Memorandum on the Republic of Sierra Leone Programme Audit report

The attached Audit and Investigations report sets out the conclusions of the programme audit of Gavi's support to the Republic of Sierra Leone's Ministry of Health and Sanitation, executed by the Expanded Programme on Immunisation (EPI), along with other implementing partners.

The audit team reviewed the EPI and implementing partners' management of Gavi support to the routine immunisation programme provided during the period 1 January 2019 to 31 December 2024. The audit scope included the following grants: Health Systems Strengthening, Inactivated poliovirus vaccine, MR campaign, HPV vaccine, 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 6) 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, 15 issues were identified in the following areas: (i) governance and oversight; (ii) programme management; (iii) vaccine supply chain management; (iv) supply chain and data management systems; (v) immunisation data management; and (vi) budgeting and financial management.
3. To address the risks associated with the issues, the audit team raised 17 recommendations, of which 12 were rated as high priority.

4. Key findings were that:

    a. The Expanded Programme on Immunisation (EPI) programme's is heavily reliant on Gavi support. The immunisation activities and plans are limited to what Gavi is able to fund. The country continues to face significant challenges in mobilising domestic resources to support immunisation activities beyond meeting co-financing requirements.

    b. Persistent weaknesses in programming and a challenging operational environment have contributed to ongoing issues within Sierra Leone's immunisation programme. There is no central mechanism to oversee and monitor the linkages between the existing multiple strategic documents. The country's National Immunisation Strategy (2024-2028) was not endorsed by the Ministry of Health and Sanitation by the time of the audit

and the costing as well as the M&E framework remains incomplete. There were no annual operational plan or micro plans during the audit period. Measles management remains a concern and there was a reliance on immunisation campaigns while strengthening of routine services was also required for long-term disease prevention. The management of the Vaccine Preventable Disease surveillance was found to be weak. There were opportunities to enhance the effectiveness of the support supervision activities. There was limited government involvement in monitoring Technical Capacity activities implemented by partners.

c. Inventory management practices at both the national and subnational levels require significant improvement. The forecasting process was partner led with limited involvement of EPI and vaccines delivered were often significantly lower than the forecasts. Intermittent stock outs were noted. Discrepancies were noted between the electronic Stock Management Tool and manual vaccine stock records as well as with distribution data. There were discrepancies with physical verification as well as unrecorded expiries. Stock counts and reconciliations were inadequately documented.

d. Sierra Leone has made some progress in digitising health information systems within the infrastructure environment which is challenging due to availability of electricity and mobile data penetration within the country. The electronic stock management tool has significant design challenges and lacks the essential functionality for use as a reliable electronic management system for vaccines. The system is unstable, has numerous errors and is unable to generate retrospective stock reports, has limited alert functionality and relies on UNICEF with no in country technical support to address issues when they arise.

e. The reliability of Sierra Leone's immunisation coverage was compromised due to the use of outdated population denominators and lack of development and implementation of the data quality improvement plans to remediate and improve the overall data quality. Weaknesses were identified in the health facilities' use of immunisation tools and the documentation, validation, verification, and collation of data including variances between the District Health Information System 2 (DHIS2) data and the underlying records.

f. Progress was made since the last programme audit in Sierra Leone in 2018. From a total of USD 4.6 million expenditures reviewed by the audit team from this period, USD 71,000 (1.5%) were questioned. This in part reflected the establishment of an assurance provider to support routine reviews of expenditures at the Integrated Health Projects Administration Unit (IHPAU). The team found that financial management reports were inaccurate, late, and required significant intervention by the AP for correction. As a result, in 2024, Gavi contracted independent financial management technical assistance to build financial reporting capacity at IHPAU, in order to address this issue prospectively.

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

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

Geneva, May 2026

PROGRAMME AUDIT REPORT

Republic of Sierra Leone
March 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 and Sanitation's management of Gavi support during the period 1 January 2019 to 31 December 2024 as "ineffective" which means, "**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."

Through our audit procedures, we identified high risk issues relating to programme management; vaccine management; supply chain and data management systems; immunisation data management; and budgeting and financial management. To address the risks associated with these issues, the audit team raised 17 recommendations, of which 12 (71%) 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 key 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 issues

Through our audit procedures, we identified 15 issues (10 high risk, 5 medium risk) relating to the use and management of Gavi support. Section 3 of this report provides details of the Republic of Sierra Leone's context and specific challenges in delivering its immunisation programme. The high-risk issues are summarised below. Details of all the issues are explained in Section 4 of this report.

A key underlying issue highlighted throughout this report is the Expanded Programme on Immunisation (EPI) programme's heavy reliance on Gavi support. The immunisation activities and plans are limited to what Gavi can fund. Although the country is in the initial self-financing phase of the Gavi transition continuum, it continues to face significant challenges in mobilising domestic resources to support immunisation activities beyond meeting co-financing requirements. These financial constraints have also delayed the completion of the costing exercise for the National Immunisation Strategy, which is essential for identifying and addressing funding gaps. It is therefore critical that available resources are prioritised for essential activities, while efforts to secure additional funding beyond Gavi—particularly through the Interagency Coordinating Committee (ICC)—are undertaken.

Programme management
Sierra Leone has developed multiple strategic and operational documents including the National Health Sector Strategic Plan (2021-2025), National Second Year of Life Vaccination Strategic Plan (2023-2026) National Immunisation Strategy (NIS) (2024-2028) and National Immunisation Policy (2023). However, there is no central mechanism to oversee and monitor the linkages between the existing multiple strategic documents developed in the same period with some Key Performance Indicators (KPIs) in common.

Although the NIS covers the period 2024-2028, it had not been endorsed by the Ministry of Health and Sanitation (MoHS) by the time of the audit in June 2025. The NIS costing remains incomplete, and the M&E framework does not include appropriate targets for some planned activities. The EPI did not develop any annual operational plans (AOP) or annual EPI workplans for the period 2019 to 2023. Furthermore, the programme did not develop routine immunisation (RI) micro plans for 2020 to 2024 at national and sub-national level.

Measles management remains a concern. Although WHO recommends 95% coverage to achieve herd immunity, Sierra Leone reported only 76% coverage in 2024 as per WHO/UNICEF estimates of national immunisation coverage (WEUNIC), which also differed from the reported administrative coverage of 90%. The audit noted a reliance on immunisation campaigns while strengthening of routine services especially with regards to second dose coverage and cross border interventions, was also required for long-term disease prevention. Also, the management of the Vaccine Preventable Disease (VPD) surveillance was found to be weak with delays in transportation, review and reporting of results.

Supportive supervision activities were clearly being implemented across all levels. However, opportunities to enhance the effectiveness of these activities, particularly in improving the quality and follow-up of supervision recommendations remain.

There was limited government involvement in monitoring Technical Capacity (TCA) activities implemented by partners. While planning and alignment efforts exist, coordination and data-sharing during implementation are weak. Government counterparts were not involved in performance reviews or monitoring prior to partner reporting to Gavi. There is no transition plan to guide the gradual transfer of responsibilities from partners to national staff. Without a structured transition plan, clear oversight of partner activities, and mechanisms for results measurement and skills transfer, there is a high risk that TCA resources will not deliver long-term value or build national capacity.

The weaknesses noted in programme management may impact strategic, operational and sustainability planning for the immunisation program, which may hinder the programme's ability to prioritise activities within the limited donor funding available.

Vaccine supply chain management
Challenges were noted in vaccine supply planning as the annual forecasting processes were partner led with limited involvement of the EPI. Also, vaccines delivered to the country were often significantly lower than the annual forecasts. Low vaccine stock levels and intermittent stock outs were noted at both national and sub-

national stores with Pentavalent vaccines stocked out for more than ten days and in some instances over 100 days in 10 out of the 16 Peripheral Health Units (PHUs) visited.

Significant discrepancies were identified between the electronic Stock Management Tool (eSMT) at the national level and manual vaccine stock records, including inconsistencies in running balances and distribution data across all vaccine stores. These discrepancies undermine both the visibility of vaccine stocks nationwide and the reliability of the eSMT. Our review of vaccine management processes revealed mismatches between physical stock and manual records, as well as unrecorded expiries at the Central Vaccine Store (CVS), District Vaccine Stores (DVS), and service delivery points. Routine physical counts, stock reconciliations, and investigations into discrepancies are inadequately documented.

The country has conducted three Effective Vaccine Management (EVM) assessments to date. In 2022, it adopted the updated EVM 2.0 tool—introduced in 2019—which expanded the evaluation from 9 criteria (E1–E9) to 13 (E1–M4). Despite these efforts, overall performance has remained low and stagnant: 66% in 2013, 65% in 2016, and 64% in 2022. This trend reflects regression in several critical areas, particularly vaccine distribution and stock management, as also highlighted by this audit.

Supply chain and data management systems

Sierra Leone has made some progress in digitising health information systems within the infrastructure environment which is challenging due to availability of electricity and mobile data penetration within the country.

However, the electronic stock management tool (eSMT) has significant design challenges and lacks the essential functionality for use as a reliable electronic management system for vaccines. The system is unstable, has numerous errors and is unable to generate retrospective stock reports, has limited alert functionality and relies on United Nations Children's Fund (UNICEF) with no in country technical support to address issues when they arise. eSMT only meets two of ten requirements outlined by Gavi for an optimised vaccine logistics system and is therefore not endorsed by Gavi.

Weaknesses noted in the eSMT tool have resulted in unreliable vaccine management data. This may also result in misallocation of Gavi's limited resources in the roll out and training on this non-Gavi endorsed tool at subnational level.

Immunisation data management

The use of outdated population denominators has led to inaccurate reporting of immunisation coverage, resulting in either overreporting or underreporting of immunisation rates across districts. Immunisation coverage data for 2019 to 2024 was above 100% for several antigens. Also, weaknesses were identified in the health facilities' use of immunisation tools and the documentation, validation, verification, and collation of data. This included variances between the District Health Information System 2 (DHIS2) data and the underlying records at the service delivery points, and variances between the underlying records at different levels.

The last comprehensive, nationwide Data Quality Assessment (DQA) was carried out in 2017 and resulted in a Data Quality Improvement Plan (DQIP) for 2018 to 2021. Although the DQIP was costed, it expired in 2021 with all 30 activities not having been fully implemented. A more recent DQA was conducted in 2022 covering 24 PHUs in four districts, however no DQIP was developed.

Overall, the gaps in immunisation data management compromised the quality of data used in decision making, targets set could not be supported by underlying reviews and achievements may have been overreported. The audit team noted that while the immunisation data challenges are known, they undermine the credibility of the reported immunisation administrative coverage and addressing them remains a challenge. Reliance on inaccurate or over-reported immunisation coverage data can result in incorrect programmatic interventions and misallocation of resources, which could negatively impact the effectiveness of the immunisation programme in reaching zero dose and under immunised populations.

Budgeting and financial management

Notable progress was made since the last programme audit in Sierra Leone in 2018. From a total of United States Dollar (USD) 4,614,463 reviewed by the audit team, USD 70,927 were questioned, a remarkable achievement due to the investment in an assurance provider to support routine reviews of expenditure at the

Integrated Health Projects Administration Unit (IHPAU). However, IHPAU's programme financial management and reporting did not meet Gavi's reporting needs during the audit period. Financial management reports were inaccurate, late, and required significant intervention by the Assurance Provider (AP) for correction. This impeded the assurance provider's independence. In 2024, Gavi engaged an independent financial management TA to build financial reporting capacity at IHPAU, therefore addressing this issue for the future. At the conclusion of the audit fieldwork, all IHPAU staff contracts had been terminated due to underperformance. Recruitment of new staff—whose capacity would need to be built—had not yet begun at the completion of the audit fieldwork, creating a new capacity gap.

Furthermore, and except for the Measles-Rubella (MR) campaign funds, no accounting records or supporting documentation were available for cash grants that had passed through the WHO to MoHS for implementation by the EPI. WHO did not provide details of disbursements and records were non-existent at the EPI. The lack of transparency for cash grants channelled through WHO hampers accountability for Gavi provided support.

Unless the budgetary and financial management weaknesses are addressed and financial management capacity at IHPAU and subnational levels is enhanced, the Government will be unable to maintain adequate accountability over Gavi's funds, impacting the effectiveness of the immunisation programme, and possibly compromising Gavi's efforts in returning funding to government.

1.4 Financial consequences of audit issues

The table below summarises amounts questioned by the audit team in Leones (SLE) and in United States Dollars (USD) equivalents using the exchange rates in section 2.5 of this report:

Table 1: Summary of questioned expenditures

Category of questioned expenditure	Amount questioned (SLE)	Amount questioned (USD)	% of expenditure reviewed	Details (report reference)
Unsupported	388,381	21,129	**1.5%**	4.6.1
Inadequately supported	633,781	46,101		
Irregular	52,143	3,673		
Ineligible*	504	24		
Total questioned	**1,074,809**	**70,927**		

**Gross Sales Tax (GST) payments totalling SLE 64,040 (USD 2,879) have been excluded from the table above. The country will be requested to refund such amounts to the Gavi in-country Health Systems Strengthening (HSS) account upon recovery from the Department of Treasury.*

1.5 Cash balances

The following table recaps on unspent cash balances in USD held by grant recipients on 31 December 2024:

Table 2: Gavi funds disbursed to Partners, remaining unspent at central level

Grant recipient	Cash balance (USD)	Source
UNICEF	9,387,328	Gavi PFM records
IHPAU	3,177,608	Gavi PFM records
WHO	402,963	Gavi PFM records
Total	**12,967,899**	

Of these total cash balances, USD 188,454 (1%) had been received within the previous twelve months, and the remaining USD 12,779,445 (99%) had been received within the previous six months.

2. Objectives and scope

2.1 Audit objectives

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

As a result, the audit team assessed the various processes and programme management arrangements governing Gavi's support (vaccines, cash and equipment) for which the respective entities were responsible, to assess the governance arrangements are effective in providing oversight over the immunisation programme, assess the design and operating effectiveness of programme management, including Targeted Country Assistance (TCA), to support the immunisation programme, review the design and operating effectiveness of immunisation data management and data quality processes to ensure that data used for decision making is complete and accurate, assess the design and operating effectiveness of the logistics and immunisation data systems to support accurate data for decision making and review the design and operating effectiveness of the vaccine and supply 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 team adopted a risk-based audit approach informed by our assessment of the risks across the immunisation programme areas supported by Gavi. This included governance and oversight, programme management including the effectiveness of targeted country assistance, vaccine supply management, immunisation data management, supply chain and data management systems, budgeting, and financial management, including procurement.

The audit scope covered the six-year period from 1 January 2019 to 31 December 2024 (the audit review period). Total cash, vaccine, and ancillary support provided by Gavi to Sierra Leone was as follows:

Table 3: Cash, equipment, Partnership Engagement Framework Targeted Country Assistance *(PEF TCA) and vaccines support (2019 – 2024) in USD*

Cash grants	2019	2020	2021	2022	2023	2024	Total
Covid19 Vaccine Delivery Support (COVAX CDS)	-	-	967,687	1,988,495	532,576	8,260,574	**11,749,332**
EAF	-	-	-	-	-	1,078,941	**1,078,941**
HPV	-	255,321	-	-	-	734,959	**990,280**
IPV	-	-	396,866	-	-	(876)	**395,990**
HSS	-	2,986,528	3,251,087	31,120	888,026	3,920,064	**11,076,825**
Malaria	-	-	-	-	196,323	-	**196,323**
Measles-Rubella	2,219,857	-	-	(788)	852,748	-	**3,071,817**
Other cash grants	75,467	-	-	(1,140)	-	-	**74,327**
Total Cash	**2,295,324**	**3,241,849**	**4,615,640**	**2,017,687**	**2,469,673**	**13,993,662**	**28,633,835**
PEF TCA							
Total PEF TCA	**6,938**	**1,870,585**	**1,072,349**	**608,491**	**681,995**	**2,500,205**	**6,740,563**
Equipment							
Total Equipment	**-**	**(14,279)**	**256,964**	**-**	**-**	**-**	**242,685**
Vaccines							
COVID-19	-	-	4,433,921	33,164,743	14,959,219	1,969,413	**54,527,296**
Ebola	-	-	-	-	-	2,061,062	**2,061,062**
HPV	-	17,738	900,397	1,350,325	415,497	350,671	**3,034,628**
IPV	938,477	500,827	2,673,874	945,870	481,179	656,218	**6,196,445**
Malaria	-	-	-	-	5,659,932	2,476,733	**8,136,665**
Measles-Rubella	171,935	304,272	321,840	87,695	1,861,854	277,870	**3,025,466**
PCV	3,766,573	1,360,533	2,376,643	1,521,556	860,030	2,057,828	**11,943,163**
Pentavalent	568,821	17,413	392,522	1,027,451	346,550	443,382	**2,796,139**
Rota virus	908,465	(1,698)	1,766,370	929,548	30,355	1,272,466	**4,905,506**
Yellow Fever	(147,990)	636,103	353,723	492,842	363,365	618,548	**2,316,591**
Diagnostics & Inj. Safety Devices	(108,423)	-	-	-	-	42,231	**(66,192)**
Total Vaccines	**6,097,858**	**2,835,188**	**13,219,290**	**39,520,030**	**24,977,981**	**12,226,422**	**98,876,769**
GRAND TOTAL	**8,400,120**	**7,933,343**	**19,164,243**	**42,146,208**	**28,129,649**	**28,720,289**	**134,493,852**

2.3 Audit approach

The audit was conducted in two phases: an initial scoping visit in March 2025 and three weeks field work conducted from 19 May to 5 June 2025. The audit team adopted a risk-based approach to determine the audit objectives. This included visiting and undertaking audit work at CVS, in 6 DVS, and in 19 PHU. Annex 4 lists the DVS and PHU visited.

During the audit, the team interacted with key stakeholders including senior officials within the MoHS, national EPI team, District Health Management Teams (DHMT), PHU, Gavi Alliance partners WHO and UNICEF, Gavi expanded partners including CHAI and ICAP, several Civil Society Organisations, and assurance providers.

Over the audit review period, a range of recipients received a total of USD 28,633,835 from Gavi, excluding support for Technical Assistance. As illustrated in the table below, some of this support was channelled through WHO, UNICEF and IHPAU to be implemented by the MoHS, specifically the EPI and DHMT:

Table 4: Total Gavi cash disbursements by grant and recipient (2019 – 2024) in USD

Gavi grant	Grant recipient	Total disbursed by Gavi	Channelled to government	Audit Comments
COVAX CDS	UNICEF	9,713,986	1,682,260	Transfers to MoHS included in scope
	WHO	1,293,984	unknown	See limitation of scope in section 2.4
	IHPAU	382,759	208,129	Included in scope
	ICAP	197,471	-	Scoped out by the audit team
	SYD	120,552	-	Scoped out by the audit team
	CHAI	40,581	-	Scoped out by the audit team
Ebola projects	UNICEF	(1,140)	-	Reimbursement to Gavi on pre-2019 grant
EAF	IHPAU	1,078,941	52	Scoped out by the audit team
HPV	IHPAU	734,959	27,066	Included in scope
	UNICEF	148,308	119,909	Transfers to MoHS included in scope
	WHO	107,013	unknown	See limitation of scope in section 2.4
IPV	UNICEF	395,990	337,398	Transfers to MoHS included in scope
HSS	UNICEF	6,204,464	2,620,526	Transfers to MoHS included in scope
	IHPAU	3,877,894	2,752,560	Included in scope
	RESOLVE	400,000	-	Included in scope
	DT GLOBAL	303,338	-	Scoped out by the audit team
	WHO	147,529	unknown	See limitation of scope in section 2.4
	KPMG	99,600	-	Scoped out by the audit team
	INSIGHT	44,000	-	Scoped out by the audit team
Malaria	IHPAU	196,323	149,709	Included in scope
Measles-Rubella	WHO	1,801,871	unknown	See limitation of scope in section 2.4
	IHPAU	852,748	808,042	Included in scope
	UNICEF	417,197	115,047	Transfers to MoHS included in scope
PCV	UNICEF	75,467	56,662	Transfers to MoHS included in scope
Total		**28,633,835**	**8,877,360**	

2.4 Limitation of scope – funds channelled to government through core partners

In accordance with section 22.2 of Annex 2 of the PFA, all funds received by MoHS are subject to the programme audit. This includes Gavi funds received by partners that are subsequently channelled to government. Funds directly executed by WHO and UNICEF were not subject to our audit and were considered out of scope, in accordance with the United Nations Single Audit principle.

To the extent that information was available, the following table summarises Gavi funds channelled through core partners to MoHS throughout the audit review period:

Table 5: Percentage of Gavi-funded expenditures reviewed by the audit team

Grant recipient	Total received from Gavi (USD)	Channelled to government and CSOs (USD)	Government and CSO expenditure selected and reviewed (USD)	% of expenditure reviewed
WHO	3,350,397	at least 1,808,871	328,560	Unknown
UNICEF	16,954,273	4,931,802	1,667,031	34%
Total	**20,304,670**		**1,995,591**	

Over the audit review period, Gavi cash grants to UNICEF, excluding USD 1,411,316 of TCA, totalled USD 16,954,273. From these, UNICEF channelled SLE 78,347,175 (USD 4,931,802) to the EPI, DHMT and local CSOs. Of this, the audit team sample selected and reviewed the equivalent of USD 1,667,031 of expenditure recorded by the EPI and a sample of six DHMT.

Over the same period, Gavi cash grants to WHO, excluding USD 1,118,351 of TCA, totalled USD 3,350,397. The audit team requested but was not given information by WHO on portions channelled to the MoHS and CSOs. Working from the EPI records, the audit team was able to identify that the EPI had received at least USD 1,808,871 from WHO of Measles-Rubella cash grants. Of this, the audit team sample selected and

reviewed the equivalent of USD 328,560 of expenditure recorded by the EPI. Information on possible other Gavi cash grants that passed through WHO to the EPI was unavailable at the time of the audit.

2.5 Exchange rate

Most in-country expenditure was incurred in SLE. Amounts are also reflected in this report in USD equivalents translated at UN average exchange rates applicable for the year in which the expenditure was incurred:

Table 6: UN average exchange rates over the audit review period

Year	USD 1 = SLE
2019	9.01
2020	9.83
2021	10.44
2022	14.05
2023	21.30
2024	22.44

3. Background

3.1 Introduction

Sierra Leone is on the southwest coast of West Africa with a land area of 72,180 km2. The country is bordered by Guinea to the north and east, Liberia to the southeast, and the Atlantic Ocean to the west and southwest. The country's landscape ranges from plateaus in the east and lowlands in the centre to a coastal plain in the west. The capital, Freetown, is located on a mountainous peninsula along the Atlantic coast.

Administrative arrangements

Sierra Leone is a republic with a clear separation of powers among the legislative, executive, and judicial branches. The president serves as the head of state and the commander in chief of the Sierra Leone Armed Forces.

The country is divided into 16 districts which are subdivided into 190 chiefdoms controlled by paramount chiefs and chiefdom councillors. The chiefdoms are further divided into sections and villages. Administratively, there are district councils, which sometimes override the chiefdom administrations. The councils deal primarily with local matters and are under the indirect control of the central government. Town councils, headed by a mayor, have also been established in the larger provincial towns.

Economy and demographics

Until the outbreak of Ebola in 2014, Sierra Leone was seeking to attain middle-income status by 2035. However, the country still bears its post-conflict attributes of high youth unemployment, corruption, and weak governance. Problems of weak infrastructure and widespread rural and urban poverty persist, despite remarkable strides and reforms.

Sierra Leone has a Gross National Income (GNI) per capita of USD 870 (current Atlas method) and a Gross Domestic Product (GDP) of USD 6.41 billion, with a growth rate of 5.7% in 2023[1]. Economic growth slowed down to 4% in 2024 from 5.7% in 2023 largely due to falling global iron ore prices and slower mining production. Despite accounting for only 7% of the economy's output, the mining sector contributes the most to growth among all sectors. The fiscal deficit reached 4.8% of GDP in 2024 while revenues improved sharply to 8.8% of GDP (from 7.4% in the previous year) due to tax policy reforms.

According to the World Bank, economic growth is projected to rebound to 4.4% in 2025 and reach 4.7% by 2027, driven by the resilient services, agricultural productivity improvements, and continued mining expansion. The fiscal deficit is expected to narrow, benefiting from improvements in revenue collections and further rationalisation of spending, especially wages and subsidies. This outlook is however subject to several downside risks. Persistent fiscal overruns could undermine both fiscal and debt sustainability, ultimately jeopardising macroeconomic stability. External risks include fluctuations in global commodity prices, global demand, and higher imported inflation.

The UN Department of Economic and Social Affairs projects Sierra Leone's population to grow from 8.82 million in 2025 to 9.69 million in 2030[2]. Life expectancy has improved from 45 years in 2000 to 62 years in 2023.

3.2 National health sector[3]

Sierra Leone developed a National Health Sector Strategic Plan (NHSSP) for 2021-2030 to guide its health sector stakeholders towards universal health coverage and health security. The health sector operates under a decentralised system, headed by the MoHS which shapes the policy environment regarding service delivery, resource mobilisation, allocation, and regulation. MoHS works with DHMT which oversee health services at the district level. DHMT are responsible for managing, monitoring, and overseeing service delivery, disease prevention, health promotion, health education, safe water, and environmental sanitation service provision.

Although the Government of Sierra Leone increased budgetary allocations to health, from 6.8% in 2012 to 11% in 2020, the National Health Accounts (NHA, 2018), indicated that household out-of-pocket (OOP)

[1] GNI per capita - Sierra Leone | World Bank Data
[2] Empirical Data | UN Department of Economic and Social Affairs
[3] Sierra Leone NIS (2024-2028)

spending was the main source of health financing (USD 206 million, 64.6%), followed by donor partners (30.6%), government (4.0%), and corporations (0.8%). 65.2% of the OPP is spent on medicines, 21.7% on consultations, 7.2% on inpatient expenses, and 5.8% for travel. In Sierra Leone, over 90% of healthcare services are delivered by the public sector, while 10% are either private or faith based.

The current health workforce on the government payroll has low density with 6.4 health workers per 10,000 population. The health sector is served by an estimated 20,000 health workers of different cadres (excluding community health workers, CHWs). However, approximately, 50% of the available health workers are volunteers and not on the government payroll. According to WHO, there are roughly four medical doctors per 100 000 inhabitants in Sierra Leone. The 9,000 CHWs deployed at community level to support the health work force are not remunerated and there is no consensus on their roles or classification.

The Sierra Leone health care system is premised on the primary health care concept and comprises three levels:

- Primary: Peripheral Health Units (PHU) comprising Community Health Centres (CHC), Community Health Posts (CHP), and Maternal and Child Health Posts (MCHP).
- Secondary: district hospitals.
- Tertiary: regional and national hospitals.

At the time of this audit, the country has a total of 65 district hospitals, 258 CHC, 433 CHP and 672 MCHP.

3.3 Immunisation in Sierra Leone[4]

The EPI, serving as the technical programme responsible for immunisation service delivery in the country, is under the Directorate of Reproductive Maternal Newborn, Child, and Adolescent Health within the MoHS. The EPI is linked with other public health programmes and Directorates such as the Malaria Control Programme, Leprosy/Tuberculosis Control Programme, Health Education Programme, Surveillance and Applied Epidemiology Programme, HIV/AIDS Control Programme, Directorate of Food and Nutrition, Directorate of Reproductive and Child Health, Directorate of Disease Prevention and Control, and the National Public Health Agency.

Although Sierra Leone's RI has improved over the past five years, with most antigens scoring above 90%, none have reached the national target of 95%. The ensuing sub-optimal access to immunisation, indicated by Bacillus Calmette Guerin (BCG) vaccine coverage of 74% and Pentavalent first dose coverage of 93%, is responsible for a build-up of zero-dose children and communities. In addition, the low vaccination in the second year of life, indicated by a Measles Containing Vaccine (MCV) second-dose coverage of 75%, further compounds the aforementioned zero dose or partially vaccinated children and communities.

Suboptimal vaccination coverage among children and the resulting low herd immunity have made many children and communities susceptible to Vaccine Preventable Disease (VPD) outbreaks. Measles outbreaks in 67 of the 190 (35%) of the country's chiefdoms further reveal evidence of the low uptake of immunisation services. The number of zero doses children is estimated at 19,636 (Gavi 2023).

The current immunisation schedule provides immunisation against 14 diseases, namely Hepatitis B, Diphtheria, Tetanus, Pertussis (whooping cough), Haemophilus influenza type b (Hib) disease, Polio, Pneumococcal, Rotavirus, Measles, Rubella, Human papillomavirus (HPV), Tuberculosis, Malaria, and COVID-19.

3.4 Gavi's relationship with Sierra Leone

Gavi support to Sierra Leone first began in 2002. In June 2013, Gavi signed a PFA with the country, providing a framework for the country's management of Gavi support.

[4] Sierra Leone NIS (2024-2028)

3.5 Entities involved in the executing and managing Gavi's funds

Over the audit review period, Sierra Leone received a total of USD 134.5 million in Gavi support, comprised of cash grants, technical assistance grants, vaccines, dry goods, and equipment (see section 2.2 Audit scope for details). The programme's core implementation partners are UNICEF and the WHO, through which over 65% of the funding flowed over the audit review period. Additional to the core partners, Gavi funding is also sent to expanded partners such as CHAI and ICAP.

Since October 2021, Gavi has also disbursed some of its cash grants through IHPAU which was established as a Programme Management Unit (PMU) in 2016 to administer all non-government donor partner funding to the MoHS.

3.5 Progress on previously identified audit issues

Gavi conducted its last programme audit in Sierra Leone in 2018, and the audit report rated the management of Gavi's support as unsatisfactory overall based on the results of testing over various areas in scope, including governance and oversight, programme management, vaccine supply management, budgetary and financial management, procurement, and fixed asset management.

This audit corroborated whenever possible on the six ongoing recommendations and 11 that had not been started. All outstanding recommendations will be superseded by recommendations articulated in the present audit report as this audit has considered the current country context, available funding and changed leadership structures within the EPI and MoHS to provide updated recommendations.

3.6 Good Practices

The audit team noted the following good practices while executing the audit:

Governance and Oversight

Governance and oversight mechanisms i.e. ICC, NITAG, and Technical Coordinating Committee (TCC) were established since that last audit to provide strategic oversight, technical advice, and manage the immunisation programme**.** There is good coordination and strong collaboration between NITAG, TCC and ICC in escalating and addressing significant challenges impacting the immunisation programme._Technical Working Groups (TWG) exist at the sub-national level to steer and manage programme implementation in the districts.

Programme Management

The MoHS has developed multiple strategic and policy documents including the National Health Sector Strategic Plan (2021-2025), National Health Policy (2023), National Primary Health Care Operational Handbook (2021), and National Second Year of Life Vaccination Strategic Plan (2023-2026). The EPI collaborates with other government ministries such as the Ministry of Basic and Senior Secondary Education and the Ministry of Finance. The NIS costing dialogue, while not completed, includes the Ministry of Finance.

There is a strong EPI team at national level to oversee the immunisation programme. In addition, the audit team noted availability of EPI focal persons at DHMT and PHU levels. CHWs and volunteers at PHUs to augment immunisation programme. The EPI team collaborated with partners on a comprehensive EPI review in 2023, introduced and routinised Malaria and HPV Vaccines. In addition, the EPI implemented an integrated approach to immunisation during the 2021 Inactivated Polio Vaccine (IPV) campaign which was integrated with RI catch up and the 2024 MR campaign and included defaulter tracing.

The MoHS developed operational guidelines for VPD surveillance with case definitions and made them available at district & PHU level. The surveillance officers at sub-national level provide weekly reporting on surveillance data using the IDSR. In addition, collaboration and coordination have been established with Liberia and Guinea for disease surveillance.

Data Management

All PHUs are reporting through DHIS2 and newly introduced vaccines like Malaria and HPV are reported through DHIS2. In addition, data quality audit was conducted in four districts covering 24 PHUs in 2022. Furthermore, the country developed a digital health road map (2024 to 2026).

Vaccine supply chain management

Electronic Vaccine Arrival Reports were used for receipt of vaccines. The country had also introduced the DRIVE initiative to support vaccine delivery to hard-to-reach/riverine locations.

A Cold Chain Equipment (CCE) capacity and needs assessment was conducted in 2022 prior to CCE deployment. Consequently, the audit team found CCE including solar refrigerators at all PHUs visited. In addition, an inventory & gap analysis (IGA) application where all CCE in the country is to be recorded has been developed.

Budgeting and Financial Management

There is tangible collaboration between the EPI and IHPAU. Standard cashbook accounting templates were in place at all DHMT visited.

An annual procurement plan is established once the Annual Activity Plan has been validated. There are effective pre-procurement controls in place as formal EPI requests are submitted to the assurance provider for validation against the annual activity plan and other verifications.

4. Audit Issues

4.1 Governance and oversight

4.1.1 Governance and oversight roles need further strengthening

Context and Criteria

Following the recommendations from the prior Gavi audit in Sierra Leone in 2018, governance and oversight structures were established in 2020 by the MoHS and the EPI to oversee and manage the immunisation programme in the country. These oversight structures include the ICC which is chaired by the Minister of Health and Sanitation. The ICC plays a critical role in strengthening the EPI by providing strategic direction, policy guidance, and oversight, as well as ensuring effective stakeholder coordination for immunisation activities. Membership of the ICC comprises heads and senior officials from the MoHS, UN agencies and the EPI. A TCC, chaired by the EPI manager, was also formulated to manage and lead the implementation of the EPI programme.

At subnational level, DHMT, led by District Medical Officers, are responsible for implementing and managing district level public health. Their responsibilities include immunisation programme planning, execution, and regular progress reporting, including escalating challenges to the national EPI team for follow-up and resolution.

Condition

The audit team identified the following opportunities for improvement in the effectiveness of the governance bodies at national and subnational levels:

ICC meeting regularity, attendance, and effectiveness: According to its Terms of Reference, the ICC is required to convene on a quarterly basis. However, since its establishment in 2020, available records indicate that the ICC has convened only five times—excluding the years 2020 and 2021, which were likely impacted by the COVID-19 pandemic. Specifically, the ICC met twice in 2022, twice in 2023, and once in 2024, compared to the expected twelve meetings during the post-pandemic period.

- Five were neither signed nor formally endorsed, and three lacked signed attendance sheets.
- There was no follow up of action points from previous meetings.
- Senior officials from the Gavi alliance partners often delegated meetings to immunisation officers
- Discussions were limited to Gavi funded activities and ensuring cofinancing for vaccines was met. There was no discussion on other resources, including partners or long-term financing for immunisation activities.

Opportunities for improvement of the feedback process between the EPI and subnational DHMT: The audit team observed that districts lacked effective and structured feedback and escalation protocols to alert the EPI about challenges encountered during immunisation programme planning and implementation. Districts often had challenges nonfunctional CCE and vaccine stockouts that were not formally escalated and addressed by the EPI team, or where escalated, no documentation on what and how these issues were resolved. During the audit, we found one location where the cold chain equipment (CCE) was malfunctioning, putting vaccines at risk of exposure to unsuitable conditions. Meanwhile, a nearby location had several unused CCE units, and this issue had not been escalated to the EPI. Although this was addressed during the audit, we also observed sporadic stockouts at service delivery points—lasting over 10 days as noted in Finding 4.3.1—which similarly had not been escalated.

Recommendation 1

To further strengthen the governance and coordination structures, MoHS/EPI should:

- Revise the agenda and minutes templates and update to include key elements like action points, follow-ups from previous meetings and a unique reference to support archiving and traceability.
- Update the ICC ToRs to ensure that at least two alternate meeting are chaired by the Minister annually and include the deputy minister as a co-chair in the Minister's absence to maintain high level oversight.
- Institutionalise discussions on immunisation financial planning at ICC beyond co-financing obligations to promote diversified funding sources.
- Ensure that the notifications for quarterly meetings provide adequate notice to support attendance by leadership of Gavi alliance partners at country level.
- Establish a centralised database for DHMT to share issues with the national level EPI team, with adequate monitoring for issue resolution.

<table>
<tr><td>Root Causes
ICC does not have a standing agenda, agreed template for capturing minutes, timelines and follow up of actions: While there were ad hoc agendas to guide discussions for each ICC meeting, there is no standing agenda to ensure that essential operational elements of the immunisation programme. Also, the template for the agenda and minutes required updates to adequately capture agreed actions, follow-up from previous meetings, references for meeting to support archival.

Scheduling constraints due to Minister of Health availability: Given that the ICC is required to be chaired by the Minister of Health, the convening of meetings may occasionally be affected by limitations in his availability due to other high-level obligations.

Communication of meetings: Meeting notices were not circulated in a timely manner which impacted the attendance of senior officials for the Gavi alliance partners.</td><td colspan="2">Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
• Ineffective ICC oversight may adversely impact the achievement of grant objectives and oversight over programme management.
• Weaknesses observed at subnational levels meant that critical issues—including inadequate programme planning, poor data quality, weak supportive supervision, and ineffective vaccine and stock management—often remained unresolved throughout the audit review period.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.2 Programme management

4.2.1 Weaknesses in strategic and operational planning have impacted programming

Context and Criteria

To improve planning and coordination, Gavi has adopted the NIS framework developed by WHO. The NIS is a streamlined planning tool covering a five-year strategic period and defines a country's direction for immunisation. Specifically, it outlines a long-term immunisation vision (typically over 10 years), measurable objectives to be achieved over Gavi's five-year strategic period and priority strategies, including costed interventions and risk mitigation measures.

MoHS and its stakeholders have launched several initiatives to strengthen strategic planning for the immunisation programme. In September 2024, Sierra Leone's MoHS, working with partners, developed a NIS for 2024-2028. NIS development was guided by WHO's Immunisation Agenda 2030 and covered the key seven strategic priorities of programme management and financing; human resource management; vaccine supply, quality and logistics; service delivery; immunisation coverage and Adverse Events Following Immunisation (AEFI) monitoring; disease surveillance; and demand generation at national, sub-national and service delivery level. In addition, the country developed a monitoring and evaluation framework for the NIS.

The EPI, with support from health development partners, revised the 2002 National Immunisation Policy (NIP) in 2023. This NIP was developed in line with the MoHS NHSSP of 2021-2025, the Public Health Act of 2022 and the revised Sierra Leone National Health Policy of 2021. Furthermore, MoHS carried out a comprehensive EPI review in 2023 which highlighted the lack of micro plans for RI services at operational level as one of the limitations for funds mobilisation and EPI programme management at sub-national level.

Condition

The audit team identified several areas requiring further attention to strengthen the strategic planning process.

Specifically, ***the NIS 2024–2028 remains under development and requires critical inputs prior to endorsement by the MoHS***. As of the time of the audit, the following elements were outstanding:

- Although an M&E framework has been drafted to include strategic and operational activities, some targets for planned activities require further refinement to ensure that progress can be effectively measured.
- At a strategic level, development of an immunisation financing policy including facilitation of immunisation financing dialogue, design of a monitoring framework to enhance the use of information and communication technology (ICT) in data management and reporting.
- At an operational level, some notable examples include supportive supervision, training of data entry personnel, mapping of human resources for health within the EPI, development of a comprehensive EPI training plan, reactivation and strengthening of facility management committees.
- The costing of all components within the strategy remains incomplete.
- Strategic activities and indicators in the NIS need to be clearly linked to the NHSSP 2021-2025 and National Second Year of Life Vaccination Strategic Plan.

The National Second Year of Life Vaccination Strategic Plan has not been signed off or operationalised. In addition, the plan does not have an M&E framework with clear targets and performance indicators.

Weaknesses in operational planning: The audit noted that the EPI did not develop any Annual Operational Plans (AOPs) or Annual EPI Workplans for the period 2019 to 2023. While a workplan was developed for 2024, it primarily reflected a consolidation of Gavi-funded budgets rather than a comprehensive and prioritised schedule of EPI activities and associated resource requirements.

Recommendation 2

To strengthen strategic and operational planning, the MoHS/EPI should:

- Accelerate stakeholder engagement to finalise the NIS including a redefined the timeframe, M&E framework and costing to ensure relevance and feasibility. Finalisation should also include prioritisation to align with the envisaged GaviLeap for the 6.0 period.
- Assign responsibility for routine immunisation management to deputies within the EPI team, with monitoring by EPI manager as this will free up EPI manager time to finalise strategic documents, including aligning EPI and MoHS documents and prioritise RI planning. This will also ensure continuity planning.
- Establish and institutionalise document retention standards for planning, operational and reporting documents to enhance institutional memory, ensure accountability and continuity.

<table>
<tr><td colspan="2">Furthermore, the programme did not develop RI microplans at either national or sub-national levels for the years 2020 to 2024. The absence of these critical planning documents has significantly limited the programme's ability to systematically guide and monitor both its internal operations and those implemented by immunisation partners.</td></tr>
<tr><td>Root Causes
The NIS, including its costing and monitoring & evaluation (M&E) framework, requires further stakeholder engagement before it can be finalised and endorsed by the MoHS.
Competing operational demands—such as outbreak responses (COVID-19, measles), vaccine introductions (HPV, malaria), and multiple Gavi grant applications - Full Portfolio Planning (FPP), TCA, Ebola, Mpox—have diverted attention from strategic planning, progress tracking, and learning. These activities strain limited human and logistical resources, affecting the timely completion of strategic and routine immunisation planning.
Until 2022, the EPI programme was not involved in strategic planning at the MoHS level, resulting in weak alignment between ministry-led and EPI-led strategies.
Document retention within the EPI has been inadequate. Operational templates are often reused and overwritten without archiving, which may explain missing workplans in some years prior to the current EPI manager's tenure.
Microplanning for RI through annual operational plans has been constrained by limited financial resources, affecting key activities such as population mapping, logistics coordination, and stakeholder engagement. The EPI remains heavily dependent on Gavi funding for operations beyond payroll, with financial discussions by governance bodies focused on drawing down Gavi support and meeting co-financing obligations.</td><td>Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
Delays in finalising the NIS and incomplete operational planning have several implications:
Strategic misalignment: Country-level priorities risk being misaligned with GaviLeap's strategic vision for future Gavi funding, potentially undermining strategic planning and related operational planning during the Gavi 6.0 period.
Unclear funding gap: The immunisation funding gap remains undefined, which hampers effective financial planning and may lead to continued, unsustainable reliance on Gavi for EPI activities as funding envelope is limited.
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.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.2.2 Challenges persist in the measles routine immunisation management processes

Context and Criteria

Measles is one of the most contagious human diseases, leading to serious illness, lifelong complications, and death. Despite a reported average coverage of 95% and 81% for Measles-Rubella MR 1 & MR 2 respectively between 2019 and 2024, measles remains a public health concern in Sierra Leone, being highly contagious and a leading cause of preventable deaths in children under five.

WHO's Immunisation Agenda 2030 identifies measles elimination as a key impact indicator. It emphasises the need for strong measles surveillance systems to detect immunity gaps and the importance of achieving equitable 95% coverage with two timely doses of MCV in childhood. The Measles-Rubella Strategic Framework 2021–2030 outlines several evolving challenges related to measles control:

- A shift in measles epidemiology, with a growing number of cases among young infants and older age groups, revealing persistent immunity gaps.
- Increased awareness of healthcare settings as significant contributors to ongoing transmission during outbreaks.
- Greater recognition of immunity gaps among refugees, displaced persons, and cross-border populations, who are often excluded from national immunisation strategies.
- Service disruptions and cancelled Supplementary Immunisation Activities (SIAs) due to the COVID-19 pandemic, resulting in widened immunity gaps.
- Decreasing support for vertical disease-specific programmes and nationwide vaccination campaigns.

WHO provides technical guidance and global standards for VPD surveillance. These include recommended case definitions, data quality indicators, specimen collection procedures, and performance benchmarks. VPD surveillance also forms part of wider infectious and non-infectious public health surveillance – the continuous and systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Surveillance for VPD provides critical, long-term data for timely detection of and response to VPDs to guide optimal use of vaccines and other disease control measures.[5]

Condition

Optimal measles management requires robust RI systems to provide a sustainable long-term strategy for measles control and elimination with campaigns for outbreak response and to address immunity gaps. The audit noted the following challenges:

Immunisation coverage remains low: The WHO recommends 95% MCV2 vaccination coverage to achieve herd immunity for measles, however, while the reported coverage for administration data is at 95% in 2024, this differs from the reported WEUNIC coverage at 76%, with consistent data variations since 2019 as indicated in table below:

Table 7: Measles immunisation coverage 2019 to 2024

		Coverages in %					
Dose	**Data source**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
MCV 1st dose	Admin	93	86	84	101	104	103
	WUENIC	93	87	87	90	90	90
MCV 2nd dose	Admin	72	69	65	82	100	95
	WUENIC	72	67	67	73	73	76

Recommendation 3

To prioritise measles management and support its eventual elimination, the MoHS and the EPI should:

- Develop a national measles elimination strategy and incorporate it into the NIS, enabling targeted interventions to address persistent gaps in routine measles management.
- Review and update RI strategies, ensuring alignment with the Measles-Rubella Strategic Framework 2021–2030, and tailor guidance to the country's specific context.
- Improve qualitative assessments from campaigns to generate actionable lessons learned and integrate these into RI programming for sustained coverage and impact.
- Strengthen supervision tools, including checklists, to better assess and manage measles routine activities at sub-national levels.

[5] Global strategy on comprehensive VPD surveillance

Nationwide campaigns are not effectively closing immunity gaps: Sierra Leone conducted four nationwide measles campaigns—in June 2015, May 2016, June 2019, and July 2024. Although reported coverage for the 2019 and 2024 campaigns was high (99%), this did not translate into significant improvements in MCV coverage according to both administrative and WEUNIC data (see Table below), indicating that high reported coverage may not reflect actual immunity levels. Additionally, an outbreak response campaign in August 2023 achieved only 67% coverage among targeted populations.

Table 8: Measles campaigns in Sierra Leone since 2015

Period	Targeted age group	Nature	Reported admin coverage
Jun-15	9 - 59 months	Nationwide	data not provided
Apr-16	6 months -14 years	Targeted outbreak response	data not provided
May-16	6 months -14 years	Nationwide	data not provided
Jul-18	6 months - 15 years	Targeted outbreak response	data not provided
Jun-19	9 – 59 months	Nationwide	99%
Aug-23	9 – 59 months	Targeted outbreak response	67%
Jul-24	9 – 59 months	Nationwide	99%

Cross-border measles transmission remains a challenge: While measles campaigns have helped reach unimmunised and under-vaccinated populations, Sierra Leone remains vulnerable to cross-border transmission—particularly along the Guinea border. Language barriers and differences in immunisation programming complicate coordination and response efforts.

AEFI concerns are a barrier to vaccination uptake: The 2024 MR campaign reported 27 Adverse Events Following Immunisation (AEFI), including 16 serious cases. Similarly, the 2023 EPI review documented 2,808 AEFI cases, 188 of which were serious. However, investigations were not conducted due to insufficient case details from PHUs and districts. These gaps in follow-up may erode public trust. Post-campaign feedback revealed that:

- 15% of respondents avoided vaccination due to fear of side effects,
- 12% lacked confidence in vaccines,
- 11% feared injections.

Disease surveillance weaknesses hinder timely response: Despite disposing of a nationwide integrated VPD surveillance and response system, several challenges persist:

- Incomplete case documentation: PHUs often failed to complete required forms for investigating and reporting suspected measles cases.
- Delays in sample transport and lab reporting: Samples from sub-national levels were not promptly transported to reference laboratories, and laboratory results were frequently delayed or not shared with sub-national teams.
- Poor coordination and feedback: Downstream of the sub-national teams, PHUs reported never receiving lab results after submitting samples of suspected measles infections.

Recommendation 4

To maintain consistent and effective VPD surveillance during both routine immunisation and campaigns, the MoHS should:

- Ensure VPD surveillance is suitably budgeted and funded, including reporting tools and transportation of samples to labs for testing.
- Reaffirm the significant role of VPD surveillance in effectively mitigating disease outbreaks.
- Ensure VPD reporting tools are available, understood and utilised by PHUs.
- Set service delivery commitments for the transportation and lab analysis of samples and dissemination of lab results, then identify and root out bottlenecks.
- Establish and enforce lab result reporting modalities from labs through to PHUs.

<table>
<tr><td>Root Causes
Measles routine immunisation planning has been hindered by the absence of microplanning since 2019 (see Finding 4.2.1). As a result, the EPI programme has struggled to effectively address known challenges in routine measles programming. Also important to note that Ebola disrupted programming prior to 2017.
Campaigns are underfunded and dependent on Gavi support. Key activities such as health worker training, supervision and monitoring, distribution of pocket guides, fuel and transport, and community awareness received average funding of 50%, 69%, 25%, 38%, and 50% respectively.
Classroom-based training has not consistently led to improved performance on the job due to delayed or absent supportive supervision. For instance, despite AEFI training conducted at sub-national level in March 2023, challenges persist in accurate case identification and reporting.
MoHS resource constraints has meant that VPD surveillance is dependent on donor financial support, leading to variability in its frequency and scope. This is particularly acute during immunisation campaigns, and it has affected the availability and analysis of disease outbreak data, thereby hindering timely and appropriate disease response.</td><td colspan="2">Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
Heavy reliance on costly campaigns in a resource-constrained environment: Campaigns are generally more expensive than RI, with a global average cost of USD 0.86 per vaccine administered, moreover, the July 2024 MR campaign in Sierra Leone cost USD 1.70 per vaccine administered—almost double the global average.
Campaigns disrupt routine immunisation services: Preparatory activities for campaigns—such as Training of Trainers (ToTs), microplanning, readiness assessments, and coordination meetings—can span 3 to 6 months. These tasks are typically carried out by the same national and sub-national personnel responsible for RI monitoring. During the campaign period, vaccinators are diverted from their regular duties at fixed sites, further impacting RI delivery.
Risk of not achieving herd immunity: The country may struggle to reach the recommended 95% coverage for the second dose of measles-rubella (MR2), which is essential for herd immunity. This shortfall could lead to increased measles-related mortality. Notably, Sierra Leone ranks 41st globally in measles deaths.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.2.3 Supportive supervision arrangements need enhancement

Context and Criteria

According to the WHO, supportive supervision is crucial for monitoring performance towards programme 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.

Section 6.4 of the Primary Health Care Handbook stipulates that "supervision is a key aspect of all community-based programmes. Strong, high-quality supervision from central to district level and from district level to PHUs and community level may improve programme outcomes. However, supervision may have significant resource demands, both human and financial. To make efficient use of limited resources and to integrate management and oversight of community-based programmes, programmes should conduct joint supportive supervision at all levels whenever possible."

An integrated supportive supervision visit is a primary function of every DHMT. It is the mutual interaction between supervisors and supervisees. The objective is to identify the health issues, offer appropriate recommendations and take actions to resolve the issues identified. Integrated supportive supervision is not an inspection or policing process, but a dialogue-oriented process which gives room for interaction among junior and senior health staff. At the end of the supervisory visit, the supervisor(s) should give a summary report to the staff.

Condition

Supportive supervision activities were clearly being implemented across all levels. However, the audit team observed opportunities to enhance the effectiveness of these activities, particularly in improving the quality and follow-up of supervision recommendations as follows:

Supervision planning: While 3 out of 6 DHOs and 16 out of 19 PHUs confirmed receiving supervision visits, they noted that these visits were largely informal, often conducted without a pre-agreed agenda or structured plan.

Gaps in the checklist: The integrated support supervision checklist provides a useful framework; however, there is an opportunity to strengthen it further by incorporating key EPI parameters such as checking issues with data collection, collation and reporting, vaccine stock availability reviews, review of cold chain equipment availability and maintenance, and discussion of root causes of the issues noted.

Quality of feedback provided after supervision visits: Feedback was mostly documented in exercise books when data collection tools, such as the mobile device app KoboToolbox, were not being used. As a result, supervision feedback was freeform and variable in its pertinence and weighting, action points were often unstructured and unclear, while there was no evidence of follow up on prior action points. At the immunisation service level, PHU visitor registers and exercise books were conducive to unstructured, superfluous feedback and scant follow-up.

Recommendation 5

To improve the supportive supervision, the MoHS/EPI should:

- Develop and formalise clear terms of reference for chiefdom supervisors.
- Work with DHMT to develop comprehensive supportive supervision plans, guidelines, and terms of reference. This plan should identify the roles and responsibilities of each player including partners and agencies to facilitate coordinated visits and optimise existing resources.
- Install KoboToolbox, or a similar configurable data collection app, on the mobile devices of chiefdom supervisors to strive for structured, consistent, real time supervision reporting, and thereafter follow up on improvement suggestions, and prioritise, plan and prepare future supportive supervisions.

Root Causes

- The chiefdom supervisor is a functional role which is not clearly defined in the primary health care handbook. Furthermore, the role of supervisor is not compensated within the payroll leading to inconsistent performance and accountability across PHUs.
- Insufficient funding for supervision - both tools and supervisory visits are donor funded with some activities and printing deprioritised when funding was constrained.
- There was no supervision planning to demonstrate prioritisation of high priority locations or follow up on high-risk issues identified.

Management comments

See detailed management responses - Annex 11

• Missed opportunities to incorporate technology to structure and consistently document supportive supervision, monitor effective implementation, measure its impact, and use the data to prioritise and rationalise future supervisions.		
Risk / Impact / Implications • Delayed resolution of known issues, which could impact the effectiveness of the immunisation programme.	Responsibility See detailed management responses - Annex 11	Deadline / Timetable See detailed management responses - Annex 11

4.2.4 Opportunities to improve the designed approach to civil society organisations (CSOs) engagement

Context and Criteria

In December 2021, the Gavi Board approved a new Civil Society and Community Engagement (CSCE) approach. A key feature of this approach is the requirement for countries to allocate at least 10% of combined HSS, Equity Accelerator Fund (EAF), and Targeted Country Assistance (TCA) ceilings to CSO-led implementation when submitting new funding requests. The CSCE approach marks a significant shift toward equity-focused immunisation delivery, with the goal of fostering stronger strategic partnerships between governments and CSOs to reach underserved populations. The rationale behind this approach includes:

- Reaching the unreached: CSOs are instrumental in extending immunisation services to remote, minority, and marginalised communities—often the last 15–20% missed by government systems.
- Inclusive decision-making: CSO involvement at all levels of policy and programme design promotes accountability, inclusivity, and responsiveness to community needs.
- Combating vaccine hesitancy: with their deep community roots, CSOs are well-positioned to understand and address localised vaccine hesitancy, including gender-related barriers, and to build trust in immunisation services.
- Community ownership: many CSO staff and volunteers come from the communities they serve, ensuring that solutions are locally informed, community-driven, and sustainable.

Condition

In Q4 2024, Gavi engaged a fund manager to support and coordinate the work of CSO in Sierra Leone. The CSO were identified and mapped by the EPI. In addition, the EPI, working with partners, identified activities to be undertaken by the CSOs. Although the audit team noted that 10% of the combined HSS (6%) and Targeted Country Assistance (42%) ceilings was allocated to CSO-led implementation, the following weaknesses in the design of the CSO engagement were identified:

Oversight over CSO activities: There is no continuous engagement and oversight over CSO activities to ensure alignment with immunisation goals, particularly in closing zero dose gaps. Gavi funded CSOs are represented in TCC and ICC meetings. Consequently, CSO activities, achievements and challenges are not discussed in these fora. In addition, the EPI does not receive reports on CSO activities from either the CSOs or the recently appointed fund manager.

Absence of monitoring and evaluation mechanisms: There is currently no framework in place to monitor or evaluate CSO contributions toward immunisation goals, such as increasing coverage and reducing the number of zero-dose or under-immunised children and differentiation with existing health systems volunteers.

Recommendation 6

To enhance the effectiveness of CSO intervention, the MoHS/EPI should:

- Update the ICC and TCC ToRs to include CSOs at the TCC meetings and a representative at the ICC.
- Leverage on-going CSO activities to establish a community of practice that addresses the challenges in the specific communities the CSOs are working.
- Within the M&E framework for the NIS, define activities, targets to track progress through CSO activities and ensure accountability.
- Document and share lessons learned with all stakeholders.

Root Causes

- The ToRs for the governance mechanisms at national and district levels have not yet been updated to include CSOs.
- While the EPI was involved in discussions to determine CSO engagement, these discussions have not evolved to include oversight of CSO activities, alignment with EPI strategy and objectives. This is because the Community for practice for demand for the CSO work has not been developed.
- Direct CSO engagement through the Gavi CSO strategy is a new practice and the design and implementation at country level is evolving.

Management comments

See detailed management responses - Annex 11

Risk / Impact / Implications

- This limits the ability to measure impact, learn from best practices, strengthen existing health systems for sustainability when funding for CSOs declines and ensure accountability from the CSO intervention.

Responsibility

See detailed management responses - Annex 11

Deadline / Timetable

See detailed management responses - Annex 11

4.2.5 Challenges in the visibility and performance monitoring of TA should be addressed

Context and Criteria

The PEF TCA Guidance defines the roles and responsibilities of key stakeholders involved in the planning, monitoring, and reporting of Technical Assistance (TA). These responsibilities are crucial for ensuring the effectiveness and impact of TA. Among the primary duties assigned to MoHS are leading the development of the OneTA plan, coordinating the identification of TA needs, assigning responsibilities to core and expanded partners, and organising quarterly meetings to track TA implementation progress.

To promote country ownership, the EPI is expected to be actively and consistently engaged throughout the TA process, particularly in planning and performance monitoring. The guidance also emphasises the importance of mutual accountability within the PEF model. This is supported through established programmatic and financial reporting requirements for partners, as well as routine in-country reviews of TA performance, jointly conducted by the EPI, implementing partners, and other stakeholders.

Partner reports must be verified for accuracy and consistency. The EPI is responsible for formally confirming data alignment across various sources, such as milestone portals, Joint Appraisal reports, and supervision documents. Additionally, the results of TA should be validated through evidence-based assessments that demonstrate capacity improvements and overall programme performance enhancements in areas such as coverage, equity, supply chain, data quality, and financial management.

Condition

The audit team noted the following weaknesses:

TA activities are delayed: The audit noted that between 2019 and 2024, only 30% of planned TA activities have been completed, 44% are in progress, and 6% have faced major delays, as shown in the table below. While the COVID-19 pandemic delayed some activities especially for the alliance partners, some critical activities, remain pending even after reprioritisation done during the annual reviews for 2023 and 2024.

Table 9: TA completion status by partner as of 31 December 2024:

Partner	Completed	On Track	Minor delays	Major Delays	No status	Reprogrammed
Aspen Management Partners	6	12	1	0	3	0
Catholic Relief Services	22	13	1	0	0	1
Centre for Disease Control	11	12	5	2	0	0
CHAI	36	21	2	0	5	0
UNICEF	55	71	45	28	9	1
University of Oslo	0	2	1	0	4	0
WHO	34	110	17	2	17	1
Total	**164**	**241**	**72**	**32**	**38**	**3**
% of overall total	**30%**	**44%**	**13%**	**6%**	**7%**	**1%**

Lack of clear and explicit modality for skills transfer: Of the 34 funded positions outlined in the TCA plan, 32 are classified as 'mixed – primarily focused on skills transfer'. However, no capacity assessments have been conducted to identify existing skills gaps among EPI staff. Additionally, there is no capacity building plan or transition strategy in place to guide the handover process for these skills-transfer roles, which is essential for ensuring effective knowledge transfer to the EPI.

Recommendation 7

To enhance oversight over PEF/TCA activities, the MoHS/EPI should:

- Leverage existing governance mechanisms such as the TCC and the ICC for partners to present, discuss and review progress on partner activities. These reviews should be formally captured in the minutes of TCC and ICC meetings.
- Sign off on all PEF TCA milestones prior to submission through the Gavi portal.
- Develop a comprehensive, timebound plan to transfer TA skills, roles and responsibilities to the EPI which includes:
  - An EPI capacity assessment to identify resource and proficiency gaps.
  - A structured capacity building plan, including on-the-job mentorship.
  - A timetable of the handover of various skills and responsibilities from TA to EPI.

<table>
<tr><td>Root Causes
The role of the EPI in monitoring the results and performance of implementing partners remains unclear, even within existing governance structures. Currently, partners report their progress directly on the Gavi portal, with no clear indication that the EPI reviews or validates performance against agreed milestones prior to submission. Although the EPI is engaged during the TA planning phase, the Gavi PEF TCA reporting framework only allows TCA recipients to submit reports, based on the assumption that activities have been validated by the MoHS—an assumption that is not consistently upheld during implementation.
Weaknesses in setting and measuring TA contribution to the EPI: Sierra Leone currently relies on the generic Gavi portal to report on implementation progress, but this system has several limitations, particularly concerning the quality and relevance of milestone data. The current approach to measuring results tends to focus either on activities, short-term outputs, and planning processes, or on end outcomes such as coverage, with limited emphasis on intermediate results and the actual contribution of TA to the EPI.</td><td colspan="2">Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
Without strong accountability mechanisms, there is a risk that TA activities may not achieve their intended outcomes. Investments made through PEF TCA grants may lack sustained impact, and in the absence of active engagement from the EPI, partner-led TCA initiatives may be implemented in ways that do not optimally strengthen EPI capacities. This could hinder progress toward Gavi's goal of enabling country systems to operate independently without the need for continued skills transfer TA.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.3 Vaccine Supply Chain Management

4.3.1 The forecasting and supply planning processes need improvement

Context and Criteria

In Sierra Leone, the forecasting and quantification of vaccines and related supplies is usually undertaken in September each year by a team comprising the EPI Pharmacist-in-Charge and UNICEF Supply Division. Stakeholders collaboratively utilise the UNICEF/WHO forecasting template which defines steps for completion and allows input of country-specific data including target population, estimated coverage, buffer quantity (25% of the forecasted quantity per antigen), WHO established wastage rates, national level Stock on Hand (SoH) at the time of generating the forecast, and country specific assumptions. Thereafter, the forecast output is reviewed and approved by the EPI Programme Manager. Following that, the output shared with UNICEF Supply Division informs a suitable shipment plan for vaccines and dry goods for the year to come.

The Gavi immunisation supply chain strategy for 2021-2025 highlights the need for countries to strengthen data-driven forecasting and agile supply planning, delineating opportunities which are aligned with both Gavi's investment priorities and its immunisation supply chain strategy.

Condition

The audit team performed various tests to review the adequacy of the vaccine forecasting process and assess the sufficiency of vaccine stock levels at national level and a sample of sub-national levels. The following challenges were identified:

Forecasting remains partner led which may hinder sustainability of the process: Although the forecasting process is described as an interactive, stakeholder-driven exercise, our review revealed limited involvement from the EPI in the UNICEF-led vaccine forecasting and supply planning process. This gap was particularly evident in the absence of a 2024 annual forecast, which occurred due to the departure of the designated UNICEF staff member, with no backup personnel available at either UNICEF or the EPI to complete the process.

There were significant variances between the quantity of doses forecasted and doses received leading to low stock levels and stock outs at national and sub-national level: During the audit review period, the audit team examined forecast outputs for various vaccines. Notably, for Pentavalent, significant percentage variances were observed between forecasted and received quantities. In addition, given the historical variances between forecast quantities and actual volumes shipped in-country, retroactive reviews had not been conducted to check or recalibrate past assumptions and drive accurate future demand forecasting. See table below:

Table 10: Variances between forecasted and received quantities of Pentavalent

Year	Pentavalent vaccine		
	Forecasted Qty (Doses)	Received Qty (Doses)	Variance
2019	1,057,042	380,000	64%
2020	849,869	689,900	19%
2021	620,500	445,500	28%
2022	699,500	526,000	25%
2023	1,017,113	802,500	21%
2024	873,600	1,329,150	(52%)

Recommendation 8

To ensure availability of adequate vaccine supplies, the MoHS/EPI management should:

- Collaborate with UNICEF to designate EPI focal persons, assess training needs, and implement a capacity development plan focused on forecasting and supply planning. This should include a clear roadmap for transitioning forecasting and supply planning responsibilities to the EPI team.
- Establish SOPs and guidelines to support a structured and transparent forecasting process at the central level.
- Conduct quarterly reviews of vaccine stock levels and escalate any supply issues to the TCC and ICC governance platforms to enable timely decision-making and corrective action. These revies will also inform the annual supply planning process.
- Engage with the Ministry of Finance to facilitate the timely release of funds for co-financed vaccines, ensuring uninterrupted procurement and supply.

Low stock and stock outs at national and sub-national level: On 1 June 2025, stock levels for Pentavalent, IPV and Bivalent oral polio vaccine (bOPV) at CVS were below the minimum stock levels, and no new deliveries were in pipeline through December 2025, per the below table:

Table 11: Antigen stock levels on 1 June 2025 at CVS

Antigen	Average monthly consumption (number of doses)	Stock on hand 1 June 2025 (number of doses)	Months of stock
Pentavalent	62,250	31,660	0.5
IPV	38,750	57,650	1.5
bOPV	63,750	960	0.0
Malaria	245,431	626,300	2.6

Furthermore, in all six district stores visited by the audit team, less than 1 month of bOPV stock was available, as shown in the below table:

Table 12: Antigen stock levels on 1 June 2025 at all six districts visited by the audit team

Antigen	Bombali			Bonthe			Kenema		
	AMC	SoH	MoS	AMC	SoH	MoS	AMC	SoH	MoS
Pentavalent	3,583	11,160	3.1	1,292	2,840	2.2	3,667	12,830	3.5
IPV	2,233	13,380	6.0	1,583	9,215	5.8	2,583	12,360	4.8
bOPV	27,583	0	0.0	13,250	0	0.0	37,667	15,305	0.4
Antigen	**Kono**			**Pujehun**			**WAU**		
	AMC	SoH	MoS	AMC	SoH	MoS	AMC	SoH	MoS
Pentavalent	3,854	12,360	3.2	2,750	9,560	3.5	5,625	1,420	0.3
IPV	3,917	7,075	1.8	1,250	11,125	8.9	1,658	16,860	10.2
bOPV	26,875	8,320	0.3	24,833	1,740	0.1	74,567	21,300	0.3

Vaccine stock outs at sub-national levels: Over the audit review period, stock outs were experienced at 4 out of 6 DVS and 16 out of 19 PHUs for at least one of the sampled vaccines, like Pentavalent, Measles Rubella and bOPV. 10PHUs visited were stocked out of Pentavalent for more than 10 days. See Annex 6a for details.

<table>
<tr><td>Root Causes
• Vaccine supply forecasting and planning were undertaken by UNICEF, which may be an indicator of a capacity gap at EPI. However, there was no training plan to transition these competencies to the EPI, further limiting EPI engagement and/or monitoring of the overall process.
• There are no forecasting and quantification Standard Operating Policies/procedures (SOPs) to guide the forecasting process and provide reference for the EPI team.
• Recurring delays in government's disbursement of co-financing funds resulted in delayed delivery of co-financed vaccines which led to stockouts at service delivery points and low stock at CVS.</td><td colspan="2">Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
• Persistent vaccine stock-outs disrupt service delivery to target populations, undermining the country's progress toward achieving immunisation goals.
• Limited collaboration between the EPI team and UNICEF results in missed learning opportunities, which impedes the development of country ownership—a key priority under Gavi 6.0.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.3.2 Inadequate inventory management impacted accountability and traceability of vaccines

Context and Criteria

Section 8.0 of Sierra Leone Effective Vaccine Management Standard Operating Procedures 2018 (SOP) states that "maintaining complete and accurate hardcopy or electronic inventory records of vaccines, diluents and safe injection materials is critical in preventing over or under stocking of supplies and disruption to the immunisation programme. The SOP requires tools to be utilised for inventory management at all levels and highlighted the Vaccine and safe injection materials requisition book (DVS and PHUs), Vaccines and safe injection materials stock ledger (CVS, DVS and PHUs) as well as the Stock Management Tool (SMT) at CVS and DVS. Section 8.2 of the Vaccine Management SOP also defines the need to conduct routine physical stock counts at all vaccine stores, ensuring that reconciliations between stock balances reported in the vaccine ledgers or Stock Management Tool match the available quantities in the stores. Physical stock takes should be conducted quarterly at CVS and monthly at the sub-national level stores.

Gavi's immunisation supply chain strategy (2021-2025) emphasises the value of digitising information, to include how an electronic logistics management information system can significantly enhance the visibility and use of stock management data for decision making. From 2017 to 2020, UNICEF supported the use of a "stock management tool" (SMT), which is Excel based, for recording and reporting stock receipts and distributions between vaccine stores. In 2021, UNICEF Sierra Leone office, in collaboration with the MoHS and the EPI, piloted its online version called the "electronic-stock management tool" (eSMT). eSMT is currently deployed and utilised at CVS and all sixteen of the country's DVS.

Condition

Note: *Systems weaknesses with eSMT are covered under finding 4.4.1 of this report.*

Inconsistencies in eSMT data have compromised its accuracy, completeness, and reliability: There were significant discrepancies between computed closing balances and eSMT closing balances were identified by the audit team as shown in the table below:

Table 13: Discrepancies between computed closing balances and eSMT

Vaccines	Doses per Vial	CLOSING BALANCE as of 31st Dec 2023	OPENING BALANCE as of 1st Jan 2024	TOTAL RECEIPTS per eSMT	TOTAL ISSUES per eSMT	ADJUSTMENTS (damaged, expired, etc)	COMPUTED BALANCE (A)	eSMT BALANCE (B)	Discrepancy (A - B)
Pentavalent vaccine	4	323,360	323,360	1,493,150	1,253,640	0	562,870	31,660	531,210
MR vaccine	10	113,160	113,160	2,972,000	1,800,269	0	1,284,891	620,340	664,551
HPV vaccine	4	109,567	109,567	1,544,041	169,618	970	1,483,020	1,223,450	259,570
Malaria vaccine	2	550,000	550,000	986,600	602,600	0	934,000	718,500	215,500

The audit team undertook a physical stock count at CVS on 26 May 2025 and noted numerous unexplained discrepancies between the stock on and eSMT records (see Annex 6b for details).Furthermore, some batches of MR and HPV vaccine were physically on hand at CVS but not in eSMT as shown in the following table:

Table 14: Discrepancies between physical stock counts and eSMT quantities

Name of Vaccine	Doses per vial	Batch No.	Expiry Date	Quantity counted (A) (Doses)	Location	Quantity recorded in eSMT (B) (Doses)	Discrepancy (A - B)
MR vaccine	10	0124W051	Dec-26	41,210	WICR2	0	41,210
	10	0123W052	Dec-26	2,290	WICR2	0	2,290
HPV vaccine	4	G0049A	Jul-25	630	WICR1	0	630

Recommendation 9

To strengthen vaccine stock management and accountability, the EPI, in collaboration with UNICEF, should:

- Include on-the-job mentoring within support supervision to improve practical performance and ensure consistent application of supply chain procedures.
- Review, update, and distribute Effective Vaccine Management (EVM) Standard Operating Procedures (SOPs) across all levels of the supply chain to promote uniform practices.
- Provide standardised stock registers and ensure staff consistently and accurately record vaccine expiries and wastage incidents to improve traceability and accountability.

Inadequate and inconsistent manual recordkeeping: At sub-national levels, manual records—including vaccine stock ledgers and requisition forms—were either missing or poorly maintained in most stores visited during the audit. This hindered the ability to reconcile vaccine stock accurately for the review period.

Unaccounted vaccine doses at DVS and PHU stores: Significant quantities of vaccines could not be traced for example 12,000 doses of MR at the Western Area Urban DVS and 615 doses of HPV at Ola During Children's Hospital (2022–2024) The audit team could not match distributed batches with receipts at 16 out of 19 PHUs due to missing records and inadequate ledger entries.

Inconsistent physical stock verification: Although most stores reported conducting monthly physical stock counts, documentation was lacking. Adjustments to stock records were made without explanation, and none of the six DVS or 19 PHUs visited had retained formal evidence of previous verification exercises.

Discrepancies between physical counts and recorded balances: During the audit, physical counts of selected vaccines were compared with inventory records. Discrepancies were found in 5 out of 6 DVS, 11 out of 19 PHUs. (Refer to Annex 7 and Annex 8 for details.)

Poor accountability for expired vaccines: At the Central Vaccine Store (CVS), expired vaccine doses were found without supporting documentation or registers. This lack of recordkeeping undermines accountability and traceability. Details of expired quantities are provided in the table below.

Table 15: Expired antigens identified during the physical stock counts at CVS

Name of vaccine	Batch Details	Expired Quantity (doses)
MR	420603023A	840
J&J	421402822	36,050
PCV	FW8787	816
HPV	G0021A	970
Pentavalent	E5V104046	8,025
IPV	IPV23732	5,400
IPV	IPV23733	300

In addition, 3 out 6 DVS and 1 PHU visited by the audit team reported to have experienced vaccine expires during the audit review period, however none recorded vaccine expiry details in their stock registers. The absence of adequate documentation and unreliability of the eSMT system made it challenging to accurately quantify the true extent of expiries and closed-vial wastage across all levels of vaccine storage.

Root Causes

- Data integrity issues during system migration: The 2021 transition from the Stock Management Tool (SMT) to the electronic Stock Management Tool (eSMT) resulted in data loss, compromising the accuracy of historical stock transaction records. The eSMT currently lacks robust quality assurance mechanisms to ensure data completeness and accuracy, undermining its reliability. No parallel manual records were maintained to support the migration process or ensure accountability during the system's initial rollout. Despite these challenges, eSMT was deployed across districts.
- Limited impact of classroom-based training: Training sessions have not translated into measurable improvements in practical, on-the-job performance.

Management comment

See detailed management responses - Annex 11

<table>
<tr><td colspan="2">

- Inconsistent support supervision: Supervision of vaccine supply chain management is irregular. Feedback provided is often vague and lacks actionable detail, limiting its usefulness. Follow-up on previously agreed actions is either absent or ineffective.
- Operational inconsistencies at sub-national levels: Standard Operating Procedures (SOPs) are either unavailable or not used consistently, even where they exist, leading to variability in practices.
- Gaps in vaccine accountability: There are no standardised registers for recording expired vaccine doses, resulting in weak traceability and accountability.

</td><td></td></tr>
<tr><td>Risk / Impact / Implications

- Inaccurate stock data impedes effective decision-making such as vaccine forecasting and reordering stock.
- Reduced assurance for vaccine stock accountability and visibility.

</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.3.3 Gaps in storage capacity, coupled with weaknesses in cold chain operations and equipment management

Context and Criteria

Vaccines are thermolabile biological products that require strict and appropriate storage conditions to maintain their efficacy. Section 5.3.1 of the EVM SOP underscores the importance of proper vaccine storage, including systematic tracking by batch number and arrangement according to the Earliest Expiry First Out (EEFO) principle to minimise wastage. Additionally, vaccine-related supplies (dry goods) must be stored in appropriate conditions as per manufacturer guidelines to preserve their quality and usability.

Section 5.6.2 of the EVM SOP outlines the requirements for monitoring cold chain equipment temperatures. This includes manually recording temperatures twice daily and comparing these records monthly with data from electronic data loggers. Any discrepancies must be justified, with corrective actions documented. These monthly reviews, along with the temperature monitoring forms, must be signed, dated, and archived for future reference.

Gavi's Immunisation Supply Chain (ISC) Strategy 2021–2025 identifies the maintenance of adequate cold chain capacity and infrastructure as a priority investment area. This includes the development of maintenance plans and the establishment of policies and procedures for regular preventive maintenance to reduce equipment failure and extend its lifespan. Key activities include temperature calibration, routine part replacement, lubrication, and maintaining cleanliness of both equipment and its surroundings. Furthermore, contingency plans, reporting mechanisms, and protocols for decommissioning and disposal must be in place to effectively manage cold chain equipment failures.

Condition

Cold chain storage capacity at CVS is insufficient: Although the 2022 cold chain capacity assessment indicated adequate space, the audit team found all four functional Walk-in Cold Rooms (WICRs) fully packed with vaccines. This overcrowding limited the ability to conduct proper inspections, physical stock counts, and stock management activities as outlined in the SOPs.

Several cold chain equipment units were non-functional at both national and sub-national levels: At CVS, one WICR (4,920L capacity) and one Walk-in Freezer Room (WIFR, 3,765L capacity) were out of service, further exacerbating storage constraints. Additionally, non-functional cold chain equipment was identified in four of the six DV) and three of the 19 PHUs visited.

Temperature monitoring practices showed notable deficiencies: During facility visits, electronic data logger reports were compared with manual temperature records for the same periods. Frequent discrepancies—sometimes as large as 8°C—were observed in five of the 19 PHUs, and staff were unable to explain the differences. Moreover, email alerts for prolonged high temperatures in WICRs were not received by designated personnel at CVS.

Lack of cold chain maintenance plans and service logs: CVS lacked both preventive and corrective maintenance plans. Although EPI indicated that regular maintenance is carried out by a UNICEF-contracted agent, there were no maintenance checklists or service logs available to verify this claim. Also, the audit team observed that two cold chain equipment were nonfunctional during the fieldwork.

Similarly, no such preventative or corrective plans or records were found in 3 out of 6 DVS and 9 out of 19 PHUs visited, making it difficult to confirm the nature and frequency of maintenance activities. Additionally, the audit team observed that temperature recalibration of the WICRs and WIFRs at CVS had not been conducted during the entire audit review period, despite best practice recommending recalibration every 2–3 years.

Recommendation 10

To strengthen its cold chain management, the MoHS/EPI should:

- Review the new construction at CVS to optimise cold and dry goods storage and incorporate connections to the established solar panels to optimise the Gavi support provided. [This recommendation was discussed with the EPI, UNICEF during the audit team planning mission for immediate corrective action.]
- Regularly extract and review data reports from temperature monitoring devices to undertake suitable remedial action and maintenance.
- Clarify roles and responsibilities for maintenance activities and collaborate with UNICEF to obtain all maintenance and warranty information from the third-party provider and assume responsibility for all CCE that is out of warranty.
- Develop and distribute cold chain management SOPs to guide cold chain management and maintenance processes.

<table>
<tr><td colspan="2">Storage challenges: Dry goods were found scattered across storage rooms at CVS, and some items—such as syringes and safety boxes—were stored in the neighbouring UNICEF warehouse. In four DVS and 15 PHUs visited by the audit team, dry goods storage practices did not comply with the EVM SOPs. Additionally, none of the sub-national vaccine stores had designated areas for storing damaged, quarantined, or expired supplies, affecting proper segregation and accountability.

While the construction of the new dry goods store at CVS may help address existing storage challenges, the audit identified planning gaps that could limit optimal use of space and available resources. The construction has focused exclusively on dry goods storage, overlooking the opportunity to redesign the layout of the scattered cold rooms and the EPI office space. Furthermore, the solar panels had been installed and wiring connection incorporated in the scattered cold chain rooms. The redesign is particularly important given the strategic location of the new facility, which offers improved access for cold chain transportation trucks. This issue was discussed with EPI management, UNICEF, and Gavi during the audit planning phase, and the EPI team committed to taking immediate corrective action. The matter has been documented for follow-up to ensure it is addressed.</td><td></td></tr>
<tr><td>Root Causes
Although cold and dry goods storage capacity challenges are well known and documented, planning for the new construction at CVS was suboptimal.
Temperature monitoring data was not extracted at any level to inform preventive or corrective maintenance decisions.
There is also a lack of clarity around who is responsible for scheduling and budgeting preventive and corrective maintenance of cold chain equipment once warranties expire. The EPI team was unaware of warranty details and maintenance procedures, as this information is held by a third-party contractor engaged through UNICEF, with limited information sharing. This lack of transparency has contributed to delays in equipment repair and maintenance.
Additionally, SOPs and job aids for vaccine and dry goods storage are either unavailable or not routinely used by the personnel responsible for vaccine stock management.</td><td>Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
Cold chain storage constraints have compromised easy access of vaccines which are scattered across various small buildings and annexures. This has impacted the ability to conduct regular stock takes, ensure Early Expiry First Out (EEFO) distribution of vaccine batches, and ensure accountability for vaccines at CVS.
The lack of preventive maintenance plans increases the likelihood of cold chain equipment failures that expose vaccines to a greater risk of expiry, potentially reduce equipment’s useful life, and unduly increase replacement costs.
Inability to timely relay cold room temperature alarms increases the likelihood of vaccines potency being compromised by undetected extended excessive heat exposure.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.3.4 Delays in implementation of EVM assessment recommendations

Context and Criteria

Effective Vaccine Management Assessments (EVMA) are independent assessments aimed at improving national vaccine supply chain management processes. The recommendations from the EVMA are included an immunisation supply chain Continuous Improvement Plan (CIP) to enable countries to plan for future supply chain improvements and investments. A good EVMA score for Gavi supported countries is 80%.

Condition

Sierra Leone has conducted three EVMA to date. The first two assessments, carried out in 2013 and 2016, utilised the EVM 1.0 tool, which evaluated nine vaccine management criteria (E1 to E9). In 2022, the country adopted the updated EVM 2.0 tool—launched in 2019—which expanded the evaluation to 13 criteria (E1 to M4). Despite these efforts, the overall scores have remained low and have stagnated: 66% in 2013, 65% in 2016, and 64% in 2022. The table below presents the performance across all three assessments by criterion, highlighting areas of progress as well as regression.

Table 16: Performance evolution across the three nationwide EVMA

Evaluation Criteria		Nationwide EVMA results in %		
		2013	2016	2022
Vaccine arrivals	**E1**	71	42	83
Temperature management	**E2**	62	58	71
Storage and transportation capacity	**E3**	69	76	60
Facility infrastructure and equipment	**E4**	76	77	66
Maintenance and repair	**E5**	62	65	55
Stock management	**E6**	67	62	73
Distribution of vaccines and dry goods	**E7**	65	66	58
Vaccine management	**E8**	66	72	78
Waste management	**E9**	69	58	75
Annual needs forecasting	**M1**	NA	NA	66
Annual work planning	**M2**	NA	NA	50
Supportive supervision	**M3**	NA	NA	73
ISC performance monitoring	**M4**	NA	NA	55
Overall score (%)		**66**	**65**	**64**

Recommendation 11

The MoHS/EPI should:

- Develop a tracker/dashboard of the CIP implementation status that takes account of and regularly discuss progress with whichever is the more appropriate of the ICC or TWG.
- Review the current implementation status of its CIP, assess, and prioritise action, develop a comprehensive implementation budget and present this to the ICC.

Root Causes

- While a CIP was developed, there is insufficient oversight over its implementation, as progress is not systematically monitored through existing governance structures, ICC, and TCC.
- Funding constraints have hindered the execution of several components of the CIP. Of the 92 recommendations from the 2022 EVMA, only six have been costed, and even among these, budget allocations were inadequate due to the absence of additional funding beyond Gavi's support.

Management comments

See detailed management responses - Annex 11

Risk / Impact / Implications

The delay in following through and implementing past EVM recommendations has been substantiated through the weaknesses and risks identified earlier in this section of the audit report.

Responsibility

See detailed management responses - Annex 11

Deadline / Timetable

See detailed management responses - Annex 11

4.4 Supply Chain and Data Management Systems

4.4.1 Weaknesses in design and implementation of eSMT

Context and Criteria

The Gavi Targeted Support Standards (TSS)[6] provide a framework for designing and evaluating effective immunisation supply chain systems. These standards set out essential requirements such as real-time visibility of vaccine stock levels, accurate and reliable data, strong stock management and reporting features, and timely alerts for low or expiring stock. They also emphasise the need for interoperability with other health systems, offline functionality for use in low-connectivity areas, robust data security, and clear user access controls. Additionally, the TSS call for integration for remote temperature management, and strong local ownership through technical training and backup procedures to ensure system sustainability.

The electronic stock management tool (eSMT) was launched nationwide in early 2022 to CVS and all 16 DVS following a brief pilot in 2021. It transitioned the country from the previously used standalone, Excel based stock management tool (SMT) to a real-time, cloud-based, multi-vaccine store system. To date, a pilot to extend eSMT to PHU is underway for a total of 96 sites. However, eSMT functionality falls well short of the TSS.

The TSS could be fully met by a Logistics Management Information System (eLMIS), a digital platform designed to capture, process, and report on the movement and stock levels within a country's supply chain health commodities. An eLMIS offers (near) real-time visibility and data collection, enabling more accurate, efficient, and transparent stock management. According to the Global Health Supply Chain Programme, a well-functioning eLMIS should: (1) Provide end-to-end visibility of health commodity stocks from CVS to PHU; (2) Track inventory, consumption, expiry dates, and losses; (3) Automate ordering, distribution, and reporting processes; (4) Generate real-time dashboards and analytics for supply chain decision-making; (5)Support quantification, forecasting, and supply planning; (6) Enhance accountability with audit trails and user access controls.

Condition

eSMT was introduced as a stop-gap digital vaccines and dry goods stock register for countries working towards implementing a fully functional eLMIS. eSMT is not an eLMIS and lacks many of the features and capabilities found in a comprehensive stock management solution. The audit noted the following gaps with eSMT:

Single point of failure with no backup: CVS relies solely on eSMT for inventory management. There is no backup stock register or system in place. In April 2025, CVS experienced over 2 weeks of eSMT outage resulting in disruption of service. This highlights the current architecture's vulnerability in potentially disrupting inventory management, order fulfilment, and timely vaccine distribution in case the system fails particularly in the absence of any backup system/process.

Non-compliance with Gavi Targeted Software Standards: The current implementation of eSMT only meets two of ten requirements outlined by Gavi for an optimised vaccine logistics system. Functionality gaps include support for forecasting, distribution management, advanced analytics, and integrated remote temperature monitoring to mention a few.

No retrospective stock status reporting: eSMT does not allow users to generate retrospective stock reports, preventing managers from reviewing or analysing historical stock positions and trends or reconciling between data points. This inhibits both accountability and data-driven planning.

Dysfunctional stock status charts: Stock status charts—meant to provide a quick visual summary of inventory—are frequently blank or fail to load, making it difficult for users to get an at-a-glance view of current stock status.

Recommendation 12

In the immediate, the EPI should:

- Identify and assess the business impact of gaps in stock records and departures from Gavi Targeted Software Standards across the country's vaccine supply chain.
- Reinstate manual stock ledgers at locations whose vaccine and dry goods stock records currently rely solely on eSMT, prioritising those sites whose eSMT records are either incomplete or whose availability of eSMT is adversely affected by infrastructure limitations.

Over the longer term, and with oversight and input from the ICC, the MoHS should develop a national digital health system strategy with the primary purpose of guiding the rational selection, integration, implementation and sustainable ownership costs of all digital public health information and communication technology. This strategy should consider:

[6] GAVI TSS

<table>
<tr><td>Constricted alert functionality: Critical stock level alerts in eSMT lack clarity and usability. Users cannot see the details of alerts immediately and must manually click into each one to understand the issue. There is no centralised dashboard to prioritise or manage critical messages, slowing down the response to urgent supply chain issues.

No offline mode: as a cloud-based tool, eSMT cannot be used even temporarily offline, which is unsuited to Sierra Leone where internet penetration is just over 30 percent. Facilities where connectivity is unstable or bandwidth is low are hindered in entering and accessing stock data, resulting in delayed information flows and incomplete reporting.</td><td colspan="2">• Human capacity and costs horizontally and transversally across public health to ensure sufficient, timely input into determining needs, systems design and scope, user acceptance testing, deployment, training, and recurring usage of any new systems being considered by the MoHS.
• Ease of integrating or, at a minimum, connecting platforms such as HMIS, eLMIS, logistics management, human resource planning, disease surveillance, etc.</td></tr>
<tr><td>Root Causes
• Significant reliance on overseas technical personnel from UNICEF for eSMT systems support. An absence of first-hand visualisation of the issues and country context can result in delayed or unhelpful responses.
• Absence of up-to-date job aids- Over 80 percent of facilities visited did not have access to current printed job aids. While eSMT was last updated in 2024, the online job aids reference outdated guidance from a prior version of eSMT.
• Lack of internal technical capacity to manage the system- No EPI technical resources or personnel in UNICEF country office have been trained to provide first-level troubleshooting, user support and implement system updates or bug fixes.</td><td colspan="2">Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
• System unavailability and the absence of backup stock ledgers impact stock visibility, leading to challenges in vaccine and dry goods stock management and gaps in the recording of stock information and stock movements.
• Incomplete and inaccurate stock data caused by insufficient end user training, system bugs, computation errors, and unreliable availability of an exclusively online tool.</td><td>Responsibility

See detailed management responses - Annex 11</td><td>Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.4.2 DHIS2 implementation needs strengthening

Context and Criteria

DHIS2 has been in use in Sierra Leone since its initial rollout in 2016 in collaboration with the MoHS, the WHO, and UNICEF. DHIS2 serves as the national health information system, enabling collection, management, and analysis of data for a wide range of programmes. While DHIS2 has significantly strengthened data-driven decision-making across Sierra Leone's health sector, the platform's stability and effectiveness depend on the timely adoption of stable software versions, integration of up-to-date analytical tools, and reliable system performance.

Condition

The audit noted the following gaps:

Use of an unstable SNAPSHOT version of DHIS2: Sierra Leone is currently operating on DHIS2 version 2.40.2, a SNAPSHOT (interim) release that is not officially designated as stable. The last stable version released was 2.40, while version 2.41.3 is now considered the most robust and secure. Reliance on a SNAPSHOT version may introduce the risk of software bugs, instability, and unresolved security vulnerabilities, which can undermine the reliability of health information.

Use of outdated WHO data quality tool: The audit found that version 1.2.3 of the WHO data quality tool is installed on DHIS2, despite newer versions being available. Continued use of this outdated tool may lead to compatibility problems, missed data quality improvements, and lack of access to advanced analytics and security features.

Unexpected session timeouts and user logouts: It was noted in our system review that from time to time, users experience unexpected session timeouts in DHIS2, resulting in forced logouts, disrupted workflows, and increased risk of data loss or incomplete entries. There is no error messaging or clear guidance for affected users.

Recommendation 13

MoHS technical teams in consultation with partners should:

- Develop and implement formal protocol for DHIS2 version management, including scheduled reviews, user acceptance testing, and migration to the latest stable releases.
- Implement a process for regular review and timely update of all DHIS2-integrated tools, including the WHO data quality tool. Engage with WHO and technical partners to ensure the platform benefits from the latest features and security enhancements.
- Conduct a technical review of DHIS2 server configurations and session management settings. Implement monitoring tools to proactively detect performance issues and communicate clear error messages with guidance to users.

Root Causes

The following root causes were noted:

- Lack of a formalised protocol for timely DHIS2 upgrades.
- Absence of a systematic process for regularly reviewing, updating, and validating third-party tools and plugins integrated within DHIS2.
- Underlying configuration or server resource issues have not been identified or resolved.

Management comments

See detailed management responses - Annex 11

Risk / Impact / Implications

Work disruptions owing to sudden system timeouts and data quality related concerns owing to use of outdated tools.

Responsibility

See detailed management responses - Annex 11

Deadline / Timetable

See detailed management responses - Annex 11

4.5 Immunisation Data Management

4.5.1 Weaknesses in immunisation data management

Context and Criteria

PFA article 8 (d) requires that all information that is provided to Gavi including its applications, progress reports, any supporting documentation, and other related operational and financial information or reports, is complete and accurate. In addition, PFA Article 16 sets out additional provisions on monitoring and reporting, specifying that "the government's use of Gavi's vaccine and cash support is subject to strict performance monitoring," such that: “Gavi seeks to use the government’s reports and existing country-level mechanisms to monitor performance.”

Gavi HSS and new vaccine support general guidelines (2015-2018), recommend that Gavi-supported countries ensure that their population projections of live births, should be broadly consistent with external projections. Furthermore, the guidelines recommend that Gavi-supported countries conduct high quality, national representative household surveys every five years. Sierra Leone carried out a nationwide immunisation coverage survey (SLICS) in 2024. The main objective of the SLICS 2024 was to ascertain vaccination coverage among children aged 12-35 months, among women who gave birth in the 12 months preceding the survey, and among girls aged 10-11 years for vaccination against Human Papilloma Virus (HPV). The report indicated that valid coverage among children aged 12-23 months was highest for PENTA1 (50.3%), OPV1 (50.2%) and BCG (49.9%). In the case of multi-dose vaccines, such as ROTA and IPV, coverage was highest for the first doses and fell in the subsequent doses. Coverage rates for the first doses stood at 47.1% for ROTA and 23.7% for IPV while second doses dropped to 34.3% for ROTA and to 3.1% for IPV. For children aged 24-35 months, the highest valid coverage was recorded for the antigens BCG (34.5%), PENTA1 (33.1%) and OPV1 (32.7%), while the lowest coverage was recorded for the antigens IPV (2.1%) and MR (7%).

The denominator for calculating immunisation coverage is total target population within each age group which is provided by Statistics Sierra Leone. Its base point is the 2015 national population census, roll forward using a relevant annual growth factor to estimate current population. The next population census is planned for 2026 and is usually every ten years.

A population data harmonisation meeting was held between the Directorate of Policy, Planning, and Information (DPPI), the National Civil Registration Authority (NCRA), Statistics Sierra Leone, the EPI, partners, and representatives from DHMT in February 2025. The primary objective of the workshop was to standardise population denominators across various data sources to enhance the accuracy and consistency of health coverage monitoring, thereby supporting evidence-based decision-making. It was subsequently decided that the EPI continue to use population projections from Statistics Sierra Leone based on the 2015 national census.

Condition

Outdated denominator for immunisation coverage monitoring: The use of outdated population denominators has compromised the accuracy of administrative immunisation coverage reporting, leading to both overreporting and underreporting across districts. A data quality audit conducted in May 2022, with support from CHAI, assessed 24 PHUs across four districts and found that 46% were overreporting and 42% were underreporting Penta-3 coverage. Moreover, administrative coverage data from 2019 to 2024 shows rates exceeding 100% for several antigens. Also, when the audit team compared 2023 administrative data with WHO / UNICEF estimates of national immunisation coverage (WUENIC) estimates, differences were above the acceptable 5%, as shown in the table below.

Table 17: 2023 immunisation coverage according to both administrative and WUENIC data sources

2023 immunisation coverage by antigen and by source			
Antigen/dose	**Administrative**	**WUENIC**	**Variance**
Penta 1st dose	102%	92%	10%
Penta 3rd dose	103%	91%	12%
Rota 1st dose	99%	88%	11%
MCV1st dose	107%	90%	17%
MCV 2nd dose	100%	73%	27%
PCV 3rd dose	103%	93%	10%

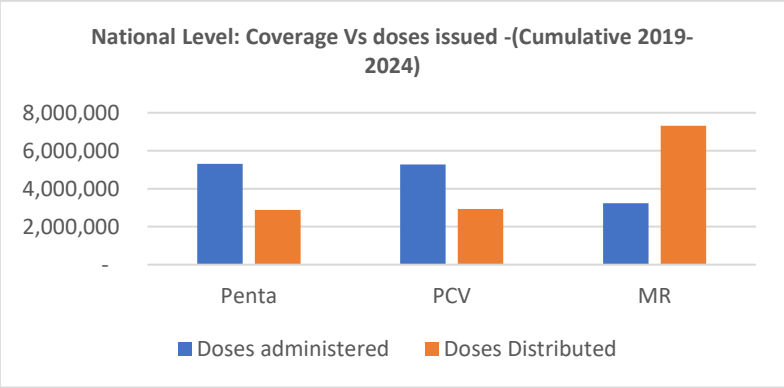
Recommendation 14

To improve immunisation data management and quality, the EPI should:

- Use bottom-up microplanning and campaign data, including zero-dose analyses, to generate more accurate service-level denominators for administrative coverage reporting.
- Advocate for realistic national denominator adjustments through the TWG and the ICC, ensuring alignment with actual population estimates from the last census, door-to-door and outreach immunisation activities.
- Ensure uninterrupted availability of official data collection tools at PHU across the country, for example by including this as a recurring action item at monthly DHMT meetings.

Anomalies in reported administrative coverage: Inconsistencies were notable between administrative coverage data reported in DHIS2 and total vaccine doses distributed from national to district level over the audit review period. The results indicated that the number of vaccine doses administered (children reported as vaccinated) was significantly higher than the number of Pentavalent and PCV vaccine doses distributed for consumption. Conversely, less than half of all MR vaccine doses distributed were administered, which is plausible given that data from the 2024 campaign may not have been fully reported in DHIS2 and MR coverage remains low:

Graph 1: Doses administered per DHIS2 compared with doses distributed per eSMT from 2019 through 2024



Additionally, the audit team identified discrepancies in 13 out of the 19 PHUs visited, where data recorded in DHIS2 was higher than the totals in the Monthly Summary Reports. Personnel from both the PHUs and the DHMT were unable to provide immediate explanations or reconcile these differences.

Data quality management challenges impacting the reliability of immunisation data for decision making: The last comprehensive, nationwide DQA was carried out in 2017 and resulted in a DQIP for 2018 to 2021. Although the DQIP was costed, it expired in 2021 with all 30 activities not having been fully implemented.

A more recent DQA was conducted in 2022 covering 24 PHUs in 4 districts, however no DQIP was developed.

- Prioritise key activities in the DQIP based on available funding, focusing on interventions with the greatest impact on data accuracy and use.

Root Causes

- The population denominator used for immunisation coverage is determined by Statistics Sierra Leone, an entity independent of the MoHS. As a result, the EPI has no direct influence over adjustments to these figures. The denominator is based on the most recent census, and it remains unclear whether updates and annual growth adjustments were made in DHIS2 following the release of the official 2021 census results in September 2022.
- Data recording challenges at PHUs: Most PHUs visited by the audit team had run out of official carbon paper data entry books. Consequently, immunisation data were recorded in notebooks or on loose sheets of paper, leading to inconsistencies when compared with monthly summaries and the final data entered into DHIS2. Data review, validation, and triangulation against available vaccine stocks are inconsistently applied.
- Inadequate supervision: Supportive supervision has not sufficiently addressed known data quality issues, leaving persistent gaps uncorrected.

Management comments

See detailed management responses - Annex 11

• Digital health planning gaps: Although the country has a Digital Health Roadmap (2024–2026), there has been no progress in planning or implementing an electronic immunisation register or digital platform for immunisation data management due to funding constraints and lack of a digital health information strategy. • Lack of a functional DQIP: The absence of a comprehensive and relevant national DQIP following the 2022 DQA has hindered effective data use. This has led to inconsistencies and gaps in data quality, which negatively impact immunisation planning, decision-making, and accurate vaccine forecasting. Moreover, recommendations from the 2018–2021 DQIP were not implemented, and the country is overdue for its next comprehensive DQA.		
Risk / Impact / Implications • Lack of DQAs and DQIPs hindering identification of data inaccuracies and implementation of meaningful remedial action - The absence of consistent DQA and DQIP make it difficult to identify and address the root causes of data inaccuracies. Issues such as poor data entry, insufficient training, and inadequate infrastructure cannot be effectively pinpointed or corrected without a structured data quality improvement plan. • Incomplete and inaccurate data leads to inaccurate decision-making - Misleading or incomplete data could result in either overestimating or underestimating immunisation coverage, ultimately causing gaps in service delivery. These gaps can affect the equitable distribution of vaccines and the targeting of immunisation efforts, undermining the effectiveness of national RI programmes, campaigns, and outreach.	Responsibility See detailed management responses - Annex 11	Deadline / Timetable See detailed management responses - Annex 11

4.6 Budgeting and Financial Management

4.6.1 Gaps in financial internal controls resulting in questioned expenditure

Context and Criteria

Section *23 Records and expenditure* of Annex 2 to the PFA stipulates 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 expenditure 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."

Condition

During the audit review period, Gavi disbursed a total of USD 28,676,066 in cash grant support excluding Technical Assistance. The audit team sampled and reviewed USD 4,614,463 of expenditure at the six districts visited as well as transactions incurred at the EPI and IHPAU and questioned USD 70,927, as summarised below (see Annex 9 for details).

Table 18: Questioned expenditure

	Total Expensed	Total tested	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible*	Total questioned	% total tested
IHPAU	81,168,634	53,875,843	53,746,883	92,550	35,906	-	504	**128,960**	**0.2%**
MoHS/EPI (via WHO)	Unknown	3,077,085	3,077,085	-	-	-	-	-	**0.0%**
MoHS/EPI (via UNICEF)	10,650,325	5,306,682	5,257,681	49,001	-	-	-	**49,001**	**0.9%**
DHMT Bombali	6,336,264	3,984,689	3,984,689	-	-	-	-	-	**0.0%**
DHMT Bonthe	6,099,804	2,373,864	2,373,864	-	-	-	-	-	**0.0%**
DHMT Kenema	6,755,915	3,750,024	3,213,921	246,300	240,940	48,863	-	**536,103**	**14.3%**
DHMT Kono	5,997,080	4,721,407	4,718,127	-	-	3,280	-	**3,280**	**0.1%**
DHMT Pujehun	5,731,448	2,831,314	2,719,239	-	112,075	-	-	**112,075**	**4.0%**
DHMT Western Area Urban	1,606,993	1,372,460	1,127,070	530	244,860	-	-	**245,390**	**17.9%**
Total GHS	**124,346,463**	**81,293,368**	**80,218,559**	**388,381**	**633,781**	**52,143**	**504**	**1,074,809**	**1.3%**
USD	**6,636,488**	**4,614,463**	**4,543,536**	**21,129**	**46,101**	**3,673**	**24**	**70,927**	

**Excluded from ineligible expenditure is SLE 64,040 (USD 2,879) of GST charged to Gavi programmes.*

***Unsupported expenditure (USD 21,129)*:** This total amount is comprised of transactions reported by the respective agencies for which the audit team did not receive any supporting documents.

Recommendation 15

To ensure visibility and accountability for Gavi support, MoHS/EPI through IHPAU should:

- Require all DHMT to adopt and adhere to national financial record-keeping and audit requirements/legislation.
- Foster compliance with standards governing financial record-keeping at the EPI and at DHMT through supportive supervision.

Recommendation 16

In compliance with the goal to use country systems, and to foster financial management capacity building, Gavi should channel funding to DHMT through IHPAU. This decision should be taken after alignment of the existing financial management capacity building TA and the role of the AP expanded to include a sample of subnational level expenditure review. This will improve the visibility of Gavi funds at national level.

<table>
<tr><td colspan="2">Inadequately supported expenditure (USD 46,101); Items where the quality of documentation maintained to support transactions related to the implementation of various programme activities, was inadequate. For example, there were no attendance sheets provided or in the absence of appropriate attendance sheets, supplementary supporting documentation such as an activity report or supervision report was not available, to confirm that the activities budgeted for took place.

DHMT accounts, records and supporting documents were found, in some cases, to be incomplete and inexistent. In one DHMT, accountants were observed by the audit team compiling and post-facto endorsing documentation substantiating expenditure sample-selected for on-site audit . The audit team concluded that all such documentation was not authentic and assessed any related expenditure as inadequately supported.

Irregular expenditure (USD 3,673): Items where the quality of documentation in support of transactions related to implementing various programme activities was not appropriate or credible.

Ineligible expenditure (USD 24): These ineligible transactions relate to funds used for activities that were not included in the approved budgets / agreements with vendors.

Gavi lacks visibility over funds channelled through the WHO to MoHS: During the audit review period, Gavi disbursed USD 3,350,397 to WHO, excluding TA. However, WHO did not provide details on the portion of these funds that were channelled to the MoHS for implementation by the EPI. As a result, except for the Measles-Rubella cash grants totalling USD 1,808,871—where EPI retained some records—there were no available expenditure records or supporting documentation for the remaining grants for our review.</td><td></td></tr>
<tr><td>Root Cause
The following root causes were identified:
• WHO informed Gavi that they would not provide Gavi with details on the portion of Gavi funds that WHO transferred to MoHS for implementation. WHO referred Gavi to MoHS, which was not able to locate the documentation.
• Incoherent record keeping requirements for expenditure among funding partners. This is compounded by document retention and archiving challenges at DHMT levels, coupled with inadequate custody of original documents.</td><td>Management comments

See detailed management responses - Annex 11</td></tr>
<tr><td>Risk / Impact / Implications
• Gavi funds not being used effectively and efficiently, including potential financial mismanagement or fraud.
• Gavi is unable to obtain adequate assurance over Gavi funds channelled to MoHS through WHO.
• Incurring GST charges, reduces the amount of programme funding, making it unavailable to implement other activities.</td><td>Responsibility

See detailed management responses - Annex 11

Deadline / Timetable

See detailed management responses - Annex 11</td></tr>
</table>

4.6.2 Inadequate accounting, programme finance management and procurement practices at IHPAU

Context and Criteria

IHPAU was established in 2013 within the MoHS to provide centralised accounting, disbursement and reporting services for donor funded projects/programmes executed by the MoHS. Longstanding donor partners include the World Bank and The Global Fund to Fight AIDS, Tuberculosis and Malaria (TGF).

In October 2021, Gavi started sending to IHPAU a portion of cash grants historically managed by UNICEF and WHO. By the year-end 2024, IHPAU had received a total of USD 7,123,624, representing 20% of total cash grants to Sierra Leone between 2019 and 2024. IHPAU's share of total Gavi disbursements has generally increased over time and, in 2024, Gavi entrusted its entire Equity Accelerator Fund (EAF) grant totalling USD 1,078,941 to IHPAU. Through its design and experience managing substantial donor partner support to the MoHS, IHPAU is expected to maintain robust internal controls, treasury management, accounting, and reporting systems.

Condition

The audit team reviewed the financial management processes at IHPAU and noted the following weaknesses:

Delayed adoption of SunSystems: Despite the substantial value and volume of Gavi transactions, grant accounting continues to rely on spreadsheet-based cashbooks that simply replicate statements from Gavi's USD and SLE-denominated bank accounts. This method lacks a structured, activity-based accounting framework. Journal entries are inconsistently numbered and not linked to supporting vouchers or documentation. Additionally, there is no audit trail to track user edits, and backup and security measures are inadequate.

Moreover, the Gavi requited financial management reports were inaccurate, late, and required significant intervention by the assurance provider for correction. Financial management at IHPAU remained suboptimal, raising concerns about the added value of the Project Management Unit (PMU) to Gavi-supported activities—despite Gavi covering a significant portion of PMU-related expenditures.

Weaknesses in procurement: The audit team identified non-compliance with the Public Procurement Regulation (2020) in the sample of procurements reviewed. Of these, 25% (USD 55,137) were classified as rushed procurements, while 38% (USD 160,434) were delayed or protracted. Additionally, poor contract management in 2022 led to a delay of over two years in the rehabilitation and construction of four DVS.

Recommendation 17

To improve financial management, IHPAU should:

- Finalise recruitment of qualified accountants to manage Gavi support.
- Train staff and implement the SunSystems as the financial management TA is already availed to provide training and capacity building through Gavi support.
- Establish a performance framework for Gavi supported personnel, with appropriate supervision and oversight by senior management at IHPAU.
- Comply to established national procurement protocol through the NPPA.
- Establish contract management guidelines for future Gavi support

Root Causes

- Suboptimal performance of the PMU was largely due to inadequate programme finance management skills among staff.
- There was no dedicated performance framework for Gavi programme finance management to ensure IHPAU staff could meet expected deliverables. Capacity-building opportunities were not leveraged, even though professional development budgets were available but underutilised. Senior-level supervision was minimal. This issue was longstanding, and by the end of the audit fieldwork, all Gavi-supported IHPAU staff contracts had been terminated, with recruitment for new staff underway.
- IHPAU did not systematically engage the National Public Procurement Authority (NPPA), which is mandated to oversee public procurement through established protocols. This led to emergency and rushed procurement processes.

Management comments

See detailed management responses - Annex 11

• Limited contract management—particularly for complex, multi-site construction projects – at IHPAU. One such project, involving the rehabilitation and construction of four DVS, was delayed by over two years due to ineffective contract oversight.		
Risk / Impact / Implications • Reliance on Excel for financial management and reporting led to inaccurate and unreliable financial reports, which hindered accountability for Gavi-funded activities and caused delays in the release of funds for programme implementation. • The assurance provider's role was compromised due to their involvement in routine transaction processing. This conflict of roles persisted until Gavi engaged a separate financial management technical assistance provider to resolve the issue.	Responsibility See detailed management responses - Annex 11	Deadline / Timetable See detailed management responses - Annex 11

Annexes

Annex 1 : Acronyms

AP	Assurance Provider
AEFI	Adverse Events Following Immunisation
BCG	Bacillus Calmette Guerin
bOPV	Bivalent Oral Polio Vaccine
CCE	Cold Chain Equipment
COVAX CDS	COVID-19 Vaccines Delivery Support
CHC	Community Health Centre
CHP	Community Health Post
CIP	Continuous Improvement Plan (immunisation supply chain)
CVS	Central Vaccine Stores
DHIS	District Health Information System
DHMT	District Health Management Teams
DPPI	Directorate of Policy, Planning and Implementation
DQA	Data Quality Assessment
DQIP	Data Quality Improvement Plan
DVS	District Vaccine Store
EAF	Equity Accelerator Fund
EEFO	Early Expiry First Out
EPI	Expanded Programme for Immunisation
EVM/A	Effective Vaccine Management/Assessments
FPP	Full Portfolio Planning
GDP	Gross Domestic Product
GNI	Gross National Income
GST	Gross Sales Tax
Hib	Haemophilus influenza type b
HSS	Health Systems Strengthening
ICC	Interagency Coordination Committee
IHPAU	Integrated Health Projects Administration Unit
IPV	Inactivated Polio Vaccine
ISC	Immunisation Supply Chain
eLMIS	Electronic Logistic Management Information System
MCHP	Maternal and Child Health Posts
MCV	Measles Containing Vaccine
MR	Measles-Rubella
NHSSP	National Health Sector Strategic Plan
NIP	National Immunisation Policy
NIS	National Immunisation Strategy
PEF TCA	Partnership Engagement Framework Targeted Country Assistance
PFA	Partnership Framework Agreement
PHU	Peripheral Health Unit
RI	Routine Immunisation
SLE/SLL	Sierra Leonean Leone (currency since 1 July 2022) SLL before
SOP	Standard Operating Procedures
TA	Technical Assistance
TCC	Technical Coordinating Committee
TWG	Technical Working Group
USD	United States Dollar

VPD	Vaccine Preventable Disease
WICR	Walk-in Cold Room
WIFR	Walk-in Freezer Room
WUENIC	WHO / UNICEF estimates of national immunisation coverage

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 Districts and Peripheral Health Units visited by the audit team

Districts (6)	Peripheral Health Units (19)
Bonthe	Mattru CHC, Red Cross (Bonthe) CHP, Moriba Town Imperi
Pujehun	Saama Perri MCHP, Gofor CHP, Bandajuma Sowa CHC
Kono	United Methodist Church, Koidu Static, Kensay CHP
Bombali	Kamabai CHC, Loreto Clinic, Makeni Government Hospital
Kenema	Largo CHC, Red Cross CHP, Nongowa Static (Under 5) MCHP
Western Area Urban	Susan's Bay, Ola During Children's Hospital, New England MCHP, Looking Town MCHP

Annex 5 : Sierra Leone immunisation schedule

No of Visit	Target population	Vaccine and dose
1st Visit	Newborn	Polio 0
		BCG
2nd Visit	At 6 weeks	Polio 1
		Rota 1
		PCV 1
		IPV 1
		DPT-Hep B-HiB1
3rd Visit	At 10 weeks	Polio 2
		Rota 2
		PCV 2
		DPT-Hep B-HiB2
4th Visit	At 14 weeks	Polio 3
		Rota 3
		PCV 3
		DPT-Hep B-HiB3
5th Visit	At 6 months	Malaria Vaccine 1
6th Visit	At 7 months	Malaria Vaccine 2
7th Visit	At 8 months	Malaria Vaccine 3
8th Visit	At 9 months	Yellow fever
		Measles Rubella 1 (MR1)
9th Visit	At 11 months to 2 years (18 months)	Malaria Vaccine 4
		Measles Rubella 2 (MR2)
1st Visit	10 years	HPV Vaccine 1
2nd Visit	10 years with any immunological condition (6 months after first dose)	HPV Vaccine 2
1st Visit	12 years & above	COVID-19 Vaccines 1
2nd Visit	12 years & above	COVID-19 Vaccines 2
3rd Visit	13 years & above	COVID-19 Vaccines 3
1st Visit	15 years & above (First Contact)	Td1
2nd Visit	16 years & above (1 month after first dose)	Td2
3rd Visit	17 years & above (6 months after the 2nd dose)	Td3
4th Visit	18 years & above (1 year after the 3rd dose)	Td4
5th Visit	19 years & above (1 year after the 4th dose)	Td5

Annex 6.a: Vaccine stock outs at sub-national level

District Vaccine Stores			
#	Facility Name	Name of vaccine	Aggregate stock out Days
1	Bonthe DVS	OPV	52
2	Western Area DVS	OPV	95

#	Facility Details	Pentavalent	MR	OPV	BCG
1	Mattru HF	24	47	26	0
2	Largo CHC	0	0	0	0
3	Susan's Bay Clinic	15	188	49	0
4	Kensay CHP	87	211	0	0
5	Looking Town MCH	517	499	0	0
6	Red Cross	258	315	0	0
7	Koidu static CHC	0	0	58	13
8	UMC HF	0	37	41	23
9	Ola During Hospital	0	0	306	124
10	Loreto Clinic	37	60	0	0
11	Kamabai CHC	0	30	0	0
12	Makeni Govt Hosptl	23	29	11	0
13	Bandajuma Sowa CHC	178	111	212	124
14	Gofor CHP	0	6	87	33
15	Saama Perri MCHP	47	92	147	106
16	New England MCH	77	49	85	52

Annex 6 b. Discrepancies between physical stock count and eSMT quantities at CVS

Vaccine	UoM (Doses per vial)	Batch No.	Expiry Date	Quantity counted (A) (Doses)	Location	Quantity recorded in eSMT (B) (Doses)	Variance (A-B)
Pentavalent	4	2864x020A	Apr-27	1,170	WICR3	1,180	-10
		2864X019B	Mar-27	2,000	WICR3	2,010	-10
		2864X009A	Nov-26	8,000	WICR1	8,020	-20
		E5V104047	Feb-27	6,000	WICR2	5,750	250
		E5V104046	Feb-27	5,500	WICR1	6,200	-700
MR	10	0124W091	May-27	468,000	WIFR2	461,840	6,160
		0123W063	Feb-26	38,160	WIFR2	64,500	-26,340
		0123W074	Mar-26	88,500	WIFR2	36,000	52,500
		0123W073	Mar-26	17,500	WICR2	6,000	11,500
		0124W051	Dec-26	41,210	WICR2	0	41,210
		0123W052	Dec-26	2,290	WICR2	0	2,290
HPV	4	G0099A	Jun-27	266,230	WICR1 & WICR2	430,390	-164,160
		G0108A	Oct-27	38,180	WICR1	38,360	-180
		G0052/1A	Sep-25	360	WICR1	240	120
		G0100A	Jun-27	10	WICR1	81,090	-81,080
		G0049A	Jul-25	630	WICR1	0	630
		G0100A	Jun-27	109,920	WICR1	109,930	-10
		G0098A	Jun-27	302,400	WICR3	561,990	-259,590
Malaria	10	A92CA109A	Aug-26	67,900	WICR2	70,500	-2,600
		A92CA149A	Jun-27	46,900	WICR2	47,000	-100
		A92CA148A	Jun-27	72,000	WICR2	136,100	-64,100
		A92CA100A	Feb-26	16,800	WICR2	21,600	-4,800
		A92CA100A	Feb-26	4,800	WICR1	21,600	-16,800
		A92CA103A	Apr-26	2,400	WICR1	2,300	100
		A92CA109A	Aug-26	2,600	WICR1	70,500	-67,900
BCG	20	E2407	Oct-26	208,000	WIFR2	198,000	10,000
		1730	Apr-26	600,000	WIFR2	510,000	90,000
		1723	Oct-25	46,020	WIFR2	46,540	-520
		1729	Mar-26	64,160	WIFR2	75,000	-10,840
IPV	10	IPV24718	May-27	28,200	WICR-2	28,198	2
PCV	4	HK4759	Sep-26	22,400	WICR-1	22,100	300
		LN8528	Aug-27	397,400	WICR-1	397,200	200
		HN4625	Aug-26	13,600	WICR-2	13,000	600

Annex 7: Discrepancies between physical stock counts and stock records at DVS

Name of District store	Vaccine Name	Batch No.	Expiry Date	Quantity counted (A) (Doses)	Quantity on vaccine stock ledger Book (B) (Doses)	Quantity recorded in eSMT (C) (Doses)	Variance (A-B)	Variance (A-C)
Western Area Urban DVS	**Measles and Rubella Vaccine (MR)**	0123W063	Feb-26	1,690	1,520	1,520	170	170
	Human Papillomavirus vaccine (HPV)	G0108A	Oct-27	5,430	4,950	4,950	480	480
Bonthe DVS	**Measles and Rubella Vaccine (MR)**	0123W055	Jan-26	4670	4600	4670	70	0
	Human Papillomavirus vaccine (HPV)	G0050A	Jul-25	1980	4280	4280	-2300	-2300
		G0108A	Oct-27	1920			1920	1920
	Malaria Vaccine	A92CA100A	Feb-26	5948	4650	4600	1298	1348
	Pentavalent vaccine	2864X019B	30-Oct-27	12,580	0	13,930	12,580	-1,350
		E5V104047	28-Feb-27	250	0	2,662	250	-2,412
	Measles and Rubella Vaccine (MR)	0124W075	29-Apr-27	8,180	0	5,900	8,180	2,280
		0124W009	30-Oct-26	2,380	0	1,990	2,380	390
		0123W055	1-Jan-26	500	0	0	500	500
		0123W063	1-Feb-26	960	0	0	960	960
	Human Papillomavirus vaccine (HPV)	G0076A	30-Oct-27	0	178	1,833	-178	-1,833
		G0108A	6-Jul-26	0	2,474	0	-2,474	0
		G0077A	8-Jul-26	0	530	0	-530	0
	Malaria Vaccine	AQ2CA105A	29-Apr-26	400	0	3	400	397
		A92CA097A	1-Feb-26	2,200	0	0	2,200	2,200
		A92CA101A	1-Apr-26	474	0	0	474	474
		A92CA100A	27-Feb-26	7,800	0	6,862	7,800	938
Kono DVS	**Pentavalent vaccine**	2864x019B	Mar-27	5860	0	0	5860	5860
		2864x019A	Nov-26	2000	0	10,380	2000	-8380
		2864x013B	Dec-26	4500	0	5,000	4500	-500
		E5104046	Feb-27	0		1,820	0	-1820
	Measles and Rubella Vaccine (MR)	0124W052	Dec-26	3390	0	2,500	3390	890
		0123WO63	Feb-26	15320	0	18,030	15320	-2710
	Human Papillomavirus vaccine (HPV)	GO108A	Oct-27	200	0	0	200	200
		GOO76A	Oct-27	1199	0	10,136	1199	-8937
	Malaria Vaccine	A92CA109A	Aug-26	9264	17,367	11,700	-8103	-2436
		A92CA101A	31April 2026			3,259	0	-3259
Pujehun DVS	**Pentavalent vaccine**	2864X019B	Dec-27	9560	9000	6500	560	3060
	Measles and Rubella Vaccine (MR)	0124W075	Apr-27	11860	11000	8780	860	3080
	Human Papillomavirus vaccine (HPV)	G0076A	Jul-26	4145	4020	1854	125	2291

Name of District store	Vaccine Name	Batch No.	Expiry Date	Quantity counted (A) (Doses)	Quantity on vaccine stock ledger Book (B) (Doses)	Quantity recorded in eSMT (C) (Doses)	Variance (A-B)	Variance (A-C)
	Malaria Vaccine	A92CA097A	Feb-26	17358	16800	10834	558	6524
Bombali DVS	**Pentavalent vaccine**	E5V104046	Feb-27	3160	0	3,450	3160	-290
		2864X009A	Nov-26	0	0	6,000	0	-6000
		2864X019B	Mar-27	8000	0	0	8000	8000
	Measles and Rubella Vaccine (MR)	0123W063	Feb-26	2360	0	8,270	2360	-5910
		0124W074	Apr-27	6000	0	0	6000	6000
	Human Papillomavirus vaccine (HPV)	GOO76A	Jul-26	0	0	480	0	-480
		GO108A	Mar-27	3030	0	0	3030	3030
	Malaria Vaccine	A92CA101A	Apr-26	4640	0	5,630	4640	-990
		A92CA109A	26-Feb-26	2600	0	4,650	2600	-2050

Annex 8: Discrepancies between physical stock counts and stock records at PHU

Facility Name	Name of Vaccine	Batch No.	Expiry Date	Quantity counted (A) (Doses)	Quantity on stock ledger book (B) (Doses)	Variance (A-B)
Mattru CHC	Pentavalent vaccine	2864X019B	Ma-27	30	40	-10
	Measles and Rubella Vaccine (MR)	0123W055	Jan-26	150	200	-50
	Human Papillomavirus vaccine (HPV)	G0050A	Oct-25	50	35	15
	Malaria Vaccine	A92AA096A	26-Feb	40	35	5
Largo CHC	Pentavalent vaccine	2864X019B	Mar-26	50	60	-10
	Measles and Rubella Vaccine (MR)	0124W075	Apr-27	40	50	-10
	Human Papillomavirus vaccine (HPV)	G0108A	Oct-27	11	0	11
		D0076a	Jul-26	45	0	45
	Malaria Vaccine	A92AA105A	Apr-26	40	40	0
New England MCHP	Pentavalent vaccine	2864X013B	Dec-2026	50	40	10
Nongowa Static	Human Papillomavirus vaccine (HPV)	GOO768	July-26	20	0	20
	Malaria Vaccine	A92CA105A	Apr-26	100	0	100
		A92CA097A	Feb-26	84	0	84
Kensay CHP	Pentavalent vaccine	2864X013B	Dec-26	96	100	-4
	Malaria Vaccine	A92CA101A	Apr-26	46	80	-34
Looking town MCHP	Pentavalent vaccine	2864x013b	Dec-27	80	100	-20
		e5v104d45	Feb-27	10	0	10
	Measles and Rubella Vaccine (MR)	0123w073	Mar-26	90	120	-30
Redcross	Pentavalent vaccine	2864X019B	Mar-27	60	100	-40
	Malaria Vaccine	A92AA109A	Aug-26	36	30	6
Koidu Static CHC	Pentavalent vaccine	2864x009A	Nov-26	210	240	-30
	Measles and Rubella Vaccine (MR)	0123W063	Feb-26	15	10	5
Loreto Clinic	Pentavalent vaccine	2864X013B	Dec-26	96	50	46
	Human Papillomavirus vaccine (HPV)	G0076A	Jul-26	25	0	25
	Malaria Vaccine	A92CA101A	Apr-26	46	0	46
Bandajuma Sowa CHC	Pentavalent vaccine	Not Legible	Not Legible	70	-50	20
Gofor CHP	Pentavalent vaccine	2864X019B	Mar-27	25	21	4
	Human Papillomavirus vaccine (HPV)	G0076A	Jul-26	30	25	5

Annex 9: Questioned expenditure

Note: 98.7% of all sample-selected expenditure was found by audit team to be adequately supported. This annex lists only the remaining 1.3% of expenditure questioned in part or in full.

IHPAU

	Programme / activity	Voucher n°	Voucher Date	Transaction description	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
1.6.6	Transportation refunds for Participants	22	12/07/22	DSA and Transportation Allowance for REC and IIP Approach-Bonthe	146,250	120,000	26,250		0	0
5.29	Nassit for Gavi staff	69	11/12/23	November 2023 Nassit for Gavi Staff	11,832	11,328	0	0	0	504
2.17.1	Field trip to Karene, Falaba and Bo districts to monitor and supervise Cold Chain and Drying Stores Construction sites	27	15/08/23	DSA for staff Fuel	24,323	14,000	0	10,323	0	0
2.20.1	Field trip to Karene, Falaba and Bo districts to monitor and supervise Cold Chain and Drying Stores Construction sites	28	15/08/23	DSA for staff Fuel	24,323	14,000	0	10,323	0	0
3.1.1	Hall rental and Facilities	Letter	03/07/24	Hall rental and Facilities	780,000	720,000	60,000		0	0
3.1.2	All district(MR Training of Social Mobilisation and Vaccinators)	Letter	03/07/24	Refreshments for 5304 + 229 Participants +160 DHMT + 48 National +358 C/Dom sup @ SLL 180,000 per person	1,830,000	1,814,740		15,260	0	0
3.1.4	All district(MR Training of Social Mobilisation and Vaccinators)	Letter	03/07/24	Fuel for Participants (Transport to and from the district)	883,800	877,500	6,300		0	0
					3,700,528	**3,571,568**	**92,550**	**35,906**	**0**	**504**
							128,960			

MoHS-EPI (via UNICEF)

UNICEF Grant N°	Programme / activity	Voucher n°	Voucher Date	Transaction description	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
SC210240	CORDINATE IPV CATCH UP CAMPAIGN CH EPI	N0.21/005 No.21/0024 No.22/054 No.21/0026 No.21.015	24/06/21 -23/11/21	Coordination, transport, DSA, fuel & internal runs for the Directorate of child health/EPI Printing of supervisory form tally sheets & summary form for child health/EPI 5.5% Withholding tax on printing of supervisory form tally sheets & summary form for child Health/EPI Fuel (National) for vaccine distribution to districts by the directorate of child health/EPI	572,974	551,826	21,148	-	-	-
SC200560	SUPPORT TRAINING COVID19 VACCINATION ACTIVITIES			Fuel DSA for Data Clerks Development of Jingles and Airing of Jingles on 32 Radio Stations Airing of Jingles on 32 Radio Stations Production of TV Spot and hearing of TV spot	613,724	585,871	27,853	-	-	-
					1,186,698	**1,137,697**	**49,001**	**-**	**-**	**-**
							49,001			

DHMT Kenema

Year	UNICEF Grant N°	Programme / activity	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
2023	SM210919	Q2 INTEGRATED NUT EPI OUTREACH IN KENEMA	293,078	291,465	-	-	1,613	-
2023	SM210919	HEALTH AND NUTRITION 3900/A0/08/881/002/010 IMPLEMENTATION OF PIRI EIGHT (8) IN KENEMA DISTRICT	246,300	-	246,300	-	-	-
2024	SM210919	HEALTH & NUTRITION - 3900/A0/08/881/002/010 PIRI 9 ASUPPORT IN KENEMA DISTRICT	120,470	-	-	120,470	-	-
2024	SM210919	HEALTH & NUTRITION - 3900/A0/08/881/002/010 PIRI 10 SUPPORT IN KENEMA DISTRICT	120,470	-	-	120,470	-	-
2022	SM220477	COVID19 VACCINATION FRANCE SURGE 8 IN KENEMA	211,090	193,340	-	-	17,750	-
2022	SM220477	COVID 19 VACCINATION SURGE 12 IN KENEMA	221,100	198,000	-	-	23,100	-
2022	SM220477	COVID19 VACCINATION SURGE 13 KENEMA	294,654	288,254	-	-	6,400	-
			1,507,162	**971,059**	**246,300**	**240,940**	**48,863**	**-**
					536,103			

DHMT Kono

Year	UNICEF Grant N°	Programme / activity	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
2023	SM210919	PIRI SURGE 19 SUPPORT IN KONO DISTRICT	318,575	316,335	-	-	2,240	-
2023	SM210919	PIRI10 IMPLEMENTATION IN KONO DISTRICT	307,650	306,610	-	-	1,040	-
			626,225	**622,945**	**-**	**-**	**3,280**	**-**
					3,280			

DHMT Pujehun

Year	UNICEF Grant N°	Programme / activity	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
2021	SM210672	COVID 19 ACTIVITIES IN PUJEHUN	186,300	169,600	-	16,700	-	-
2022	SM220477	COVID19 VACCINATION SURGE 13 IN PUJEHUN	197,454	167,454	-	30,000	-	-
2022	SC210240	IPV CATCH UP CAMPAIGN IN PUJEHUN DISTRICT	145,812	105,047	-	40,765	-	-
2022	SC200560	SUPPORT HPV INTRODUCTION IN PUJEHUN	159,990	140,180	-	19,810	-	-
2022	SM210919	Q2 INTEGRATED EPI OUTREACH IN PUJEHUN	220,898	216,098	-	4,800	-	-
			910,454	**798,379**	**-**	**112,075**	**-**	**-**
					112,075			

DHMT Western Area Urban

Year	UNICEF Grant N°	Programme / activity	Reported expenditure	Adequately supported	Unsupported	Inadequately supported	Irregular	Ineligible
2021	SM210672	Fund transfer for Covid 19 surge	267,650	266,920	530	200	-	-
2019	SC180798	Fund transfer for periodic intensified routine immunisation (PIRI)	117,750	116,750	-	1,000	-	-
2021	SM210672	COVID 19 CDS ACTIVITIES	32,800	-	-	32,800	-	-
2021	SC210240	IPV CATCH UP CAMPAIGN IN WESTERN AREA URBAN DISTRICT	225,710	33,300	-	192,410	-	-
2019	SC180798	2ND QUARTER PIRI IN WESTERN URBAN	101,960	83,510	-	18,450	-	-
			745,870	**500,480**	**530**	**244,860**	**-**	**-**
					245,390			

Annex 10: Questioned expenditure by grant and recipient

Questioned expenditure by grant

Gavi grant	Grant recipient	Questioned expenditure			
		Unsupported	Inadequately supported	Irregular	Ineligible
HPV	UNICEF	-	1,410	-	-
IPV	UNICEF	-	24,362	-	-
HSS	UNICEF	16,306	18,680	3,673	-
	IHPAU	4,542	969	-	24
Measles Rubella	IHPAU	281	680	-	-
Total		**21,129**	**46,101**	**3,673**	**24**

Annex 11: Detailed management responses

Issues	Audit Recommendations	Management Action	Action Owner	Timelines
Governance and oversight roles need further strengthening	Recommendation 1 To further strengthen the governance and coordination structures, MoHS/EPI should: • Revise the agenda and minutes templates and update to include key elements like action points, follow-ups from previous meetings and a unique reference to support archiving and traceability. • Update the ICC ToRs to ensure that at least two alternate meeting are chaired by the Minister annually and include the deputy minister as a co-chair in the Minister's absence to maintain high level oversight. • Institutionalise discussions on immunisation financial planning at ICC beyond co-financing obligations to promote diversified funding sources. • Ensure that the notifications for quarterly meetings provide adequate notice to support attendance by leadership of Gavi alliance partners at country level. • Establish a centralised database for DHMT to share issues with the national level EPI team, with adequate monitoring for issue resolution.	**Action 1** We acknowledge receipt of your recommendation. The leadership of the EPI and partners will ensure the recommendations are implemented. The ICC agenda includes an agenda item 'highlight from the last meeting' which contains action points from previous meeting and their respective status. However, consistency is not there with respect to actual title/ naming of this agenda item. The minute template for ICC has been improved recently based on Gavi recommendation to include highlight of the discussions during the ICC meeting. All ICC materials (invitation letter, minutes, agenda and attendance) are stored in hard copy on a yearly file. The soft copies of these ICC documents are also stored online on a yearly and quarterly basis. The ICC ToR will be reviewed and updated as recommended in line with best practice. The updated ToR will be presented to the ICC during the first quarter meeting of 2026. Further, depending on the schedule of the senior management, the Hon'ble Minister would delegate a representative to chair ICC meetings. Discussion on Immunisation financial planning and the promotion of diversified funding sources which includes domestic resource mobilisation will be incorporated as an agenda item for each ICC meeting starting from the first quarter 2026. Budget discussion, gaps and fund generation for immunisation activities has always formed part of previous ICC discussions. This recommendation is accepted and adequate notice with at least 1 week will be provided starting from Q1 2026. An issues tracker will be created at the beginning of 2026. Monthly meetings with DHMT will be strengthened and issues identified during these meetings will be maintained in an online excel database. National EPI staff has been assigned to respective districts to provide support and follow-up on district issue. A reporting tool on stock management is currently in existence and this will be expanded to include other components. This expansion will be included as part of the EPI server with access granted to the district and national staff.	EPI Leadership and Coordination	31 December 2026

Weaknesses in strategic and operational planning have impacted programming	Recommendation 2 To strengthen strategic and operational planning, the MoHS/EPI should: • Accelerate stakeholder engagement to finalise the NIS including a redefined the timeframe, M&E framework and costing to ensure relevance and feasibility. Finalisation should also include prioritisation to align with the envisaged Gavi Leap for the 6.0 period. • Assign responsibility for routine immunisation management to deputies within the EPI team, with monitoring by EPI manager as this will free up EPI manager time to finalise strategic documents, including aligning EPI and MoHS documents and prioritise RI planning. This will also ensure continuity planning. • Establish and institutionalise document retention standards for planning, operational and reporting documents to enhance institutional memory, ensure accountability and continuity.	**Action 2** NIS document timelines and framework has been revised pending completion of the budget and review of prioritisation to align with the Gavi 6.0 leap period. The EPI and Partners will ensure this is completed by Q1 2026 and it will be used to update the FPP to the consolidated plan. The EPI job description will be reviewed, updated to include district and service delivery staff, and implemented. More responsibilities will be assigned to other deputies/ staff within the EPI. The EPI will develop and operationalise SoP and guidelines that will capture among others document retention to enhance accountability and continuity in line with the MoHS national policy.	M&E Team Lead EPI Leadership and Coordination	31 December 2026
Challenges persist in the measles routine immunisation management processes	Recommendation 3 To prioritise measles management and support its eventual elimination, the MoHS and the EPI should: • Develop a national measles elimination strategy and incorporate it into the NIS, enabling targeted interventions to address persistent gaps in routine measles management. • Review and update RI strategies, ensuring alignment with the Measles-Rubella Strategic Framework 2021–2030, and tailor guidance to the country's specific context. • Improve qualitative assessments from campaigns to generate actionable lessons learned and integrate these into RI programming for sustained coverage and impact. • Strengthen supervision tools, including checklists, to better assess and manage measles routine activities at sub-national levels.	**Action 3** Draft measles elimination plan developed with the support by WHO is already in existence but is yet to be completed and validated. This draft plan will be reviewed and validated as well as will be included as part of the NIS review. Based on Gavi recommendation, the revised catch up policy for measles allow children to be vaccinated up to 14 years and the cap for 59 months has been removed. Qualitative report has been used to identify communities with high number of zero dose and under immunised children. These reports had been a guide in targeted intervention focus on reaching zero dose and under immunised children. The existing supervision checklist will be jointly reviewed with the surveillance unit to focus on measle elimination strategy.	M&E Team Lead Team Lead Service Delivery	30 June 2026

	Recommendation 4 To maintain consistent and effective VPD surveillance during both routine immunisation and campaigns, the MoHS should: • Ensure VPD surveillance is suitably budgeted and funded, including reporting tools and transportation of samples to labs for testing. • Reaffirm the significant role of VPD surveillance in effectively mitigating disease outbreaks. • Ensure VPD reporting tools are available, understood and utilised by PHUs. • Set service delivery commitments for the transportation and lab analysis of samples and dissemination of lab results, then identify and root out bottlenecks. • Establish and enforce lab result reporting modalities from labs through to PHUs.	**Action 4** EPI will collaborate with the national public health agency and surveillance program to enhance sample collection and transportation. There is an assigned VPD surveillance focal person at the EPI. There has been an establishment of the National Public Health Agency with an assigned role to respond and manage all VPD outbreaks. This agency is working in close collaboration with the surveillance program and EPI, at all levels. EPI will collaborate with NSP for printing and distribution of all surveillance tools and training of IDSR focal persons EPI will collaborate with the national public health reference Lab to strengthen sample collection for VPD transportation and testing and timely result dissemination to all. The VPD focal person at EPI will engage the National Public Health Reference Lab during the weekly EPRRG (Emergency Preparedness Responds Resilience Group) meeting for timely lab result dissemination to all districts in line with required standard of response. The EPI will collaborate with the NPHA to ensure the representation of the DMOs and DSOs in the weekly EPRRG meetings where updates on lab results are discussed.	VPD Team Lead	31 December 2026

Supportive supervision arrangements need enhancement	Recommendation 5 To improve the supportive supervision, the MoHS/EPI should: • Develop and formalise clear terms of reference for chiefdom supervisors. • Work with DHMT to develop comprehensive supportive supervision plans, guidelines, and terms of reference. This plan should identify the roles and responsibilities of each player including partners and agencies to facilitate coordinated visits and optimise existing resources. • Install Kobo Toolbox, or a similar configurable data collection app, on the mobile devices of chiefdom supervisors to strive for structured, consistent, real time supervision reporting, and thereafter follow up on improvement suggestions, and prioritise, plan and prepare future supportive supervisions.	**Action 5** MoHS has an existing Primary Health Care Handbook which includes the ToR for National, District and Chiefdom Supervision along with the detailed supervision process. EPI will review and update the existing ToR to ensure the EPI services is reflected as part of the regular supervision. The Primary Health Care Handbook provides clear supervision plans, guidelines and ToR for the supervision process at all levels (national being quarterly and district on monthly basis). The handbook provides the supervision checklist which are adapted by EPI for supervision purposes. For partners and agencies the SLA (Service Level Agreement) gives clear guidelines on their operations and supervision. EPI currently has a free version of the Kobo Toolbox which is limited in capacity, operation and security. To ensure proper utilisation and security the EPI will procure a licensed Kobo Toolbox for service delivery levels/chiefdom supervisors.	Team Lead Service Delivery	31 December 2026
Opportunities to improve the designed approach to civil society organisations (CSOs) engagement	Recommendation 6 To enhance the effectiveness of CSO intervention, the MoHS/EPI should: • Update the ICC and TCC ToRs to include CSOs at the TCC meetings and a representative at the ICC. • Leverage on-going CSO activities to establish a community of practice that addresses the challenges in the specific communities the CSOs are working. • Within the M&E framework for the NIS, define activities, targets to track progress through CSO activities and ensure accountability. • Document and share lessons learned with all stakeholders.	**Action 6** CSOs are part of the list of invitees to the ICC and TCC meeting. As part of the partner's presentation during the TCC meetings, CSOs provides the status of their activities and interventions including challenges. At the ICC meeting a representative from the CSOs provides an overall update. The EPI consider this recommendation timely in strengthening the work of CSOs across the 16 districts. Community of Practice is a proper approach in addressing challenges in specific communities with a high sense of ownership. The EPI will engage with CSOs in identifying the communities with challenges, create the domain and as financial resources allow, collate these practices in these communities. Recommendation will be implemented during the NIS M & E framework revision. CSOs will use the TCC as a platform to share lessons learned with all relevant immunisation stakeholders. Reports from CSOs are currently filed by the EPI manager.	EPI Leadership and Coordination M&E Team Lead	30 June 2026

Challenges in the visibility and performance monitoring of TA should be addressed	Recommendation 7 To enhance oversight over PEF/TCA activities, the MoHS/EPI should: • Leverage existing governance mechanisms such as the TCC and the ICC for partners to present, discuss and review progress on partner activities. These reviews should be formally captured in the minutes of TCC and ICC meetings. • Sign off on all PEF TCA milestones prior to submission through the Gavi portal. • Develop a comprehensive, timebound plan to transfer TA skills, roles and responsibilities to the EPI which includes: • An EPI capacity assessment to identify resource and proficiency gaps. • A structured capacity building plan, including on-the-job mentorship. • A timetable of the handover of various skills and responsibilities from TA to EPI.	**Action 7** Recommendation for partner's presentation at the TCC has been implemented while that for the ICC will be incorporated as part of the first quarter ICC meeting of 2026 The recommendation has been implemented after the Gavi audit conducted in 2025 A comprehensive plan for all TA activities will be developed	EPI Leadership and Coordination	30 June 2026
The forecasting and supply planning processes need improvement	Recommendation 8 To ensure availability of adequate vaccine supplies, the MoHS/EPI management should: • Collaborate with UNICEF to designate EPI focal persons, assess training needs, and implement a capacity development plan focused on forecasting and supply planning. This should include a clear roadmap for transitioning forecasting and supply planning responsibilities to the EPI team. • Establish SOPs and guidelines to support a structured and transparent forecasting process at the central level. • Conduct quarterly reviews of vaccine stock levels and escalate any supply issues to the TCC and ICC governance platforms to enable timely decision-making and corrective action. These revies will also inform the annual supply planning process. • Engage with the Ministry of Finance to facilitate the timely release of funds for co-financed vaccines, ensuring uninterrupted procurement and supply.	**Action 8** There is an existing EPI focal person for forecasting and supply planning that is responsible for capacity building across all Level. Even though EPI are transitioning forecasting responsibility from UNICEF to EPI, the 2026 forecasting was EPI led with a bottom-up approach, starting from district level. The Program held a 2-day workshop on the 16th and 17th December 2025 to develop iSC SOPs which includes SOP for forecasting but is pending stakeholders review, validation, printing and dissemination. The Logistics team has been consistently holding their quarterly TWG meeting for the last three quarters of 2025. These meetings includes staff at district and national levels to review iSC data. MoHS will engage with the Ministry of Finance as a matter of priority to facilitate the timely release of funds for co-financed vaccines. This engagement will focus on strengthening coordination and ensuring that financial commitments are met promptly to avoid any delays in procurement and to guarantee an uninterrupted supply of vaccines.	Logistic and Supply Chain Team Lead EPI Leadership and Coordination	31 December 2026

Inadequate inventory management impacted accountability and traceability of vaccines	Recommendation 9 To strengthen vaccine stock management and accountability, the EPI, in collaboration with UNICEF, should: • Include on-the-job mentoring within support supervision to improve practical performance and ensure consistent application of supply chain procedures. • Review, update, and distribute Effective Vaccine Management (EVM) Standard Operating Procedures (SOPs) across all levels of the supply chain to promote uniform practices. • Provide standardised stock registers and ensure staff consistently and accurately record vaccine expiries and wastage incidents to improve traceability and accountability.	**Action 9** To strengthen vaccine stock management and accountability, the EPI, in collaboration with UNICEF, will integrate structured on-the-job mentoring into routine support supervision. This approach will enhance hands-on skills, improve practical performance, and ensure the consistent application of standard supply chain procedures across all levels of the immunisation system. The EPI will review, update, and systematically distribute the Effective Vaccine Management (EVM) Standard Operating Procedures (SOPs) across all levels of the supply chain. This will promote standardised practices, strengthen compliance, and enhance efficiency and accountability in vaccine storage, handling, and distribution. The EPI will provide standardised stock registers and ensure that all staff consistently and accurately document vaccine receipts and expiries, VVM stages and wastage. This measure will enhance traceability, strengthen accountability, and support evidence based decision-making across the vaccine supply chain.	Logistic and Supply Chain Lead and UNICEF Immunisation Specialist	31 December 2026
Gaps in storage capacity, coupled with weaknesses in cold chain operations and equipment management	Recommendation 10 To strengthen its cold chain management, the MoHS/EPI should: • Review the new construction at CVS to optimise cold and dry goods storage and incorporate connections to the established solar panels to optimise the Gavi support provided. [This recommendation was discussed with the EPI, UNICEF during the audit team planning mission for immediate corrective action.] • Regularly extract and review data reports from temperature monitoring devices to undertake suitable remedial action and maintenance. • Clarify roles and responsibilities for maintenance activities and collaborate with UNICEF to obtain all maintenance and warranty information from the third-party provider and assume responsibility for all CCE that is out of warranty. • Develop and distribute cold chain management SOPs to guide cold chain management and maintenance processes.	**Action 10** To enhance cold chain and cold store management, MoHS and EPI will review the new construction site at the Central Vaccine Store (CVS) to optimise cold and dry storage. Additionally, connections to the existing solar panel system will be integrated to maximise the Gavi support provided The SC unit have designated staff for temperature monitoring. Consistent monitoring, downloading and filing of endorsed temperature monitoring data have commenced since 2025. Conversation with UNICEF has been initiated to share agreements and contracts with third party service Provider. The iSC has also planned to review the log book for PPM and enforce its use at all levels. The SOP for cold chain management is part of the SOPs reviewed in Dec 2025 and will be finalised in 2026.	Logistic and Supply Chain Team Lead	31 December 2026

Delays in implementation of EVM assessment recommendations	Recommendation 11 The MoHS/EPI should: • Develop a tracker/dashboard of the CIP implementation status that takes account of and regularly discuss progress with whichever is the more appropriate of the ICC or TWG. • Develop and distribute cold chain management SOPs to guide cold chain management and maintenance processes.	**Action 11** The EPI will review the current CIP to track progress and update as required. The EPI have made a significant progress in making sure improvement is made in all the areas that contributed to the low score. EPI have strengthened governance system, construction of bigger store for dry materials, constructed new cold store that will host over 12 cold room and over 20 Ultra cold chain equipment, procurement of new vehicle for vaccine distribution to the two hard to reach district (Karene & Falaba), procured more vehicle that will accommodate more staffs for supportive supervision, procured distribution truck for the distribution of ancillaries materials, increased the training of the Logistics and supply chain office including the district operation officers. The remaining issues that led to the score 64% will be continuously addressed.	Logistic and Supply Chain Team Lead	30 September 2026
Weaknesses in design and implementation of eSMT	Recommendation 12 In the immediate, the EPI should: • Identify and assess the business impact of gaps in stock records and departures from Gavi Targeted Software Standards across the country's vaccine supply chain. • Reinstate manual stock ledgers at locations whose vaccine and dry goods stock records currently rely solely on eSMT, prioritising those sites whose eSMT records are either incomplete or whose availability of eSMT is adversely affected by infrastructure limitations. Over the longer term, and with oversight and input from the ICC, the MoHS should develop a national digital health system strategy with the primary purpose of guiding the rational selection, integration, implementation and sustainable ownership costs of all digital public health information and communication technology. This strategy should consider: • Human capacity and costs horizontally and transversally across public health to ensure sufficient, timely input into determining needs, systems design and scope, user acceptance testing, deployment, training, and recurring usage of any new systems being considered by the MoHS. • Ease of integrating or, at a minimum, connecting platforms such as HMIS, eLMIS, logistics management, human resource planning, disease surveillance, etc.	**Action 12** Sierra Leone has previously implemented the electronic Stock Management Tool (eSMT) to support vaccine stock management and temperature monitoring. While eSMT initially improved visibility and reporting, system performance challenges emerged over time, including system instability, limited scalability, and sustainability concerns, which affected reliability and user confidence. The country arrived at a decision to switch from eSMT to m-Supply in Q1 2026. Stock ledgers have been provided for each antigen at National and District level Sierra Leone had previously implemented the electronic Stock Management Tool (eSMT) to support vaccine stock management and temperature monitoring. While eSMT initially improved visibility and reporting, system performance challenges emerged over time, including system instability, limited scalability, and sustainability concerns, which affected reliability and user confidence. The country arrived at a decision to switch from eSMT to m-Supply in Q1 2026.	Logistic and Supply Chain Team Lead	31 December 2026

DHIS2 implementation needs strengthening	Recommendation 13 MoHS technical teams in consultation with partners should: • Develop and implement formal protocol for DHIS2 version management, including scheduled reviews, user acceptance testing, and migration to the latest stable releases. • Implement a process for regular review and timely update of all DHIS2-integrated tools, including the WHO data quality tool. Engage with WHO and technical partners to ensure the platform benefits from the latest features and security enhancements. • Conduct a technical review of DHIS2 server configurations and session management settings. Implement monitoring tools to proactively detect performance issues and communicate clear error messages with guidance to users.	**Action 13** EPI will work with DPPI for the popularisation of DHIS2 protocol EPI will work with DPPI and partners to ensure DHIS2 is regularly updated to latest version The national EPI program will continue to monitor data reported in DHIS2 on immunisation to maintain highest quality at all time.	M&E Team Lead EPI and Director DPPI	31 December 2026
Weaknesses in immunisation data management	Recommendation 14 To improve immunisation data management and quality, the EPI should: • Use bottom-up microplanning and campaign data, including zero-dose analyses, to generate more accurate service-level denominators for administrative coverage reporting. • Advocate for realistic national denominator adjustments through the TWG and the ICC, ensuring alignment with actual population estimates from the last census, door-to-door and outreach immunisation activities. • Ensure uninterrupted availability of official data collection tools at PHU across the country, for example by including this as a recurring action item at monthly DHMT meetings. • Prioritise key activities in the DQIP based on available funding, focusing on interventions with the greatest impact on data accuracy and use.	**Action 14** The EPI has just concluded a bottom up micro planning across the country. The micro planning data will be validated with the district leadership, community stakeholders, ministry leadership and partners. The program is intending to use the micro planning. EPI will continue to work with partners to ensure regular bottom-up microplanning is conducted every two years. EPI will continue to use the statistics provided by Sierra Leone population authority for routine immunisation denominators. EPI will work with DPPI and other partners to ensure printing of HMIS tools Activities not implemented in the DQIP will be prioritised in the NIS based on funding availability.	M&E Team Lead	31 December 2026

Gaps in financial internal controls resulting in questioned expenditure	Recommendation 15 To ensure visibility and accountability for Gavi support, MoHS/EPI through IHPAU should: • Require all DHMT to adopt and adhere to national financial record-keeping and audit requirements/legislation. • Foster compliance with standards governing financial record-keeping at the EPI and at DHMT through supportive supervision.	**Action 15** EPI will organise annual training for key stakeholders i.e. vote controllers and program staff at DHMT on the national financial record keeping and audit requirement and popularise the Joint Financial Management Handbook. The EPI/IHPAU/MoHS will conduct a joint integrated supervision to support the district finance team in terms of compliance with the standard governing financial record-keeping. Establish and enforce timeline inline with the Joint Financial Management Handbook	Deputy Team Lead IHPAU and Senior Accountant IHPAU	31 December 2026
	Recommendation 16 In compliance with the goal to use country systems, and to foster financial management capacity building, Gavi should channel funding to DHMT through IHPAU. This decision should be taken after alignment of the existing financial management capacity building TA and the role of the AP expanded to include a sample of subnational level expenditure review. This will improve the visibility of Gavi funds at national level.	**Action 16** The TA and the Assurance Provider were embedded in the last quarter of 2024 in supporting capacity building and financial monitoring. Going forward the TA and Assurance Provider will continue to review all disbursement requested from IHPAU to DHMTs.	Deputy Team Lead IHPAU and Senior Accountant IHPAU	30 June 2026

Inadequate accounting, programme finance management and procurement practices at IHPAU	Recommendation 17 To improve financial management, IHPAU should: • Finalise recruitment of qualified accountants to manage Gavi support. • Train staff and implement the SunSystems as the financial management TA is already availed to provide training and capacity building through Gavi support. • Establish a performance framework for Gavi supported personnel, with appropriate supervision and oversight by senior management at IHPAU. • Comply to established national procurement protocol through the NPPA. • Establish contract management guidelines for future Gavi support	**Action 17** The first bullet point of this recommendation has been completed. Recruitment has been completed for qualified accountants and the staff is in position. An initial training was done but due to the new recruitment there is a need for another training All procurement process follows the National Procurement Guidelines. The core finding is accepted that certain procurement activities were expedited without adequate justification or adherence to established controls, thereby increasing operational and compliance risk. Our analysis confirms that the primary drivers included urgent operational requirements, staffing capacity in meeting Assurance Provider requirements, and gaps in planning coordination. The corrective action plan is built on three pillars: (1) Immediate remediation of specific instances related to the urgent procurements, (2) Strengthening of policies and controls, and (3) Enhancing staff competency and planning discipline. The EPI/IHPAU management will require and document formal justification for all "urgent" procurements, with mandatory pre-approval by a designated authority. EPI/IHPAU will implement a quarterly review by management of all expedited procurements to identify systemic planning issues. EPI/IHPAU will establish mandatory training on procurement policies for all staff involved in the requisition process, and align with DT Global for standardised requirements for Program Implementation requests/procurement requisitions to improve the quality of documentation and reduce delay in seeking necessary approvals. We would like GAVI to approve liaising with NPPA and DT Global to develop and launch a mandatory procurement certification course for all budget holders and project managers. Systemic Improvements Beyond the specific recommendations, EPI is initiating the following cross-functional improvements: · Integrated Planning Calendar (Annual Work Plan): Establishing an organisation-wide planning calendar to align budget, procurement, and project timelines. · Vendor Prequalification Rosters (Framework Contracts): Developing rosters for commonly procured goods/services to	EPI manager, Team Lead and Deputy Team Lead IHPAU, Procurement Officer	30 June 2026

		expedite legitimate competitions, and to utilise existing framework contracts within IHPAU, optimising the one IHPAU policy. Sound contract management polices will be established with clear timelines for deliverables, expectations, outcomes and payment processes including quarterly supervision of the agency/contractor.		