracker. • Plans are underway to enhance mandatory minimum data fields (e.g., caregiver name, contact number and information) to improve record matching and reduce duplication. • Development/use of routine de-duplication algorithms and dashboards to support proactive identification and resolution of duplicate records. • Alignment with broader national digital health and civil registration initiatives to explore future interoperability with national identifiers.		
Improvements needed in quality assurance mechanisms to reduce data inconsistencies	**Recommendation 9** To strengthen data quality assurance and reduce inconsistencies, the MoH/EPI should: i. Plan and conduct a comprehensive Data Quality Assessment (DQA) using a WHO-endorsed methodology, including development and resourcing of a Data Quality Improvement Plan (DQIP).	**Action 9** Management will harmonise and validate population denominators for routine immunisation monitoring, strengthen DHMIS data validation controls, and ensure the consistent use of nationally approved denominators for planning and reporting. Capacity-building for subnational data managers will also be strengthened to improve data quality, interpretation, and use for decision-making. The challenge with	GHS	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	ii. Institutionalise routine data triangulation at national and sub-national levels, including systematic comparison of administrative coverage, vaccine distribution and utilisation data, and available survey estimates, with documented analysis and explanation of identified variances. iii. Strengthen routine data verification and validation at sub-national level by ensuring that districts and regions conduct and document regular data quality checks, with clear accountability and follow-up. iv. Expedite completion of the ongoing EPI coverage survey to provide updated population-based estimates for validation of routine data. v. Prioritise funding to accelerate scale-up of the eTracker platform for routine immunisation, to improve individual-level data capture and reduce aggregation errors. vi. Strengthen supportive supervision and follow-up on data quality issues, ensuring that findings from data reviews and supervision visits are communicated back to sub-national levels and corrective actions are tracked to completion	estimates of target population is a national challenge impacting EPI and other health programmes. Previous national census has not fully resolved the discrepancies. To improve on data quality and accurate estimates to guide operations, the following steps are being pursued by the Ghana Health Service to address this challenge: i. GHS plans to conduct a comprehensive immunisation Information system assessment and data quality audit in 2026 to strengthen the data reporting system. The findings from the audit will be used to develop the data quality improvement plan (DQIP) 2026-2030. ii. Data triangulation will be done monthly and feedback shared during the monthly data reconciliation meeting with the Regional Teams. iii. The EPI has assigned staff to regions as "Parents" to support immunisation activities. These Parents will follow up with sub-national Data validation and verification activities within regions. iv. EPI Coverage survey has been completed, and findings are being disseminated. v. Efforts are being made to scale the e-tracker throughout the country to produce an immunisation registry. This is a priority activity for the Programme in 2026. vii Supportive supervision will be strengthened by the following: a. The EPI Routine Supervisory Checklist will be updated with addition of a section to help identify data quality challenges b. Evidence of feedback to the region/districts will be made a requirement of all supervisory teams after every supportive supervision c. Supervisors will develop action plans with supervisees to guide follow up on identified gaps for redress after every supervision		
Stock levels are low stock levels resulting in vaccine stock outs and affecting service delivery	**Recommendation 10** To ensure availability of adequate supply of vaccines and related supplies, MoH/GHS management should:	**Action 10** i. The MoH would strengthen advocacy and coordination with the Ministry of Finance to support the timely release of funds for vaccine procurement. In 2025, the Government of Ghana honoured its vaccine procurement fully without default and has assured the same in 2026.	MoH and EPI (NLWG)	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	i. Strengthen advocacy and coordination with the Ministry of Finance to support the timely release of funds for co-financed vaccines, improving predictability of procurement and supply planning (see finding on transition financing and co-financing delays). ii. Develop and implement country-specific forecasting and quantification SOPs, including explicit definition of minimum and maximum stock levels at each tier of the supply chain, documentation of planning assumptions, review timelines, and approval processes, and expedite the development of Terms of Reference for a logistics Technical Working Group (TWG) to strengthen stakeholder engagement. iii. Institutionalise periodic stock and forecast reviews, including regular assessment of stock levels across national and sub-national levels and structured review of forecast assumptions with UNICEF and Gavi to improve accuracy in subsequent forecasting cycles.	ii. Ghana currently uses the Global SOP from UNICEF to undertake forecasting and supply planning. The National Logistics Working Group (NLWG) would develop a country-specific forecasting and supply planning SOP from the Global SOP. The Group would also ensure a quarterly review of the stock levels at the different supply levels, as well as the forecast. The ToR for NLWG has been finalised, awaiting the group's inauguration by the Director General of GHS. iii. Management plans to implement the following with regards to the recommendation on vaccine stock and forecast reviews: a. On quarterly basis, the NLWG will include reviews of stocks and vaccine forecasts as part of its agenda during meetings b. GHS will institutionalise quarterly vaccine stock taking at the national level and monthly stocks assessment at the regional and district levels		
Gaps in end-to-end supply chain visibility have weakened accountability across the vaccine supply chain	**Recommendation 11** To enhance vaccine stock visibility and close accountability gaps identified, MoH/GHS should: i. Develop and disseminate comprehensive vaccine inventory management SOPs, clearly defining procedures for stock recording, reconciliation, investigation of discrepancies, documentation standards, and accountability at each level, and train staff on their practical application. ii. Accelerate the rollout and adoption of a reliable electronic LMIS (GhiLMIS) across all vaccine storage points, ensuring that it meets immunisation-specific requirements and enables timely, ideally near-real-time, visibility of stock balances down to district and facility levels. iii. Strengthen reconciliation and oversight mechanisms by requiring routine comparison of physical stock counts with system records, formal investigation and documentation of variances, and independent cross-checks by designated staff not involved in day-to-day stock handling.	**Action 11** i. Recommendation on SOP development is well noted, and the NLWG would develop all immunisation supply chain (iSC) SOPs. ii. In January 2026, EPI and SSDM has organised a 5-day refresher training for National and Regional officers on the use of the GhiLMIS to improve its utilisation across the supply levels. District teams will be coached by the Regional teams to cascade the use of GhILMIS to the district and facility levels, ensuring improved stock visibility at all levels. The report is attached. iii. Periodic vaccine stock taking is being conducted at all levels of the service. Documentation of the process would be enforced at all levels in the immunisation supply chain and would be prioritised during quarterly supervisory visits. iv. Following the MLM trainings held in 2025, staff will be provided mentorship and guidance during supportive supervisory visits to districts and regions to ensure that standards are adhered to.	EPI and SSDM	30 June 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	iv. Integrate on-the-job mentorship into supportive supervision, focusing on practical application of inventory management procedures, timely data entry, and follow-up of identified gaps to improve consistency and accountability.			
	Recommendation 12 To strengthen vaccine distribution and last-mile accountability across the supply chain, MoH/GHS should: • Expedite the development and operationalisation of Logistics TWG Terms of Reference, and ensure regular engagement of NCR, CMS, and relevant partners to align distribution schedules for vaccines and related dry supplies. • Strengthen governance and performance management of third-party logistics arrangements by defining and enforcing Key Performance Indicators (including OTIF delivery, order cycle time, and exception management), and improving visibility of last-mile distributions to enable timely monitoring and corrective action.	**Action 12** i. The TOR of the NLWG has been completed and is attached here. It will be inaugurated in February 2026. The Group as part of its function, will be to ensure the review of the distribution schedules of vaccines at the NCR to align with the devices at the CMS. ii. KPIs are being developed to guide the operations of Zipline and other 3rd party logistics distribution. Performance management as part of governance oversight will also be implemented	MoH / GHS	30 June 2026
Cold chain management practices need to be improved	**Recommendation 13** To strengthen its cold chain management operations, MoH/EPI with support from partners should: i. Develop and implement comprehensive cold chain management SOPs, detailing standard procedures for operations, preventive and corrective maintenance, calibration, and procurement timelines for CCE spare parts and replacements. ii. Introduce and enforce routine use of maintenance plans, service logs, and checklists at national and sub-national levels to ensure systematic documentation and follow-up of CCE maintenance activities. iii. Provide targeted training for cold chain managers, technicians, and biomedical engineers on the application of maintenance tools, SOPs, and troubleshooting procedures. iv. Prioritise completion of ongoing infrastructure works and conduct temperature mapping of all national and regional cold rooms in line with WHO requirements.	**Action 13** There has been a delay in temperature mapping of all cold rooms in the country because of the delay in the cold rooms installations across the regional and National cold rooms. Temperature mapping of all cold rooms is planned to be conducted in February 2026. The Ultra-low freezers were originally procured for the storage of Pfizer COVID-19 vaccines that required ultra-low temperatures (-60 to -80). After the pandemic response, these equipments have been recalibrated to provide negative temperature between -15 to -25. These equipments are used whenever the WIFRs are inadequate to store vaccines that require freezing temperatures. At the time of the audit visit, stock levels of OPV and Rotavac vaccines were low and therefore all were stored in the WIFR. However, the balance of the nOPV used for the Polio outbreak response was stored in one of the UCC and the rest were turned off. Each time these equipments are in use there is a temperature monitoring chart attached to the equipment where temperature is monitored every morning and evening to monitor the performance of the equipment. There is evidence of these filled temperature monitoring charts for the equipment whenever they are in use and were provided to auditors during the exercise. The "Partially agreed" was in response to the issues raised not	MoH / EPI	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	v. Strengthen power contingency arrangements at sub-national level by disseminating clear guidance on vaccine handling during power outages and advocating for dedicated budgets to support installation and maintenance of power backup systems.	the recommendation. What is not agreed is the explanation under the "Redundant and non-functional CCE were observed across levels". The six UCC units at the NCR were not in use because of low stock of vaccines not delayed servicing. i. The programme will develop and implement comprehensive cold chain management SOPs. ii. There is a comprehensive maintenance plan at the National level and the service would ensure its availability and implementation at the subnational levels. Maintenance logs would also be used for all cold chain equipment maintenance for both preventive and curative at all levels. iii. Cold chain technicians and Biomedical engineers from all the 16 regions were trained from 25th to 28th November 2025 on preventive and curative maintenance of CCE which included the use of tool kits provided for the regions. Participants were taken through practical sessions to troubleshoot broken down equipment. iv. All WICRs have now been installed and temperature mapping training has been organised for all regional cold room users (Regional EPI coordinators and Regional Cold Chain Managers) from 16th to 20th February 2026 and following up with the temperature mapping study itself at the National cold room and all regional cold rooms. All cold rooms would be mapped by the end of March 2026 v. All districts would be supported by their respective regions to prepare contingency plan for their district cold rooms. These contingency plans would address all emergencies including power outages that could affect the potency of the vaccines. All districts plan would be ready by the end of 2nd quarter 2026.		
Delays in implementation of EVM assessment recommendations	**Recommendation 14** To strengthen immunisation supply chain performance and ensure effective follow-through on EVM assessments, the MoH/GHS should: i. Undertake a comprehensive review of the current implementation status of the Continuous Improvement Plan, identifying completed, ongoing, delayed, and unimplemented actions.	**Action 14** i. & ii. The country will undertake the EVM assessment in 2026, and a new costed cIP will be prepared after the assessment. iii - vi An implementation plan of the cIP with a detailed Monitoring and Evaluation framework will be developed to ensure accountability. All partner support would be identified and indicated in the cIP. This cIP would be updated on quarterly basis as it would be one of the key activities of the NLWG which would be launch on the 26th February 2026.	MoH / GHS	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	ii. Develop a prioritised and fully costed action plan, informed by risk, impact, and feasibility, and aligned with available financial and human resource capacity. iii. Integrate systematic monitoring and reporting of cIP implementation into existing supply chain governance structures, with regular progress reviews and escalation of bottlenecks to senior management. iv. Align future supply chain investments and partner support to the prioritised cIP to ensure coordinated, sustained improvements rather than fragmented interventions.	The UNICEF cIP tool which is online would be used for the 2026 cIP and it will provide adequate visibility for all stakeholders including partners.		
Weaknesses in financial controls and documentation led to questioned expenditures	**Recommendation 15** To ensure that funds are properly and adequately accounted for, MoH and GHS management should ensure that: • Ensure all expenditures are fully supported by appropriate documentation, including signed attendance sheets, meeting minutes, activity reports, detailed per diem and allowance schedules, third-party invoices and receipts, acknowledgement forms, and completed vehicle logbooks. • Develop, approve, and disseminate a standardised per diem policy applicable across MoH and GHS, aligned with approved benchmarks and applied consistently at all levels. • Ensure that Gavi funds are not used to pay VAT or other ineligible taxes and establish controls to prevent such charges. • Strengthen internal review and validation processes, including routine verification of supporting documents at accounts offices and enhanced financial oversight during supportive supervision visits. • Strengthen review of sub-national expenditures, including regular validation of statements of expenditure from RHDs and DHDs. • Strengthen review of sub-national expenditures, including regular validation of statements of expenditure from RHDs and DHDs. • Liaise with WHO and UNICEF to strengthen financial reviews of reports submitted by MoH and GHS to include	**Action 185** Inadequately supported expenditure We partially agree with this finding. After receiving detailed classifications from the auditors, we proceeded to provide additional documentation/information on some of the transactions questioned to the auditors. We are waiting for feedback on those initial responses. Irregular expenditures We partially agree with this finding. After receiving detailed clarifications from the auditors, we proceeded to provide additional documentation/information on some of the transactions questioned to the auditors. We are waiting for feedback on those initial responses. Our responses included evidence that per diem payments were supported by documents (deployment list in most cases) beyond mobile money payments. Also, the said supporting documents (deployment lists) had columns for activity duration, applicable rates etc. Moreover, while we concede that there were a few instances where per diem processed differed from the standard rates, we state on record that we have an approved and standardised per diem rates in place. Lastly the use of different rates for national, regional and district levels is informed by differences in the cost of living in these locations. For instance, the cost of food and accommodation, which are key elements in the per diem computation differ between regional and non-regional capitals etc. Unsupported expenditures We agree with this finding. We have taken note of this and will address it going forward	MoH / GHS	30 September 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	detailed inspection of supporting documentation, rather than reliance on summary expenditure reports.	Ineligible expenditure We agree with this finding. We have taken notice of this and will address it going forward Conclusion We take note of all other recommendations and will implement them as may be applicable within our context, policies and laws.		
Traceability and accountability of Gavi Funds at GHS and MoH needs to be improved	**Recommendation 16** • GHS EPI team should immediately make available for use the amount of GH¢ 2,189,569 (USD 226,429) held in the Gavi refund account ledger. • GHS (HQ and EPI) should reconcile monthly the external expenditure listings/financial reports to the SAGE system/cash book balances. Any variances noted should be investigated and resolved. Reconciliations should be signed off by the preparer and reviewer to maintain transparency of process and accountability for review. • At both GHS and MoH, where Gavi funds are used to fund other projects/programmes, journal vouchers should be maintained and followed up periodically to ensure that Gavi provided funds are returned to the designated Gavi account as required by the grant management requirements; and • Bank reconciliation statements and relevant journal vouchers (with corresponding schedule of balances per funding source) should be reviewed and signed off by senior management within MoH and GHS management team to ensure transparency, accuracy and completeness.	**Action 16** MoH Response - as at 31 December 2024 Management agrees with the audit observation and acknowledges the variance of USD 160,425 (GH¢ 1,551,313) identified between the expected Gavi fund balance and the bank reconciliation balance as at 31 December 2024. Management wishes to note that the account into which the funds are to be restored has been subjected to garnishment. Consequently, management is currently engaging the Bank of Ghana to resolve the garnishment issues and facilitate the restoration of the outstanding amount. Efforts are ongoing to ensure that the funds are fully replaced once the matter is resolved. GHS Response 1. There was a variance of GHS 19,969,585/$2,065,107 between the ledger and analysed SAGE ACCPAC balances as of 31 December 2024. Response: There was no variance between the ledger and Sage Accpac analysed balance as of 31st December 2024. The amount of GHS19,969,585 represents the total GAVI balance (in SAGE) as of 31st December 2024, made up of GAVI ledger amount of GHS17,780,016 and GAVI refunds ledger balance of GHS2,189,569 both of which were in SAGE as at the said date. Please refer to your own comments on row 11 of the table under “Variances - bank balances and GAVI activity ledgers 31 Dec 24” in page 103 where you have referenced these figures. 2. The financial reports (expenditure ledgers) balances were higher than both the actual bank and reconciled cash book (SAGE system) balances as of 30 June 2025. Response: The variance of GHS10,379,599 between the financial report balances of GHS 64,557,354 and the bank balance and reconciled cash	MoH Finance	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		book (in SAGE) of GHS 54,177,7555 is explained as follows: i) a duplicated (debit) transaction in SAGE of (GHS10,371,200) which we noted and reversed in August 2025. ii) a shortfall of GHS8,400 in the opening balance of MVIP which was corrected during the audit. 3. There is a difference of GHS20,368,034/$2,106,312 between the expenditure ledger and actual bank balance. Response: We made a transfer into the account in October 2025 to address the shortfall of GHS20,368,034. Copies of the transfer letter and the bank statements were shared with the auditors during the field work. 4. There is a difference of GHS 8,269,663/$855,187 between the expenditure ledger and cash book (SAGE system) balances. Response: The difference is GHS10,379,599 (which has been explained in 2 above) and notGHS8,269,663. The auditor arrived at GHS8,269,663 because he inadvertently accounted for the GAVI refund of GHS GHS2,189,569 in arriving at GHS 56,287,691 though he rightly did not account for same in arriving at GHS 64,557,354 5. The SAGE system had an account ledger named 'GAVI refunds' which had funds totalling to GHS 2,189,569/$226,429. There were 2 transactions in the account that were refunds from GF accounts GHS2,020,740 on 21 November 2022 and GHS 168,829 on 7 March 2018). Response: There is no issue with the GAVI refunds ledger. The amount of (GHS2,189,569) represent refunds of taxes paid by Government of Ghana from Gavi funds which were flagged in previous audit for refunds. As explained in 1) above, it adds to the GAVI balance of GHS17,780,016 as of 31 December 2024 to bring the total GAVI balance to GHS19,969,585 The balances in the financial reports were less than what was in the SAGE accounting system. Response to “Variances -bank balances and GAVI activity ledgers 31 Dec 24” IPV2 funds (GHS5,096,341.80) and the GAVI refund (GHS2,189,569) were inadvertently omitted from the financial reports. The necessary corrections have been made.		

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
		SUMMARY Responses to "Variances -bank balances & GAVI activity ledgers 30 June 25" The attached sheet to the right named "Recon Variance Bn Bank and Gaci" shows how our responses above (from 1 to 5) have led to the reconciliation and confirmation of the GAVI balance as of 30 June 2025, after integrating the said responses into the reconciliation process. This is a further prove that the said variances did not exist to the extent portrayed **Audit note:** **This action remains open from the previous audit as the country has not effectively implemented the recommendation as observed during our audit. Reconciliations between cash positions, the system and other trackers / ledgers should be prepared timely, reviewed for accuracy and completeness, all reconciling items must have clear explanation, variances in cash position must be investigated promptly and reconciliations reports must be signed off by a senior member of the team on a quarterly basis especially as Gavi funds are in a comingled account. All records of reconciliations and related signoffs should be archived for reference.**		
Improvements required in advances management at national level	**Recommendation 17** To strengthen advances management and improve the accuracy of financial reporting, it is recommended that: • GHS Headquarters and EPI fully implement the ATF (2016) and FMSOP requirements for Gavi-funded activities. Specifically: o all disbursements to sub-national levels should be recorded as advances, not as expenditure; and o expenditure should only be recognised upon receipt, review, and validation of SoEs evidencing actual costs incurred. • Accounting adjustments should be systematically made in the SAGE system to reverse unretired advances and to recognise only verified expenditures. Any unutilised funds should be recovered or returned in line with FMSOP requirements. • The 90-day utilisation and retirement requirement for advances should be reiterated and enforced at sub-national	**Action 17** Management agrees with this finding. Following the implementation of the Financial Management Standard Operating Procedures (FMSOP), controls and procedures around advances/transfers and SoEs have been strengthened in 2025. In fact, all GAVI transfers to regions are treated as advances and are only recognised as expenditure when SoEs are received from the regions.	GHS	31 December 2026

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
	levels, supported by regular monitoring and escalation of non-compliance to senior management.			