SEVENTY-SEVENTH WORLD HEALTH ASSEMBLY
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Report of the External Auditor

Report by the Director-General

The Director-General has the honour to transmit to the Seventy-seventh World Health Assembly the report of the External Auditor on the financial operations of the World Health Organization for the financial year ended 31 December 2023 (see Annex).

ANNEX

Office of the Comptroller and Auditor General of India

SUPREME AUDIT INSTITUTION OF INDIA

लोकहितार्थ सत्यनिष्ठा

Dedicated to Truth in Public Interest

Our audit aims to provide independent assurance and to add value to the World Health Organization (WHO) by making constructive recommendations.

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Audit of the World Health Organization (WHO) for the Financial Year ended 31 December 2023

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SUMMARY

The report of the External Auditor

1. The report of the External Auditor on the audit of the financial statements and operations of the World Health Organization (WHO) is issued pursuant to Regulation XIV of the Financial Regulations of WHO and is transmitted through the Executive Board to the Seventy-seventh World Health Assembly.

2. The general objective of the audit is to provide independent assurance to Member States, increase transparency and accountability as well as operational efficiency and effectiveness in the Organization, and to support the objectives of the Organization's work through the external audit process. We have detailed in this report the financial and governance matters that we believe should be brought to the attention of the World Health Assembly.

Overall result of the audit

3. In line with our mandate, we audited the financial statements of WHO in accordance with the Financial Regulations and in conformity with the International Standards on Auditing (ISA) issued by the International Auditing and Assurance Standards Board (IAASB).

4. We concluded that the financial statements present fairly, in all material respects, the financial position of WHO for the financial year ended 31 December 2023, and its financial performance, the changes in net assets/equity, the cash flows, and the comparison of budget and actual amounts, in accordance with the International Public Sector Accounting Standards (IPSAS). Based on our conclusion, we issued an unqualified audit opinion on the Organization's financial statements for the financial year ended 31 December 2023.

5. We also concluded that the accounting policies were applied on a basis consistent with that of the preceding year, and the transactions of the WHO that have come to our notice during the audit or that have been tested as part of the audit of the financial statements were, in all significant respects, compliant with the Financial Regulations and legislative authority of the WHO.

6. In addition to the audit of financial statements at WHO headquarters, we also conducted audits of the WHO Regional Office for Africa (AFRO), Brazzaville, WHO Country Office, Congo (WCO Congo) and WHO Country Office, Nigeria (WCO Nigeria). To add value to WHO's financial management and governance, we conducted performance audits of (i) WHO supply chain management with focus on long-term agreements, shipping and transport management system; (ii) data management of the World Health Organization and (iii) emergency preparedness and response mechanism in WHO. The results of the audit on these areas and offices were communicated to WHO management through management letters and are incorporated in this report.

7. I wish to thank the Member States for giving me the opportunity of serving as the External Auditor of WHO.

Audit opinion

8. We have issued an unqualified audit opinion on the financial statements for the period under review.

EXECUTIVE SUMMARY

9. Our analysis of the financial statements and compliance checks, carried out during the financial cum compliance audit, an extensive exercise conducted from September 2023 through March 2024 suggested to the Organization measures to strengthen its compliance to IPSAS; for instance, we noticed that the accounting policy was not being consistently applied in line with provisions of "IPSAS 31 on intangible assets" and based on our observation the changes in the statements were carried out. We noticed instances of expired items in our study of inventories and recommended that this disposal be prioritized by the Organization. Apart from this, we reviewed the resource mobilization efforts of the Organization, as well as its procurement processes and identified issues related to delays in deliveries. We studied the accountability checks in place, particularly the status of the investigations and the Framework of Engagement with Non-State Actors and made recommendations thereon.

10. The performance audit of supply chain management focused on long-term agreements (LTAs) entered into for purchase of goods, the management of shipping, including freight services and the upcoming transport management system (TMS). LTAs increase the efficiency of procurement by decreasing bidding time and administrative costs for frequently purchased goods, while ensuring price stability. As it was observed that the percentage of catalogue goods procurement during 2020–2023 was low, at only a 4.26%, a recommendation to enhance reliance on LTAs by developing a centralized procurement plan, across the three levels of the Organization, has been made. The TMS was envisaged to integrate the complete supply chain, from initial forecasting and up to last-mile delivery and reporting along with synchronization with the business management system (BMS). Wave one of BMS with TMS was made operational from May 2023 in ten countries as a pilot. The objective of the audit exercise was to assess the performance of this pilot and recommend measures for improving the software. It is to this end that we recommended improving the data quality, timely updating of data, monitoring to ensure completeness of data through management information systems (MIS) and enhancing the details being captured in TMS, to the extent feasible.

11. We carried out a performance audit of data management at WHO to assess the effectiveness of the governance framework in relation to data management, the linking of data with digital working and the presence of adequate safeguards for data security and protection of privacy. We observed that, thus far, the funding support (other than staff costs) has primarily been from "in-kind and financial contributions from donors" and the World Health Data Hub (WHDH) was yet to be accorded priority resource allocation in the budget. We noticed that while certain components of the WHDH had been rolled out, their utilization by the technical groups was as yet limited. The incomplete components included the country portal (data collections), data calendar and the catalogue. Thus, the goals of elimination of fragmentation of data and reduction in the Member States' reporting burden have yet to be completely realized. It was also seen that, in order to establish a linkage between the generation of data and its impact on the work of the Organization, the acceptance or otherwise of the intervention priorities (accelerated scenarios/stock takes) required documentation and the results of the Delivery for Impact Division (under the WHO Division of Data, Analytics and Delivery for Impact (DDI)) required integration into the budget module of the new enterprise resource planning (ERP) i.e., BMS, being implemented by WHO. We recommended that the data protection policy, approved by the Data Governance Committee (DGC), be implemented as personal identification information was beginning to be collected by various technical units.

12. The COVID-19 pandemic brought into prominence lead role of WHO as a global agency involved in health emergency operations by providing technical leadership in epidemiological research, vaccination development and administration, as well as leading field operations for managing COVID-19 response. For WHO to continue to play a lead role in directing global efforts for

strengthening preparedness and effective emergency response, it needed to be equipped with adequate resources, strengthened mandate and robust procedures corresponding to its Emergency Response Framework. Through the performance audit, we assessed the emergency response operations of WHO for selected emergencies which revealed that emergency health surveillance, a key component for triggering WHO's emergency response, required a focused strategy on matters like sources, coverage, minimum standards of data collection and frequency of reporting. We noted that WHO's procedures, such as carrying out rapid risk assessments and procedures related to activating the Inter-Agency Standing Committee (IASC) level 3 activation procedures, for informing the United Nations Secretary-General of graded emergencies, as well as procedures for declaring health events as public health emergencies of international concern required adherence to timelines and documentation. Further, it was evident that the impact of WHO's vaccination partnerships, like COVAX and the International Coordination Group on Vaccine Provision (ICG), faced challenges on account of limited capacity of health systems of countries and shortage in required levels of funding.

A. MANDATE, SCOPE AND METHODOLOGY

13. The Seventy-second World Health Assembly, through resolution WHA72.11 (2019), appointed the Comptroller and Auditor General of India as the External Auditor of WHO for the four-year period 2020–2023. Regulation XIV of the Financial Regulations of WHO and the Appendix elaborate the terms of reference governing the external audit. The regulations require that the External Auditor report to the World Health Assembly on the audit of the annual financial statements and on other information that should be brought to its attention with regards to Regulation 14.3 and the Additional Terms of Reference.

14. Our audit is an independent examination of the evidence supporting the amounts and disclosures in the financial statements. It also includes an assessment of WHO's compliance with Financial Regulations and legislative authority.

15. We also carried out a review of WHO operations consistent with Financial Regulation 14.3, which requires the External Auditor (EA) to make observations with respect to the efficiency of the financial procedures, accounting system, internal financial controls, and in general, the administration and management of WHO operations.

16. Likewise, we conducted an audit on the financial statements and operations of the five WHO hosted entities, namely, the Joint United Nations Programme on HIV/AIDS (UNAIDS); the United Nations International Computing Centre (ICC); the International Agency for Research on Cancer (IARC); UNITAID; and the Staff Health Insurance (SHI) Fund. Separate reports on these entities are issued to the governing body.

17. Overall, the audit intends to provide independent assurance to Member States, increase transparency and accountability as well as operational efficiency and effectiveness in the Organization, and support the objectives of the Organization's work through the external audit process.

18. With respect to the review of WHO operations based on our risk assessment, we focused on the assessment of risk controls in the operational and functional processes in the audited areas and offices. We also reviewed the governance arrangements, implementation of risk management including the internal control systems and processes to determine their effectiveness.

19. During the financial year 2023, aside from the audit of the financial statements at headquarters, we audited the WHO Regional Office for Africa (AFRO), Brazzaville, WHO Country Office, Congo (WCO Congo) and WHO Country Office, Nigeria (WCO Nigeria) as well as conducted performance audits of (i) WHO supply chain with focus on long-term agreements, shipping and transport management system; (ii) audit of data management of the World Health Organization and (iii) emergency preparedness and response mechanism in WHO.

20. This report does not include any comments on the financial statements of the Pan American Health Organization (PAHO), the Regional Office for the Americas, which are being audited by the National Audit Office (NAO) of the United Kingdom. We placed reliance on their audit based on the Comfort Letter. The National Audit Office of the United Kingdom informed us their audit of 2023, thus far, has not detected any material errors, misstatements or any other matters that would adversely affect the audit opinion on the PAHO financial statements.

21. We coordinated with the Office of Internal Oversight Services (IOS) on the planned audit areas to avoid unnecessary duplication of efforts.

22. We continued to report the audit results to WHO management through audit observation memoranda and management letters containing detailed observations and recommendations. We issued 10 audit management letters to the WHO heads of offices and hosted entities during the financial year 2023. The practice provides a continuing dialogue with WHO management.

B. AUDIT FINDINGS AND RECOMMENDATIONS

1. Status of Implementation of previous external audit recommendations

23. There were 97 outstanding recommendations up to the period ending 31 December 2023, of which management proposed 50 for closure. We examined and noted that 31 recommendations had been implemented, one was overtaken by events and others were either pending to be implemented or under implementation. As of 31 December 2023, 65 old recommendations were outstanding. Details of recommendations are given in **Appendix 1.**

2. Financial Overview

24. WHO's revenue has been increasing over the last five years, from US$ 3.12 billion in 2019 to US$ 3.34 billion in 2023. Revenue for 2023 saw a decrease of US$ 1.01 billion compared to 2022 (US$ 4.35 billion). The decrease in revenue was due to the decrease in voluntary contributions by US$ 0.91 billion as compared to 2022.

25. Assessed contributions, in terms of proportion to total revenue, have shown a declining trend, from being 16% of the revenue[1] in 2019 to 15% of the revenue in 2023. On the other hand, voluntary contributions have increased from 80% of the revenue in 2019 to 82% of the revenue in 2023.

26. Expenses were 123% of revenue in 2023 as compared to 88% in 2022. Contractual services, which constituted the biggest item of expense, showed an increase from 31% of the total revenue in 2022 to 48% of the total revenue in 2023. Staff costs, which constituted second highest item of expense, showed an increase from 27% of the total revenue in 2022 to 37% of the total revenue in 2023. The expenses on travel increased by 43% to US$ 231 million in 2023 from US$ 161 million in 2022.

27. As at 31 December 2023, the total assets of WHO were US$ 7.23 billion, a decrease of US$ 0.58 billion as compared to 31 December 2022. The decrease was mainly due to the decrease in short-term investments and cash and cash equivalents. Short-term investments decreased by US$ 424 million, accompanied by a decrease of US$ 105 million in cash and cash equivalents. As a percentage of the total assets, they remained at a similar level as the previous year.

28. Liabilities of WHO decreased by US$ 0.09 billion, mainly due to reduction in the accrued staff liabilities (non-current) by US$ 0.09 billion.

[1] The figures are based on common size analysis of the financial statements. For comparison, all items of the statement of financial performance and financial position are taken as a percentage of revenue and total assets respectively.

3. Financial management

29. The following ratio analyses were used to assess the financial management of WHO:

3.1 Short-term Solvency

30. We analysed the liquidity position of WHO to assess its ability to meet its short-term commitments or operating needs and observed that it has been sound in last five years. The quick ratio and current ratios have been showing a comfortable position with both being more than three times current liabilities (**table 1**).

Table 1

	2023	2022	2021	2020	2019
Quick ratio (quick assets/current liabilities)	3.38	3.58	3.32	2.93	2.75
Current ratio (current assets/current liabilities)	3.48	3.68	3.48	3.05	2.82

3.2 Operating cycle efficiency

31. The operating cycle efficiency was assessed in terms of how fast WHO was able to:

- collect its contributions receivables.
- utilize its inventory or materials purchased.

32. The contribution receivable ratio for the last five years is shown in **table 2**, below:

Table 2

	2023	2022	2021	2020	2019
Contributions recognized[1] (US$ millions)	3 239.82	4 152.34	3 914.52	4 170.17	2 982.11
Average contribution receivables (current)[2]	1 500.75	1 424.34	1 304.62	1 244.88	1 153.89
Contribution receivable ratio	2.16	2.92	3.00	3.35	2.58
Number of days taken to encash receivables	169	125	122	109	141

33. The decrease in receivable ratio indicates that collection of contributions was slower as compared to previous years. The time to collect receivables was 169 days in 2023 as compared to 125 in 2022. This is further corroborated by the fact that current receivables as on 31 December 2023, have increased in the last four years. Current receivables were 20% of total assets as on 31 December 2023 and also as on 31 December 2022.

34. Inventory turnover ratio and days in inventory for the last five years are shown below (**table 3**):

[1] Excluding voluntary contributions in-kind and in-service.

[2] Average of opening and closing balances of current assessed contributions and current voluntary contributions.

Table 3

Sl No	Description	2023	2022	2021	2020	2019
(1)	Procurement of materials (US$ millions)	329.71	511.08	497.30	523.59	259.39
(2)	Inventory Opening Balance (US$ millions)	178.29	190.43	144.32	59.19	37.47
(3)	Inventory Closing Balance (US$ millions)	170.29	178.29	190.43	144.32	59.19
(4)	Average inventory (US$ millions)	174.29	184.36	167.38	101.75	48.33
(5)	**Inventory turnover ratio**	**1.89**	**2.77**	**2.97**	**5.15**	**5.37**
(6)	**Days in Inventory**	**193**	**132**	**123**	**71**	**68**

35. Expenditure on "medical supplies and materials" saw a decrease in 2023 as compared to 2022. Average inventory held by WHO as on 31 December 2023 was lower as compared to the previous year (2022). The average number of days for which the materials were in inventory was 193 days in 2023 as compared to 132 days in 2022.

4. Changes made in the financial statements at the instance of Audit

36. The following observations were accepted by management and necessary adjusting entries/disclosures were made in the financial statements:

(i) WHO expensed US$ 10.47 million hitherto disclosed as "software under development", in line with accounting policy to expense expenditure on cloud-based software used on a subscription basis and not controlled by the Organization.

(ii) WHO added a disclosure to Note 2.1 and made necessary corrections at Note 4.12.

4.1 Changes agreed to be carried out in 2024

37. WHO agreed to review the current accounting policy on intangibles in 2024 to align with provisions of "IPSAS 31 on intangible assets".

5. Areas for potential enhancements in accounting systems, policies and practices

38. We noted the following areas which merit a review for effecting improvements in accounting systems, policies and practices being followed presently:

5.1 Property, Plant, and Equipment

39. As per paragraph 67 of IPSAS 17 – Property, Plant, and Equipment, the residual value and the useful life of an asset shall be reviewed at least at each annual reporting date and, if expectations differ from previous estimates, the change(s) shall be accounted for as a change in an accounting estimate in accordance with IPSAS 3, Accounting Policies, Changes in Accounting Estimates and Errors.

40. We noticed that WHO had 3321 Fixed Assets, having a total purchase cost of US$ 74 million, that were still in use beyond their useful life. Accordingly, the reason for not reviewing the useful life of assets was requested. WHO stated that it shall consider suitably updating the depreciation policy of WHO. The acceptance of WHO to align its policy as per IPSAS 17 and IPSAS 3 has been noted and compliance shall be checked by Audit in the next financial year.

5.2 Other issues

41. As per Note 1 to the financial statements, the financial statements of the WHO are to be prepared on accrual basis of accounting. We noticed, during examination of special service agreements (SSA) for contractual services, that a salary of US$ 21 555 pertaining to the period 2023 was actually paid and accounted for in the year 2024, without accrual being made in the year 2023. WHO, while confirming non-accrual of US$ 21 555, stated that this provision could not be created for lack of timely action on the part of the country/regional offices.

Recommendation 1: A close monitoring of the accruals by the country offices and regional offices is needed to ensure that accruals are made in a timely fashion. (Medium)

42. Management accepted the recommendation.

43. Note 4.6 to the financial statements, stipulates that prepayment represents payments to suppliers in advance of the receipt of goods or services. When goods or services are delivered, prepayments are applied to the appropriate expense account. We noticed, during a test check, that prepayment of US$ 134 393 made by WHO to suppliers for three purchase orders (POs) was not adjusted, though the respective material/services had been received by WHO as on 31 December 2023.

44. WHO also confirmed that services/goods were delivered in year 2023 amounting to US$ 134 393 against these prepayments, however, necessary adjustment to the appropriate expense account had not been carried out.

5.3 Prior period items

45. While reviewing the addition to plant and equipment during 2023, we noticed that an error pertaining to the year 2022 was corrected in 2023 for US$ 56 400. This is a prior period error. While acknowledging the error, based on materiality grounds, WHO proposed not to restate the 2022 figures for this item.

46. We observed that the imprest cash account of a country office did not match/tally with GL balances as at 31 December 2023 and remained unreconciled. A transaction of US$ 19 891.39 (value in 2011) kept on rolling over for the past 12 years. WHO stated that the debit of US$ 19 891.39 to this imprest account related to exchange loss on cash disbursement and not an actual cash disbursement by UNDP.

47. WHO confirmed this and made a corrective entry in 2023.

Recommendation 2: We recommend that WHO ensures that year-end bank reconciliations provide full details of all items reconciled and discrepancies, if any between the cash certificate and the corresponding cash book balance (as per the general ledger) or imprest account (as per the general ledger), are explained in full. (Medium)

5.4 Inventory management

5.4.1 Expired inventory

48. A significant portion of inventory in WHO consisted of items with limited shelf life. We noted that WHO had a stock of 450 expired items valuing US$ 21.52 million as on 31 December 2023. Out of

this stock, 162 items valuing US$ 17.56 million (82%) pertained to the inventory centre-headquarters including 79 vaccines **(Appendix 2)** valuing US$ 15.34 million and 84 items of other consumables valuing US$ 2.22 million. The expired inventory of vaccines included 68 polio vaccines valuing US$ 15.34 million, which had expired during the period August 2023 to December 2023. No guidance/instruction was available to suggest ways to avoid/minimize expiry of inventory.

49. We also observed that 82 items valuing US$ 15.47 million were stored in warehouses outside Switzerland. It is important to note that section 3.1, along with 10.2 and 10.3 of standard operating procedure (SOP) XIII.001 – Inventory transactions and reporting, stipulate that WHO headquarters is responsible for review of record of all movements in and out of each warehouse, receipts and disposals for financial reporting purposes. WHO headquarters did not have a plan of action for disposal of expired inventory as per the laws of the respective countries.

50. While we appreciate WHO's efforts for initiating disposal of stocks at Yemen and Dubai based on the recommendation made by the External Auditor during 2022, we emphasize the necessity for a graded approach to accelerate the disposal of the remaining expired stock.

Recommendation 3: WHO expedite disposal of expired items following a graded approach, starting with warehouses holding maximum proportion of expired items while factoring in the method and cost of disposal prescribed by the laws of the respective countries where they are stored. (Medium)

5.5 Resource mobilization

5.5.1 Donor reporting

51. The SOP for reporting to donors is part of financial SOP IV.010 under paragraph 7, Reporting to donors. As per the reports due to donors (quarter 4 of 2023 – issued on 12 February 2024), donor reporting (particularly timeliness and quality) has been highlighted by donors, Member States and the External Auditors as an area requiring improvement.

(i) We noticed that as at 31 December 2023, a total of 645 reports were overdue (out of 4003) compared to 661 (out of 4243) as at 31 December 2022.

(ii) Further, out of the 4003 reports to be submitted, overdue reports were 645, and reports submitted late were 1399. The percentage of reports which were overdue and late was 51%. Out of these, 753 reports (37%) pertained to WHO headquarters.

52. WHO stated that a technical unit might need to submit multiple reports in varying formats and deadlines to comply with donor agreements leading to delay. Further, efforts to enhance donor reporting are underway, and that the number of final certified reports (final certified financial statements) produced in 2023 increased by 26% over 2022.

Recommendation 4: WHO should strive to implement necessary measures, in a time-bound manner, to enhance donor reporting efficiency. (High)

53. Management accepted the recommendation.

5.5.2 WHO Foundation

54. WHO entered into an affiliation agreement (the Agreement) (27 May 2020) with WHO-Foundation (WHO-F), a non-profit charitable organization, with the main purpose to strengthen and support WHO's general programme of work. The Agreement was based on a business case[1] outlining the objectives, fundraising strategies, projections, donor categories and fund-sharing details. We observed that against the envisaged fund raising of US$ 1.020 billion in three years of operation, WHO-F could only raise US$ 68.88 million with a shortfall of US$ 951.12 million. WHO-F did not raise any funds in 2020. The funds raised between 2021 and 2023 ranged from 0.43% to 14.12% of the projections. During 2023, against US$ 510 million, only US$ 2.21 million could be raised with a shortfall of US$ 507.79 million. We also observed that the funds transferred by WHO-F to WHO constituted less than one per cent of the voluntary contributions received by WHO.

55. WHO stated that the business case set aspirational targets during the peak of the 2020 COVID-19 pandemic which may have led to unrealistic expectations. The WHO-F Board acknowledged the need to revise the targets outlined in the business case.

56. The Agreement further envisaged constitution of a WHO-WHO-F planning and coordination committee, which was required to meet on a quarterly basis, but such meetings were not held quarterly as envisaged. Also, annual evaluation of performance of both the parties against the approved joint strategic plan (JSP) was not done as required. WHO accepted that the JSP was finalized only in December 2023 and prior to JSP, discussions were held on an informal basis.

57. As per the business case and Agreement, WHO-F was to create an endowment fund to provide a long-term sustainable and unrestricted funding stream for WHO. WHO accepted that no endowment fund was created.

58. The Agreement also provided that WHO-F shall not seek or accept funding from entities that have or can provide funds directly to WHO, except where exceptional approval has been obtained (paragraph 11.3 of the Agreement). We observed that funds were raised by WHO-F from one of the major donors to WHO. We did not find any specific exceptional approval. WHO stated that the approvals were based on discussions and the authorization was verbal and not documented.

Recommendation 5: We recommend that WHO-F adhere to prescribed procedure in all cases of fund-raising from donors. (High)

5.6 Grant management and direct implementation

59. Transfers and grants to contractual partners by WHO include grants provided to national counterparts (direct financial contribution (DFC)) and letters of agreement signed with other counterparts (grant letter of agreements (GLOA)) and through direct implementation (DI), to perform

[1] The business case is the product of consultations with members of the advisory group convened to provide a strategic guidance around establishment of WHO Foundation.

activities that are in line with Organization's objectives. During the year 2023, WHO incurred an expense of US$ 156.09 million towards DFC, US$ 98.90 million towards GLOA and US$ 414.71 million towards DI.

60. As per the Financial SOP[1] of WHO, the final deliverables, i.e. DFC report, GLOA report, DI report, consisting of two parts, viz., technical report and funding authorization and certification expenditure (FACE) report, is required to be submitted within 3 months of completion of activity.

61. We noticed that in the case of DFC, against 86 POs (February 2024), valuing US$ 22.80 million having expenditure of US$ 22.70 million, there were overdue reports with delays ranging from 2 to 2804 days. In GLOA, in 122 POs (February 2024), valuing US$ 24.50 million having expenditure of US$ 20.96 million, there were overdue technical and financial reports with delays ranging from 3 to 2347 days. In DI, against 216 POs (February 2024), valuing US$ 7.20 million having expenditure of US$ 5.71 million, there were overdue reports with delays ranging from 2 to 2530 days.

62. Management attributed delays to reasons such as late issuance of reports by grantee, disagreements between the managing units and grantee, omission of recording receipts of initial POs, incorrect contact details of beneficiaries, etc.

63. While we note the difficulties in obtaining technical and financial reports for activities, especially in affected areas, it is imperative that WHO coordinate with the budget centres to ensure timely reporting and consequent receipt of refunds.

Recommendation 6: WHO should ensure that the budget centres carry out continuous monitoring, especially for regions/WCOs with highest pendency of reports, to enable timely refunds and completion of envisaged activities. (High)

64. Management accepted the recommendation.

5.7 Procurement of Materials and Supplies

5.7.1 MoU with UNICEF

65. During the review of MoUs with UNICEF for polio vaccines/medicines, we noticed delays of 6 to 340 days, in 36 out of 51 POs placed with UNICEF between January 2021 and December 2023, for delivery of medicines and polio vaccines.

66. In eleven Purchase Orders valuing US$ 30.64 million, there were delays of 105 to 272 days. The delayed supply of critical vaccines and medicines by 4–5 months was mainly due to unilateral renegotiation of the existing MoU by UNICEF insisting on prepayment, time consumed in the process of internal approvals of WHO, delay by UNICEF in placing contracts on vendor, delay by WHO in placing order and issues originating at the manufacturers end, etc.

[1] Para. 3.5 of FIN.SOP.XVI.001 of DFC; para. 2.12 of FIN.SOP.XVI.003 of GLOA; and para. 2.5 of FIN.SOP.XVI.002 of DI.

67. WHO in reply stated that henceforth as per the new arrangements, it would no longer be placing orders with UNICEF for polio vaccines. However, delays were pointed out in cases of procurement of medicines and other medical supplies as well, to which no response has been provided by WHO.

Recommendation 7: WHO should develop a mechanism to monitor the purchase orders placed on UNICEF for timely delivery of medicines and other medical supplies. (Medium)

5.7.2 Cancellation of POs for contractual services

68. We noticed that WHO headquarters cancelled 267 POs amounting to US$ 7 358 966 between 1 January 2023 to 31 August 2023, for different reasons such as inability of the supplier to carry out the work, refusal of supplier to sign the terms and conditions, expiration of awards etc. We also noticed that in 62 POs, the time taken to cancel the PO ranged from 104 days to 512 days from the date of issue of PO. Further, out of these, in respect of five POs, the delay ranged from 432 to 512 days.

69. Management stated that whereas WHO can issue the PO to the successful vendor after completion of the procurement process, the vendor has the right to accept the offer or reject it depending on the circumstances and cancellation of POs are to be done by the responsible task holder.

Recommendation 8: WHO may strengthen the guidance to technical officers and budget centres to ensure timely initiation of cancellation requests. (Low)

5.7.3 Non closure of POs

70. As per paragraph 2.2 of the WHO procurement manual, it is to be ensured that the contract is closed (including the closure of the purchase order in the system) when delivery of goods is completed and supplier evaluation is carried out. Final closure of POs is an important step in the financial management process at WHO, whereby unutilized funds are returned to the relevant budget and become available for utilization in other relevant work plans. It also facilitates the provision of accurate and complete financial reports to donors.

71. We reviewed the service-related POs of WHO headquarters for the period 1 January 2023 to 31 August 2023. We noticed that in 411 POs, where service deliveries had been completed as of 31 August 2023 (1 to 21 days) and in five specific POs, the records reflected status of these POs as open.

72. Management explained that it is crucial to recognize that POs can only be closed once all deliverables are fulfilled and payments settled. It also stated that premature closure may necessitate creating new POs to address remaining balances, as the PO closure process is irreversible.

Recommendation 9: We recommend that the extant provisions regarding closure of POs be adhered to rigorously to facilitate the transfer of remaining funds to other projects before the expiration of donor agreements. (Low)

5.7.4 Rejection of purchase requisition

73. We found that a total of 559 purchase requisitions (PRs) were rejected during the period 1 January 2022 to 31 August 2023 for reasons such as attachment mismatch with PR details, activity not having taken place, incorrect mandatory deliverable, mandatory documents not provided, supplier unable to carry out the contract, incorrect contract type, etc. Of these, 39 PRs amounting to US$ 871 861

were cancelled due to the supplier being unable to carry out the contract. Out of these 39 contracts, in six cases amounting to US$ 78 518, the work was of emergency nature.

74. Management replied that these cases involved individual consultants that do not fall under procurement directly but under Human Resources Department and procurement rules and guidelines would not apply for such PO.

75. While the distinct role and jurisdiction of Human Resources Department and Procurement and Supplies Services Department (SUP) with respect to individual consultants is noted, there is a need to develop a framework/mechanism to minimise rejections of PRs pertaining to individual consultants under the jurisdiction of Human Resources Department.

Recommendation 10: We recommend that WHO may consider the creation of a centralized data repository, for services POs, to allow oversight on status of deliveries, efficient resource management and effective implementation of policies and procedures. (Medium)

5.7.5 Retroactive approvals

76. As per paragraph 1.2.2 of the guidance note on procurement of services, it is not allowed to submit a PR after the supplier has started work on the service. However, in exceptional and operationally justified POs, a service registration may be submitted retroactively. Hence, retroactive approvals are required in situations where the services have been rendered and goods have been received without the proper award and issuance of a contract. Such contracts undermine the transparency of the procurement process and can pose a legal risk to the Organization. We test checked retroactive approvals for 29 POs (each more than US$ 250 000) with a total value of US$ 21.58 million for procurement of services by WHO between January 2022 and October 2023, and found that the reasons cited fell under broad categories like delay in seeking approvals, delays in internal processing, shortage of funds, system errors etc.

77. Management agreed that retroactive approvals could have been avoided in some cases.

Recommendation 11: WHO may monitor the use of this provision and justify its application in every instance. (High)

5.8 Accountability systems

5.8.1 Status of investigation function

78. The Office of Internal Oversight Services (IOS) provides investigation services at WHO. The complaints or “reports of concern” received from staff and/or various other sources are first examined by an intake committee, followed by a preliminary review and full investigation, depending on the case. The investigation report and closure letters are submitted by IOS to the administrative authorities for necessary action.

79. IOS maintains a case management system (CMS) to record and monitor the progress made on the complaints/reports. We reviewed the complaints data from the CMS for the last six years and noted that there had been an increasing trend of complaints received over the last six years, with a rise of around

50% during 2023. A total of 1860 complaints[1] were recorded in years 2018 to 2023, out of which **1225 complaints have been closed as at March 2024.** Out of these, 136 cases were closed with an investigation report, 125 cases with a case closure report, 831 cases were closed at different stages in the entire process of investigation. In 133 cases, the method for closure was not available.

80. WHO informed that in March 2023, IOS changed the basis for case prioritization from "risk severity" to "priority levels", for which the SOP was issued on 23 August 2023. The SOP details the procedure for case prioritization and requires that allegations are given a preliminary priority at intake. After the "intake" stage, these cases are classified as cases for "preliminary review", "quality assurance", "report writing", "case closure" and "monitoring".

81. As per the information provided by WHO, there are 636 cases pending at different stages between the preliminary review and monitoring stages as of March 2024. Out of these, in 260 cases prioritization was not done (251: preliminary prioritization stage, 2: case closure and 7: monitoring). Further, out of these 260 cases, 237 cases were at "preliminary review" stage, and for these cases, the preliminary review deadline was not met for various reasons. Although the case prioritization SOP was issued on 23 August 2023, we noted delays in its implementation. Specifically, 119 out of these 237 cases from August 2023 to December 2023 missed the preliminary review deadline. WHO replied that a risk level will be assigned at the conclusion of the preliminary review.

82. To ensure adherence to prescribed timelines, close monitoring and enforcement is imperative.

83. We noticed that WHO did not have any provision for linking the pendency of any allegation and/or allegation being at any stage of investigation, with the staff separation process. Management stated that the development of such provisions is currently being considered as a part of the establishment of the misconduct incident management system (a new tracking platform for investigation and disciplinary cases).

Recommendation 12: WHO should prioritize cases where preliminary review deadlines are not met, establishing both priority levels and risk scores for cases received post-SOP issuance. Additionally, a mechanism should be formulated to link allegation pendency with staff separation process. (High)

84. Management accepted the recommendation.

5.9 Enterprise risk management

5.9.1 Framework of Engagement with Non-State Actors

85. The Framework of Engagement with Non-State Actors (FENSA) was implemented on 28 May 2016 to replace the Principles governing relations between the World Health Organization and non-governmental organizations and Guidelines on interaction with commercial enterprises to achieve health outcomes.

[1] Harassment, fraud, irregularities in recruitment, abuse of authority and complaints of sexual nature, etc.

86. Under FENSA, a WHO register of non-State actors, a publicly available electronic tool, is used by the Secretariat to document and coordinate engagement with non-State actors. Information on entities (total 218 such entities) in official relations with WHO is reviewed on a triennial cycle.

87. During the Seventy-sixth World Health Assembly (2023) in Geneva, Switzerland, WHO and the president of a non-State actor (the Entity) signed a four-year extension to the memorandum of understanding (MoU) which has been in place since 4 October 2019. Regarding the classification of engagement of WHO with the Entity, WHO responded that the engagement with the Entity, in the form of an MoU, is considered a formal engagement.

88. We noticed that an initial informal assessment conducted in February 2019, highlighted the risks and possible conflicts of interest and recommended an approach for not working directly with the Entity, but through other means. However, WHO decided that the public health benefit of a direct collaboration with the Entity outweighed the risk and mandated negotiations towards an MoU, mitigating risks as much as possible. Since the Entity was a non-governmental organization, assessment on "conflict of interest", "due diligence and risk assessment" and "risk management" were required to be carried out in line with FENSA, prior to entering into an engagement with it. The response provided by WHO did not contain information/details of such assessments having been carried out either at the time of entering into MoU with the Entity in 2019 or before the extension to the MoU in May 2023.

89. We did not come across the standard information to be provided by non-State actors and high-level descriptions of the engagement that WHO has with these actors.

90. WHO, in its reply, provided details of mitigation measures taken to mitigate the risk of engagement with the Entity. While agreeing with the need to adhere to the due diligence and risk assessment process outlined in FENSA, it stated that the register on non-State actors was being upgraded to cover all the non-state actors comprehensively.

Recommendation 13: WHO should adhere to due diligence, risk assessment, and risk management requirements outlined in FENSA for engagements with non-State actors. Additionally, WHO should consider upgrading the register of non-State actors by uploading information on all non-State actors engaging with WHO." (Medium)

C. PERFORMANCE AUDIT OF WHO SUPPLY CHAIN WITH FOCUS ON LONG-TERM AGREEMENTS, SHIPPING AND TRANSPORT MANAGEMENT SYSTEM

1. Introduction

91. WHO's Procurement and Supply Services Department (SUP) at Budapest provides corporate procurement services to the Organization. It was created as a separate department in WHO's Business Operations Group (WHO/BOS) in 2020. It also provides global shipping and logistics operations, liaises with WHE/OSL[1] for movement of inventory into and out of warehouses. It oversees the development and roll out of the supply chain transformation initiatives including the roll out of the Transport Management System (TMS).

[1] World Health Organization Health Emergencies Programme/Operations Support and Logistics Unit.

92. Presently, SUP comprises 70 staff positions (15 in Budapest, 1 in Tunisia, 3 in Geneva, 51 in Kuala Lumpur). The detailed roles and responsibilities under SUP are as follows:

A. **Global Procurement and Logistics (GPL) Unit at Kuala Lumpur:** It delivers various administrative, operational and strategic services to WHO and partner entities for procurement and supply of goods and services.

B. **Procurement Operations Unit at Budapest:** It delivers various services including the global LTA development and management, product data and headquarters (Geneva) procurement support for purchase of goods and services.

C. **Quality Assurance Unit**: Responsible for quality assurance services for procurement related to emergency medicines and health equipment.

2. Audit Scope

93. The audit covered the period from 2020 to September 2023.

3. Audit Objectives

94. A performance audit was taken up of the services provided by SUP Budapest, including the GPL unit at Kuala Lumpur on supply chain management with focus on LTAs, shipping and TMS. The audit objectives of this performance audit are to assess:

- whether there exists a policy for supply chain management viz., the end-to-end delivery of goods and services in an efficient, effective and sustainable manner;
- whether the LTAs are comprehensive, efficient, and effective;
- whether the transport and logistics management for goods is effective; and
- the progress of implementation and functioning of IT system, viz. the TMS.

4. Audit findings and recommendations

4.1 Supply chain transformation

95. The WHO aims to have an integrated supply chain function that delivers goods and services in an efficient, effective and sustainable manner, supporting WHO's mandate. SUP is leading the supply chain transformation (SCT) strategy which envisages achievement of the following three strategic goals through a set of 12 projects:

- to design and implement an end-to-end supply chain function;
- to deliver responsive and resilient emergency supplies;
- to achieve operational excellence in procurement and supply chain.

96. We noted that the SCT initiative comprising the 12 projects was identified in April 2018; however the initiative was significantly delayed, and the project milestones had been revised. We had reported[1] earlier also that most of the envisaged SCT initiatives had not taken off. Thereafter in 2022, WHO Executive Board endorsed the revised SCT strategy. We now observed that the target timelines for all 12 projects has been set for December 2024; and the projects are at different phases of initiation, planning, and execution (**Appendix 3**).

97. We are of the opinion that given the time overrun in completion of the SCT strategy, and absence of risk mitigation measures in the interim, the pain points identified in WHO supply chain management continue to affect the procurement process adversely. Management accepted the Audit observation.

Recommendation 14: We recommend that projects of the SCT Strategy should have realistic timelines for every project along with milestones. The projects should be closely monitored to ensure timely completion as per target timelines and to mitigate the risk of time overrun for achieving the long-pending goal of integrated end-to-end supply chain management. (Medium)

98. The Management accepted the recommendation.

4.2 Implementation of quality assurance policy

99. WHO quality assurance policy lays down the principles and requirements regulating procurement of essential medicines and health products and provides for independent monitoring of their quality at different points of the supply chain, quality control testing and sampling.

100. We further observed that SUP was conducting quality assurance at the sourcing level, but there were no instances of pre-shipment, in-transit or post-shipment random sampling for the period 2020 till September 2023.

101. We noted that the risk "lack of organizational capacity in quality assurance of medical/pharmaceutical related procurement exposing the Organization to unsafe and ineffective products in WHO supply chain" was categorized as having a risk level "significant" in the risk register[2] of SUP. The risk also continued to be categorized as "open".[3]

102. Management responded that WHO did not have quality assurance staff at each level of the supply chain. SUP is in the process of engaging a consultant for developing quality assurance guidance material. Management further stated that while WHO has substantial organizational capacity in quality assurance, these resources may not always be available to sourcing and procurement team members, a gap which will be addressed in future.

[1] External Audit Report for the year 2021.

[2] A risk register is being maintained by WHO SUP mentioning risks identified across different functional areas on which action is required to be taken. The risk item is "closed" after required action is taken.

[3] Risk not yet addressed.

Recommendation 15: SUP should increase organizational capacity and develop SOPs for quality assurance of medical procurement to ensure risk mitigation and effective compliance with the quality assurance policy of WHO. (High)

103. The Management accepted the recommendation.

4.3 Procurement planning

104. WHO procurement handbook[1] envisages that several technical units may have a requirement to acquire the same goods or services. In such cases, a long-term agreement for provision of the required goods or services may be entered into. Considering the advantages of LTAs, WHO offices are expected to check if a LTA for provision of the required goods or services exists, before proceeding for any procurement.

105. We observed that SUP did not have a mechanism for preparing a strategic/annual procurement plan based on collation of region/country offices' plans, thus assessing the holistic requirement of LTAs for WHO. The WHO's Supply Chain Transformation also mentions lack of a holistic and coordinated approach to planning for procurement as a pain point.

106. We observed that WHO entered into 172 Global LTAs, from January 2020 to September 2023 adding around 22 – 34 LTAs each year through piggybacking[2] on LTAs of other UN agencies and on the basis of requests received from technical units. This reflected that 25 to 35% (4 to 8) LTAs each year was on account of piggybacking. However, the procurement of goods through LTAs was around 4.26% during 2020–2023.Thus the benefit of the fixed price mechanism available through LTAs was not being realized.

107. Management accepted the above observations and stated that procurement planning was impacted by the limitations of the current ERP system and that the core issue of centralized planning would be addressed by the upcoming ERP i.e., Business Management System (BMS).

Recommendation 16: We recommend that WHO should consider developing a centralized procurement plan by collating procurement plans of HQ/RO/CO to enable a holistic assessment and create a long-term strategic plan with a view to increase efficiency in procurement by enhanced reliance on LTAs. (Medium)

108. The Management accepted the recommendation.

4.4 Long-term agreements

109. WHO carried out procurement of goods and services amounting to US$ 2.16 billion during the period January 2020 to September 2023, out of which procurement of goods amounted to US$ 813.997 million (37.67%).

[1] Para. 2.1.

[2] WHO may determine that an LTA established by another UN entity may best meet its needs.

110. WHO enters into LTAs[1] with external parties for procurement of recurring items. These LTAs include freight transportation service, procurement of medicines, vaccines, medical testing kits and other services. LTAs are expected to increase the efficiency of procurement by decreasing bidding times and the administrative costs for frequently purchased goods and/or services and by ensuring price stability by leveraging economies of scale. Procurement of goods under LTAs for the years 2020 to 2023[2] ranged between 1.31% to 14.90% (by value) of emergency purchases, and between 19.54% to 30.65% (by value) of non-emergency purchases.

4.4.1 Award of LTAs

111. Procurement and Supply Services Department (SUP) floated[3] invitations to bid (ITB) for LTAs for supply of COVID-19 PPE medical devices. We test-checked 10 out of these 34 LTAs and noted that there were significant delays in finalisation of tenders/LTAs. The SUP took 483 to 597 days, beyond the bid validity period of 180 days, to finalize these 10 LTAs. The contracts were awarded in April–September 2023.

112. Management responded that these delays were for the COVID-19 LTAs and were an exception. The staff resources from both SUP and technical departments were constrained during the pandemic period.

113. However, we noted that the time taken to finalize the LTAs beyond the COVID-19 pandemic period also was significantly high. We test checked five LTAs which were finalized during 2018–2019 and 2022–2023 (non-pandemic period) and observed that SUP took 205 to 358 days in finalizing[4] these LTAs. Furthermore, no norms were available detailing the time frame within which the LTAs were to be finalized. We believe that this area needs to be made more efficient by introduction of timelines and process benchmarks.

Recommendation 17: We recommend that SUP should develop well defined criteria and timelines for completing the process of LTAs in a timely manner. (High)

114. The Management accepted the recommendation.

4.5 LTAs with Freight Forwarders

4.5.1 Monitoring performance of freight forwarder LTAs

115. The LTAs with freight forwarders have pre-defined key performance indicators (KPIs) pertaining to time limits for confirming bookings with carriers, shipment dispatch, expected time of arrival at destination, dispatch of documentations, etc. It also includes separate time limits for normal and emergency shipments.

[1] An LTA is an agreement between WHO and a supplier for the provision of certain defined services or goods at a fixed price during a defined period of time (e.g. 2 or 3 years).

[2] For three quarters of 2023.

[3] During the period May 2021 to July 2021.

[4] From Bid closing date to award of contract.

116. We examined KPI reports for air shipments of Scan Global Logistics (SGL) for 2023, wherein shipment bookings and dispatch of shipment were captured. We observed that shipment booking and Shipment dispatch were beyond the time-limits in more than 79% and 67% of cases respectively, out of which emergency POs constituted more than 30%.

117. We further noted that the performance of the freight forwarder in the KPI reports was not linked to the timeliness of shipment bookings and shipment dispatches. Instead, the performance was assessed only in terms of whether the shipments were eventually booked and dispatched, irrespective of delays, if any.

118. Therefore, even though the freight forwarder did not adhere to the timelines in more than 50% of booking cases each year during 2020–2023 (which falls in the category of "poor"), we observed that in the KPI reports, its performance was recorded as "most satisfactory", on account of the shipments being only depicted as booked/dispatched, while ignoring the delays in booking/dispatching.

119. Furthermore, as per the provisions of the LTA with the freight forwarder, KPI reports submitted by freight forwarder should contain requisite information on multiple parameters including pre-advice sent; quotations requested/provided, green light[1] requests sent, green lights received, performance of emergency deliveries etc. for measurement and review. We observed that the KPI reports did not contain these details. We could not ascertain the action taken by the SUP, if any, to ensure the reporting requirements as per the LTA.

120. Management stated that measuring dispatch performance remains an important metric, and numerous elements contribute to "on time booking" and "on time dispatch" which management intends freight forwarders to capture. It also added that delays cannot be exclusively attributed to freight forwarder or WHO-award timeline.

Recommendation 18: We recommend SUP to ensure that the freight forwarders report on all the KPI details required to be captured in terms of their LTAs, and measure their performance from the perspective of timeliness. (High)

121. The Management accepted the recommendation.

4.5.2 Demurrage responsibilities of Freight Forwarders

122. The LTAs with freight forwarders lay down that WHO be assisted in obtaining possession from carriers at the ports of discharge, while guaranteeing the longest possible free time demurrage for goods. It further lays down that the freight forwarder shall monitor the situation of containers which have not been picked up by the consignee and shall advise WHO/GPL on containers which are either not picked up or not returned empty within the demurrage-free time period.

123. We examined 699 pending cases for one of the six freight forwarders for the year 2023[2] and observed that demurrage in respect of 437 pending containers exceeded the free time period. The delays

[1] A "green light" from recipient country offices means they are all set to accept the shipment, confirming that customs and other formalities are cleared.

[2] As of September 2023.

were in excess of 30 days for 152 containers. Furthermore, 282 of these containers related to emergency procurement which included 174 refrigerated containers.

124. When we enquired about the demurrage costs incurred by WHO, the SUP responded that it was responsible for delivery only up to airport/port of destination. Port-side costs (including demurrage and detention) are borne by the receiving WHO country offices. Furthermore, the delivery at the end location is not monitored at headquarters level. Although management responded that the cases in which demurrage charges are incurred are few, we were not provided with the details.

125. We feel that in order to ensure an efficient end-to-end supply chain, data pertaining to status of shipment should be captured and made available in near-real time. We have already pointed out instances of delayed delivery in this report. Without information about the financial cost of these delays being available at central level, it is difficult to comment on the materiality of the issue and level of intervention required. Furthermore, specific attention needs to be accorded to delays in respect of shipments pertaining to emergency procurements and refrigerated containers.

Recommendation 19: We recommend that SUP should devise an SOP for monitoring of all pending shipment cases. (High)

126. The Management accepted the recommendation.

4.6 Transport management service

127. Transport Management System (TMS) was envisaged to integrate the complete supply chain, from initial forecasting and expression of needs to sourcing, purchasing, shipment tracking, warehousing, and last mile delivery and reporting, along with synchronization with the WHO ERP application – BMS. The first phase of BMS application was made operational from May 2023 which included TMS. The TMS module with functionalities of shipment "track and trace" and greenlight management[1] was rolled out in 10 countries as pilot. The system generated the following three key reports:

(a) shipment tracking report;

(b) end to end requisition line report;

(c) shipment tracking event report.

4.6.1 Data quality of the TMS application

128. We noticed the following issues in the quality of TMS data:

129. **Data accuracy:** We found instances where data was being captured inaccurately. These instances included:

[1] Confirmation from a country and/or regional office that all the government or local authorities and/or ministries have been obtained for a shipment to be dispatched to consignee and/or destination. This is in the form or import permit/tax exemption from government or local authorities and/or Ministries.

(a) implausible dates such as dates of delivery of goods being prior to that of the creation of the order itself, or dates of receipt of goods being prior to the same being ready for pick up;

(b) line orders that had been deleted were shown as received;

(c) updating of the data in system, prior to the occurrence of an event.

130. **Data completeness:** We found that significant data such as those pertaining to dates of initiation of greenlight requests, greenlight receipt, goods readiness and information relating to the weight and volume remained incomplete, even in cases where shipments had been delivered.

131. **Data relevance:** We brought to notice of the management, irrelevant, duplicate or multiple entries in all three standard reports. Such incorrect data can result in generation of inaccurate reports from the system. We further noted that no PO number or other details (except shipment number) were allotted for the standalone shipments originating from WHO facilities. Such entries may have no relevance for any report generated for the management.

132. **Data timeliness:** We found that the "shipment tracking event report" was incomplete in 7% of the cases, since the details were not updated in the system after creation of the cases. Further, there was a lag in updating events subsequent to their occurrence. We observed that the events were updated on the day of occurrence only in 68% of the cases. Further, there was a delay in updating of more than a week in 6% of the cases. This dilutes one of the high-level objectives of the TMS viz. "*real time visibility, tracking and monitoring of shipments pipeline for an increased efficiency in the performance of the shipping function.*"

4.6.2 Performance metrics reported in TMS

133. The TMS application generates three standard MIS reports viz., shipment tracking report, shipment tracking event report and end-to-end requisition line report. We noticed that there is scope for improvement in MIS reporting so that key performance indicators such as time to delivery, and other important instances where the management's intervention may be required. For illustration, we analysed the data for shipment tracking report and noticed the following:

(a) Delay in dispatch/pickup of goods: The LTAs with freight forwarders provide that the freight forwarder has to dispatch the consignment within five working days of the "date of readiness" (at the supplier's end). We examined 529 Air shipments that were either in-transit or delivered. We observed that the forwarder had delayed the pickup of goods from the supplier in 71% of air shipments (**table 4**):

Table 4

Delay range (days)	Number of air shipments
Dispatched in less than 6 days – No delay	153
Dispatched in 6–15 days	164
Dispatched in 16–45 days	171
Dispatched in 46–75 days	37
Dispatched in more than 76 days	4
Total	**529**

The average time taken for dispatch of goods was around 17 days in comparison to the mandated time frame of five working days for the freight forwarder. It reflects the performance of the freight forwarder.

(b) Transit time for shipments: We examined the time taken in transit for air-shipments and noticed that even for this fastest mode of transportation, the average shipment-transit time was around seven days.

(c) Overall delay in delivery of shipments: We reviewed the data pertaining to the delivered shipments and noticed that in 33% of the shipments, there was a delay ranging from 1 day to 120 days from the planned delivery of goods. Furthermore, around 16% of total air-shipments were delayed by more than two days.

134. Thus, "end-to-end" supply chain management, with focus on shipping, needs availability and monitoring of stage-wise MIS reports to identify delays at various stages and facilitate regular monitoring. An essential prerequisite for this, is to make sure that accurate, relevant and complete data is entered in a timely manner so that visibility of the supply chain pipeline may be improved for all the stakeholders. Specifically, in addition to the current dataset, more information needs to be captured in TMS for each leg of transport such as scheduled pick up date and place, scheduled departure and arrival dates, actual departure and arrival dates, modes and places, etc.

135. Management in its response stated that TMS is based on a software as a service (SaaS), i.e. cloud platform, that provides limited configuration. In addition, TMS capabilities can be optimized subject to the data delivery capabilities provided by freight forwarders' systems. Further, they acknowledged that the data may not be entirely accurate, and they captured as much information as possible from the freight forwarders' systems. However, adding more data fields is challenging due to limitations in those systems.

136. We are of the opinion that in order to make TMS capable of real time reporting, required data-fields such as time to delivery or delays in dispatch or other stages of the shipment process need to be obtained from freight forwarders (through application integration or other manual interventions) at appropriate periodicity. Further, the application data needs to be made error free by putting in place necessary validation checks and ensuring meticulous and timely data entry. Moreover, MIS reports should be customized to capture key performance indictors so that in case of delays, management may intervene in a timely manner.

Recommendation 20: We recommend improving the data quality, timely updation of data, monitoring to ensure completeness of data through MIS and enhancing the details being captured in TMS, to the extent feasible. Further, it is recommended that MIS Reports are designed to measure efficiency of the SHP function, enabling effective monitoring. (High)

137. The Management accepted the recommendation.

D. PERFORMANCE AUDIT ON EMERGENCY PREPAREDNESS AND RESPONSE MECHANISM IN WHO

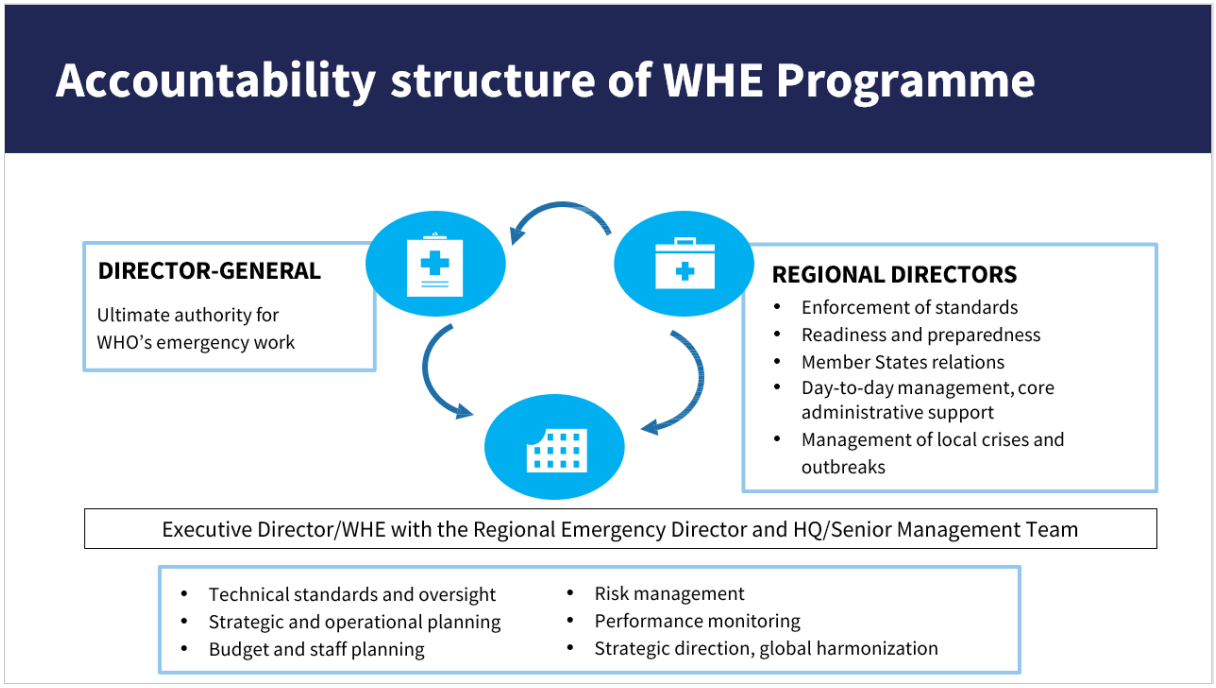
1. Introduction

138. WHO's work in emergencies was brought under a single programme as WHO Health Emergencies Programme (WHE) based on the 2016 decision of World Health Assembly in its

Sixty-ninth session to bring speed and predictability to WHO's emergency work. WHE adopts an all-hazards approach, encourages collective action, and covers preparedness, readiness, response, and early recovery activities. It also establishes a consistent structure across all regional offices to improve coordination, operations, and information sharing within the agency. Relevant functions of the Programme were replicated at country level, as appropriate.

139. The responsibility and accountability structure of WHE is shown below (**Fig. 1**):

Fig. 1



2. Funding position of WHE Programme

140. The strategic priorities (SP) during the Biennia 2020–2021 and 2022–2023 were governed by WHO's Thirteenth General Programme of Work, 2019–2023 (GPW 13), focusing on universal health coverage (SP1), protection from health emergencies (SP2), and better health and well-being (SP3) with each of the three priorities aiming to cover 1 billion people. Notably, SP2, aligned with the "triple billion" goal, is closely associated with the WHO Health Emergencies Programme (WHE).

141. The total funds available under the emergency programme (both under base budget[1] and OCR)[2] during 2020–2021 and 2022–2023 is as under (**table 5**):

[1] Strategic priority programme budget approved by WHA.

[2] Outbreak crisis response fund received from donors against specific emergency appeals.

Table 5: Funds available and utilized (US$ millions)

No.	Description	Biennium 2020–2021		Biennium 2022–2023	
		Funds available	Funds utilized	Funds available	Funds utilized
1	Health Emergency Preparedness	159.8	166.65	234.70	228.70
2	Prevention of Epidemics and Pandemics	308.6	292.93	275.30	252.50
3	Rapid Detection of Health Emergencies and its response	237.6	219.42	326.60	314.50
4	Total Base Strategic Programme	706.00	679.00	836.60	795.70
5	Outbreak Crisis and Response (OCR) Programme	2778.80	2599.70	2700.00	2487.90
	Total under WHO Health Emergencies Programme	3484.80	3278.70	3536.60	3283.60

Source: GSM BI Programme Budget figures

3. Audit objectives

142. The audit objectives of this performance audit are to assess:

- Adequacy of WHO's interventions in strengthening country health emergency preparedness and prevention of epidemics and pandemics, in achieving desired outcomes as per GPW 13 and strategic priorities approved by WHA.
- Adequacy of WHO's health emergency information and risk assessment mechanisms in achieving early detection of acute health events and developing effective response mechanisms.
- Adequacy and effectiveness of WHO's emergency operations in supporting Member States in emergency situations.
- Adequacy and effectiveness of WHO's partnerships in securing funds and essential medical supplies for global health emergencies.
- Adequacy of management structures and communication within different levels of WHO.

4. Scope of audit and audit sample

143. The performance audit of emergency preparedness and response mechanism in WHO focused on the activities of WHO's Health Emergencies Programme over a period of two bienniums, namely 2020–2021 and 2022–2023. The units covered under audit were selected from all the three levels, i.e. WHE Division in headquarters Geneva along with departments/units thereunder, regional emergency directors and selected incident management support teams (IMSTs) and incident management teams (IMTs) in regional/country offices respectively.

144. Audit sample for detailed check included four emergencies which were graded by WHO as either grade 3[1] or grade 2[2] emergencies. The grade 3 emergencies selected as audit sample were 2020-G001 COVID-19, 2023-G001 multi-region cholera and 2022-G013- Greater Horn of Africa (food insecurity

[1] Grade 3 Emergency is a single or multiple country emergency, requiring a major/maximal WHO response. Organizational and/or external support required by the WCO is major and requires mobilization of Organization wide Assets.

[2] Grade 2 Emergency is a single or multiple country emergency, requiring a moderate response by WHO. The level of response required by WHO always exceed the capacity of the WCO (WHO offices in countries, territories and areas).

and drought). The grade 2 emergency selected was 2022-G014 mpox. Out the four, three emergencies pertained to the category of infectious diseases while one health emergency was under the natural disaster category.

5. Audit methodology

145. Audit methodology was based on the INTOSAI standards for performance auditing, standard operating procedures issued by the CAG of India and CAG guidelines on performance audit.

146. Audit accessed databases of WHE such as EMS/EMS2 and SPRP databases, as well as other related information, relevant information and reports. Interviews with key personnel and survey questionnaires were used as audit methodology.

147. Field audit was conducted in two phases: In phase 1, remote audit from India for initial risk assessment was conducted from 4–15 December 2023. Onsite audit was conducted at WHO headquarters in Geneva from 8 January to 2 February 2024.

148. During remote audit, an induction presentation was made by the chief operating officer (COO) of WHE/headquarters introducing the WHE Programme and its organizational structure at all three levels, the oversight of the Programme and key activities. Preliminary discussions were held online with regional emergency directors (REDs) and PHI unit of WHE/headquarters.

149. Onsite audit commenced with an entry conference on 9 January 2024 with the WHE Division, during which audit objectives, scope and audit sample were agreed upon. An exit meeting was held on 2 February 2024 with the Executive Director and COO of WHE, wherein audit observations and audit recommendations were discussed.

6. Audit Findings and Recommendations

6.1 Resource mobilization for the WHE Programme

150. Strategic priority 2 under WHO's GPW 13 is to protect one billion people from health emergencies. SP2 consists of following sub-priorities: (i) SP2.1 – preparedness in health emergencies; (ii) SP2.2 – prevention of epidemics and pandemics; (iii) SP2.3 – rapid detection and response to health emergencies. The WHE Programme aligns with SP2.

151. Financing the work of the WHE Programme is from the following sources:

- Allocation under base Programme budget for core financing of the Programme at the three levels of the Organization.
- Donor financing of the Contingency Fund for Emergencies to enable it to rapidly initiate operations in acute emergencies.
- Crisis-specific financing, for example COVID-19 Global Appeal, through Outbreak and Crisis Response (OCR) funds

6.1.1 Resource mobilization for WHE base budget

152. The funding gap between the approved budget and funds available in overall fund position of WHO at the end of each biennium was as below (**table 6**):

Table 6: Approved budget and funds available (US$ millions)

Sl. No.	Description	Biennium 2020–2021			Biennium 2022–2023		
		Budget approved	Funds available	Funding gap	Budget approved	Funds available	Funding gap
1.	Health emergency preparedness (SP2.1)	231.1	159.8	31%	431.8	234.7	46%
2.	Prevention of epidemics and pandemics (SP2.2)	380.4	308.6	19%	311.7	275.3	12%
3.	Rapid detection of health emergencies and its response (SP2.3)	277.3	237.6	14%	507.0	326.6	36 %
4.	Total base strategic programme for SP2	888.8	706.0	21%	1250.5	836.6	33%

153. One third to half[1] of the Emergency preparedness budget remaining unfunded during the last four years is a matter of concern, especially in light of the magnitude of the recent COVID-19 pandemic. Shortage of funds limits WHO's efforts to strengthen Member States' capacity to respond promptly and effectively during health emergencies.

154. We noted that 33% resource gap for WHE Programme was further exacerbated by limited flexible funds.[2] Flexible funds finance the base programmes of WHO, wherein WHO has exclusive strategic and operational control over the activities concerned and over the choice of means, the location and the timing of implementation. Further total funds available for the emergency program SP2 for the year 2022–2023 was US$ 836.6 million, out of which 17% was available for flexible funds (**table 7**).

Table 7: Apportionment of staff costs from flexible and non-flexible funds (US$ millions)

Category	Biennium 2022–2023		Biennium 2020–2021	
	Flexible funds	Other funds	Flexible funds	Other funds
Base budget of SP2	214.02	627.84	187.53	536.71
Staff cost of WHE (SP2)	168.45	256.80	123.08	204.75
	79%	41%	66%	38%

155. It was seen that in biennium 2020–2021, 66% of the flexible base budget of SP2 was expended on staff costs, which increased up to 79% in the biennium 2022–2023, representing more than three fourth of the flexible funds being spent on staff costs.

156. This indicated that out of the flexible funds allocated for WHE Programme, a substantial proportion was being spent to meet the staff costs.

157. In the scenario that WHE already faces serious resource crunch for meeting the strategic outcomes of emergencies programme, limited availability of flexible funds was an added challenge.

[1] Based on 31% gap for biennium 2020–2021 and 46% gap for biennium 2022–2023, which one third to half of the emergency fund remaining unfunded.

[2] Flexible funds are defined by WHO as assessed contributions (AC) + core voluntary contributions (CVC) + project support costs (PSC) – flexible funds are untied contributions which allow WHO the flexibility to allocate funds according to its own priorities and needs.

158. In reply to our query on challenges faced by WHE in mobilizing resources for its base budget strategies, WHE stated (January 24) that Member States have agreed in WHA 2022 to an increase in AC[1] of 50% on the base component of the 2022–2023. The aim is to increase roughly US$ 600 million a year of income that comes from the most sustainable and predictable sources.

159. While the strategies put in place for enhancing the AC contribution for the Programme budget are welcome, they are yet to translate into actual fund flows even 17 months (June 2022 to November 2023) after the 2022 Health Assembly, as seen from the existing funding gaps.

160. We noted that through the health emergency appeal call 2023, WHO proposed to raise US$ 2.54 billion to provide support to 54 health crises around the world, including 11 of the highest-level "grade 3" emergencies – those which require an urgent and major WHO response. While the resources raised through the emergency appeal will address the resources gap for WHE's emergency response activities, the appeal did not specifically address the resource gaps for health preparedness.

161. The Management stated (February 2024) that the inclusion of preparedness in appeal, would likely deter some traditional humanitarian donors from financing WHO. However, accepting the audit's view, it also stated that the references to preparedness have been built into the year 2024 appeal, in a holistic manner to ensure that donors better understand the importance of the work that happens before, during and after a response – namely preparedness.

Recommendation 21: WHO may consider putting in place a long-term strategy for enhancing flexible funding for each of the three outcomes of health preparedness, prevention and emergency response under SP2, and build a strong case for enhanced donor support for health preparedness. (Medium)

6.1.2 Contingency fund for emergencies

162. The contingency fund for emergencies (CFE) funded by donors/Member States through voluntary contributions, is a mechanism to provide rapid financing for WHO emergency operations at the onset of an emergency or in response to an escalation of needs in existing crises for up to three months, extendable to six months if necessary. It is not intended to support ongoing WHE Programme costs.

163. CFE operates as a revolving fund with the expectation that every allocation to the country office would eventually be reimbursed by them through raising donor resources as much as possible without compromising the response.

164. As of the close of December 2023, the CFE's closing balance stood at US$ 36.03 million. During the four years over 2020–2021 to 2022–2023, WHO had released US$ 234 million to COs under CFE mechanism at an average annual release[2] of US$ 58.50 million. Thus, the need to replenish the fund is evident, as the current balance falls short of the historical annual average releases.

165. While replenishment of CFE is a matter of concern, an analysis of actual utilization against the commitment highlights the gap between the amounts committed and utilized (**table 8**).

[1] Assessed contributions of Member States.

[2] US$ 234 million/4 = US$ 58.50 million.

Table 8: Summary of CFE (US$ millions)

Biennium	CFE approved/ committed[1]	Funds utilized by WR/WCO	Donor fund received	Difference between commitment and utilisation
2020–21	66.32	38.53	69.15	27.79
2022–23	167.68	108.44	114.57	59.24
Total	234.00	146.97	183.72	87.03

Source: CFE Annual Reports 2020, 2021 and WHE reply.

166. We noted a significant gap of US$ 87.03 million (37%) between the funds committed by donors and the funds utilized by WRs/WCO during the last two biennia, indicating underutilization of funds already committed. There was a gap of US$ 50.28 million (27%) between the amount committed by the donors and the funds received. However, the unspent amounts highlighted above may be one of the deterring factors for donors to release further amounts.

167. Management, while accepting the observation stated that timing of both incoming donor contributions and releases of CFE to emergency events vary. Though the trend over time is interesting to note for both values, calculating a cumulative "gap" in this manner is of limited usefulness.

Recommendation 22: WHO may consider strategies to garner sufficient funding for the CFE and collaborate with WR/WCO to realistically assess CFE requirements and ensure timely and efficient utilization of CFE funds. (Medium)

6.1.3 Allocation of OCR funding to the Member States

168. The release of funds from the OCR category is dependent on the real-time unfolding of an outbreak or crisis.

169. We noted that out of the 194 Member States, 115 Member States (**Appendix 4**) received a total of US$ 3 688.96 million from the OCR funding during the last two biennia. Additionally, in PAHO region, which encompasses 35 Member States, a combined total of US$ 158.28 million was released out of the OCR funding during the two biennia.

170. In order to assess the allocation among 115 Member States, the comparative OCR allocation to countries with respect to COVID-19 case load was examined.

171. We observed that Member States with lower COVID-19 case load received 1.4 times more funding on average compared to states with higher COVID-19 case load per million, indicating higher distribution of funds towards States with lower case rates.

172. The Management replied that the OCR allocation was not linked to COVID-19 case load only and included other events too. These decisions are impacted by numerous other factors, such as Member State capacities/requests for support, demographics, population density, COVID-19 variants/varying severity, reliability of surveillance data (testing and reporting capacities), presence/support from other

[1] Approved/committed denotes the funds committed by donors and approved by WHE headquarters.

international agencies, other non-OCR funds available that are reprogrammed to respond to such emergencies, etc.

173. Management further stated that WHO is not a funding institution, but a technical agency. The documents influencing resource allocation primarily include donor appeals guiding the distribution of funds for prioritized needs. WHE also conveyed that OCR funding typically involves a degree of earmarking by donors.

174. Management's response indicates that though several factors influence allocation of OCR fund among countries, the decision-making process for such allocation could not be benchmarked against any laid-down criteria. Absence of well-defined criteria for allocation of OCR funds and earmarking of funds by donors may not be consistent with prioritized needs of Member States. Since OCR appeal has been transformed into an annual health emergency appeal since 2022, it is desirable that a criteria-based allocation process based on principles of equity and objectivity in distribution of funds among various countries/emergencies is put in place for a transparent process of allocation.

Recommendation 23: WHE may consider developing criteria for prioritizing allocation of annual health emergency appeal funds adhering to principles of equity, needs assessment and transparency. (Medium)

6.2 Status of implementation of International Health Regulations (2005)

175. The International Health Regulations (2005) (IHR 2005) monitoring and evaluation framework (MEF) serves as a framework for Member States to monitor and evaluate the implementation of IHR capacities and involves mandatory annual reporting (SPAR) and voluntary external evaluations. Under GPW 13 outcomes, WHO aims to consolidate its core capabilities, particularly in line with work on implementing the IHR 2005.[1] The results framework or GPW 13 stipulated two components for health emergency preparedness, namely, health security preparedness and country readiness preparedness.

176. According to the Programme budget 2024–2025, WHO reported that as of April 2023, preparedness level in 112 out of 194 Member States (58%) was assessed as high, while in other 57 and 12 countries it was assessed as medium and low respectively.

177. Further, as of November 2023, out of the 194 Member States, 87 Member States had completed 115 National action plans for health security[2] (NAPHS). Among the 115 NAPHS completed, only 15 (17%) had been published.

178. In respect of country readiness, WHO stated that for operational readiness WHO is covering only WHE priority countries. Further, over the last three years by considering multiple threats, including COVID-19, WHO has reached the total target of 60 countries that assessed their operational readiness capabilities. Of these 60 countries/territories, 57 are WHE priority countries/territories.

[1] The International Health Regulations (IHR) 2005 represent the legally binding international framework under which all States Parties are required to report on the status of IHR implementation annually.

[2] NAPHS is prepared by member countries to strengthen emergency preparedness, multi hazard emergency risk profiling and health emergency risk mapping, and to identify gaps in national health preparedness to be addressed by the national action plans.

179. We noted from the WHE's Strategic Partnership for Health Security and Emergency Preparedness (SPH) database that as of December 2023, only 13% of the countries had completed the joint external evaluations (JEE) to examine capacities across 19 technical areas to establish a baseline assessment, enabling countries to have a greater understanding of their gaps and weaknesses in health security.

180. Management replied that unlike SPAR, which is an annual questionnaire received from countries, JEEs are voluntary assessments that countries may choose to conduct once every five years. Since 2016, a total of 151 JEEs have been completed in 122 countries.

181. WHO's explanation that countries may be opting for external evaluations once in five years is acceptable since such reviews are resource intensive which may not allow resource-limited countries to have such evaluations frequently. The WCOs and regional offices have a key role in demonstrating country preparedness through structured processes such as JEE, after action reviews[1] and simulation exercises, for which they themselves need to be resourced sufficiently. Underfunding of WCOs has already been highlighted in section 6.1.3 above.

182. Further, as reported in WHO's Programme budget 2024–2025, only 58% of Member States were shown as high in preparedness level indicating medium/low level of preparedness in remaining 42% Member States.

Recommendation 24: WHO should lead the global effort in advocacy and strengthening of country health preparedness plan in active collaboration with Member States that are falling behind in health security and response preparedness. (Medium)

6.3 Emergency health surveillance by WHE

183. In WHE, the Alert and Response Coordination Department (ARC) under the WRE[2] leads the detection, verification, risk assessment, coordination, response, and monitoring of alerts and signals.

184. The signal management application[3] (Signal App) is a key application used by WHE headquarters for monitoring of health events from the stage of reporting up to the stage of verification of signals.

185. WHE gathers signals regarding health events from several sources. WHE/headquarters stated that for getting intelligence on public health events, apart from the IHR, WHO and region-specific databases/sources, headquarters used signals from epidemic intelligence from open sources (EIOS), partners, technical teams at headquarters, and other official and non-official sources.

186. We noted from the above that headquarters and RO teams relied on similar data sources for information which could be a potential signal, and had separate systems of verification of the information respectively at headquarters and RO. This potentially resulted in duplication of efforts at

[1] After action reviews on health preparedness within the World Health Organization (WHO) are critical evaluations conducted following significant health events or emergencies. These reviews aim to assess the effectiveness of WHO's response efforts and identify areas for improvement.

[2] WRE refers to the response division under WHE. As of 1 January 2024, WRE is no longer in existence, although ARC as a department remains.

[3] Signal refers to data and/or information detected that represents a potential acute risk to human health. Signals may consist of reports of cases or deaths (individual or aggregated), potential exposure of human beings to biological, chemical, or radiological and nuclear hazards, or the occurrence of natural or human-made disasters.

different levels of WHO offices as similar raw information is analysed across multiple offices to arrive at daily list of signals to exchange. We noted that the various signal management systems, including the Signal App, were not connected to Event Management System (EMS), and verified signals were manually being recorded in EMS. In the EMS database, it was not possible to segregate events by source as the sources were not recorded accurately. Absence of this functionality prevented detailed analysis of the sources of events, thus limiting the benefits of WHE collecting data on public health events and sources.

187. We found there was a considerable variation in the number of signals detected and verified by different ROs. For instance, in the Regional Office for Europe (EURO), the number of detected signals ranged from 74 to 98 during 2020–2023, while for AFRO they ranged from 109 to 291. On the other hand, the figures for the Regional Office for the Eastern Mediterranean (EMRO) ranged from 2658 to 9995, for The Regional Office for South-East Asia (SEARO) it ranged from 1432 to 2103, and for the Regional Office for the Western Pacific (WPRO) it ranged from 835 to 1070. This indicated differences in the health intelligence monitoring capacity of the ROs and limitation of human resources on one hand, and on the other hand also pointed towards absence of a common understanding of signals across WHO levels.

188. Management replied (February 2024) that the information relating to natural variation in signals/events between countries and regions did not indicate an absence of shared understanding of signal. However, WHE also stated that what would be considered a signal of relevance for each office might differ because of differing scopes of work and priorities.

189. Regarding sharing of signals, WHE stated (March 2024) that signals of interest are shared on a daily basis between ROs and headquarters in a summary list. On Signal App, WHE stated (January 2024) that it was decided in early 2023 to pause the rollout to the regions for several factors, in particular that the system was not fit-for-purpose at headquarters and did not have the ability to store large quantities of data.

190. However, in March 2024, Management responded that Signal App is under development and not yet launched. Thus, WHO is yet to stabilize technological solutions for emergency health surveillance.

191. Absence of a uniform process of detecting and managing signals limits management's capacity to review the surveillance system for variations in the procedural and information management practices which form the basis of emergency response by WHO.

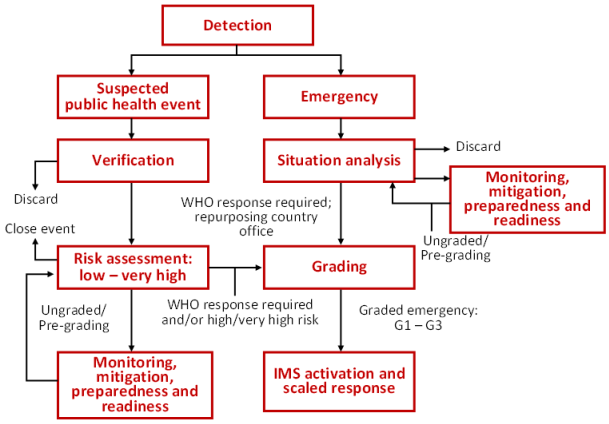
Recommendation 25: WHE may consider linking various databases of signals in a common cloud-based platform which is connected to EMS for a seamless flow of information and for strengthening the analytics capacity of the system. (Medium)

6.4 WHE's risk assessment and grading procedures

192. WHO's Emergency Response Framework version 2, 2017 (ERF 2017) provides WHO staff with essential guidance on how the Organization manages the assessment, grading and response to public health events and emergencies with health consequences, in support of Member States and affected communities.

193. Flowchart showing Management of an emergency from detection to response is given below (**Fig 2**):

Fig. 2



194. Once an event is verified, WHO conducts a range of assessments to guide its emergency response. Among these assessments, the most crucial are the rapid risk assessments (RRA) conducted for public health events and the situation analyses conducted for sudden onset emergencies. The RRA recommends if the grading call should take place, which determines the response of WHO.

195. During the biennium 2020–2021 and 2022–2023, 12 Grade 1; 38 Grade 2; 10 Grade 3 and two protracted emergencies were declared. We examined the RRAs conducted for a sample[1] of emergencies for assessing the efficiency of risk assessment procedures implemented by WHO, and have the following observations to offer:

6.4.1 Risk Assessment

196. ERF 2017 states that rapid risk assessment should be undertaken as soon as possible, ideally within 24 hours of verification. ERF 2017 also states that verification is not a necessary condition, if other information is already available which suggests risk assessment is warranted.

197. We noted that time gap in conducting RRAs from the first information received ranged from four days in case of COVID-19 outbreak to 35 days in case of cholera outbreak in Malawi.[2] In case of multi-region cholera, the first RRA was conducted more than six months after the first RRA of cholera outbreak in Malawi had identified regional risk of geographical spread as very high. Pertinently, 30 countries had reported cholera outbreaks to WHO in the preceding nine months. The lag in conducting RRAs in the sampled emergencies prevented WHO from timely assessment of the likely extent and impact of the health event, which delayed further interventions.

198. We also noted that in respect of COVID-19, the first RRA as well as the subsequent four RRAs stated that insufficient information on epidemiology, laboratory investigations, control measures and clinical data available to WHO did not allow assessment of the risk reliably.

199. Further, we noticed that in respect of COVID-19, Multiregional cholera and Monkeypox, invariably the first and subsequent RRAs recommended seeking further information rapidly and repeat RRA (including field risk assessment) to be done on immediate basis. However, repeat RRAs were

[1] Three grade 3 emergencies and one grade 2 emergency.

[2] In the multi-region cholera emergency, Malawi was the most affected country.

conducted with lags, ranging from 7–25 days in case of COVID-19, 3–4 months in case of multi-region cholera, and 1–3 months in case of Monkeypox.

200. The Management stated (February 2024) that after verification of the event, a report is published in consultation and consideration of the inputs from the RO and CO. It was also replied that the initial information provided for the COVID-19 and mpox events was insufficient to start with a formalized RRA and the IHR mechanism was activated to gather rapidly the key epidemiological details. In case of COVID-19, it stated that the delayed official confirmation from the State Party was the reason for the delayed RRA.

201. For Cholera, Management stated (March 2024) that the first RRA of Malawi cholera of 8 April 2022 had indicated a low global risk, so there was no need for multi-region cholera (global) RRA at the time. Management further stated that following the second RRA of Malawi cholera on 3 Oct 2022 and given the worsening situation in other countries, global RRA was conducted three weeks after on 26 October 2022.

202. Management further stated that there is no precisely defined time for subsequent RRAs. The situation is monitored; further information received on the epidemiological situation before a repeat is undertaken.

203. Repeat RRAs indicated insufficiency of national data, as well as capacity gaps at WHO's regional and country offices level in conducting reliable surveillance.

204. In case of cholera, we noted that WHO undertook a global RRA after 30 countries had reported cholera outbreaks in the preceding nine months and overall regional risk increased to very high for Malawi Cholera, indicating gaps in regular surveillance and monitoring of the situation as it developed.

205. Further, ERF 2017 is silent on the SOPs to be followed in case repeat RRAs are recommended. The lack of guidelines for repeat RRAs should be addressed by WHO by addressing issues such as minimum time gap between the first and subsequent RRAs to bring predictability and uniformity in procedures. In ERF 2.1, the updating of RRA within 90 days of grading would be applicable to just one RRA and not to the subsequent RRAs.

6.4.2 Grading of the public health event

206. According to the ERF 2017, grading is an essential internal process to trigger WHO's incident management system (IMS) and emergency SOPs. For acute events and emergencies, the ERF 2017 mandates that grading shall be conducted swiftly, ideally within 24 hours of a risk assessment indicating a high level of risk.

207. We observed a delay of eight days in conducting grading call for COVID-19 after the RRA team assigned high national risk with a concern about risk of spread to other countries. Though high regional risk was assigned for mpox in the European region, there was a delay of 10 days in conducting grading call. The delay for grading in respect of multi-region cholera was three months despite assigning very high global risk to the event.

208. Management (February 2024) stated that in respect of COVID-19, a grading call was not recommended in the first RRA. In respect of mpox, while there may be a perceived delay between RRA and grading, the operational response started as the RRA was circulated.

209. As per ERF 2017, the recommendation for grading by the RRA team is not essential for the grading call when the assessed risk is high. Further, formal grading of an emergency is the first step that determines the nature and extent of WHO's response to the graded emergency. Hence, WHO needs to strengthen its procedures for enabling quick decisions on the grading call.

6.4.3 Communication with the United Nations Secretary-General under IASC protocols

210. As per ERF 2017, based on the IASC[1] level 3 activation procedures for infectious disease events, the Director-General of WHO will inform the United Nations Secretary-General, with copy to the emergency relief coordinator, within 72 hours of detection/reporting of an infectious disease event that is assessed as high or very high risk, or when it is assessed as a WHO grade 2 or grade 3 emergency.

211. In case of COVID-19, the event was risk assessed as high for China, moderate for the region and low for global on 5 January 2020. On 14 January 2020, the risk assessment remained the same for China and the region, while for global it increased to moderate. The event was graded as grade 2 on 14 January 2020. The United Nations Secretary-General and emergency coordinator were, however, not informed as per the ERF 2017 provision. Instead, the first communication to them by the Director-General WHO was sent on 2 February 2020.

212. Management stated that the event was assessed as a global high risk only in RRA3 (21 January 2020) and graded as grade 3 on 25 January 2020, and the grading memo sent to United Nations Secretary-General the same day. They also stated that due to plethora of grade 2 infectious hazards occurring, the threshold for notifying the Secretary-General has been raised to grade 3 infectious hazards, as reflected in ERF 2.1.

213. The reply of Management that the grading memo was shared with the United Nations Secretary-General on 25 January 2020 when the event was graded as grade 3 indicated that WHO refrained from invoking IASC level 3 as soon as the event was graded as grade 2 on 14 January 2020, which was the requirement of the ERF as well as IASC protocols. We noted from the documents provided that WHO notified the Secretary-General on 2 February 2020 and not on 25 January 2020. Further, the changes in the notification threshold for infectious diseases referred by WHO in ERF 2.1 were not applicable at the time, since the ERF version 2.1 was approved only in December 2021.

214. We are of the view that assessed risk in case of some of the grade 2 emergencies could also be sufficiently high to warrant invoking level 3 procedures. Therefore, decision to activate level 3 procedures should be taken on case-by-case basis, depending on the assessed risk of grade 2 emergency concerned. Criterion of grading alone is not sufficient to decide the threshold of notifying the United Nations Secretary-General, since grading call is an internal decision of WHO to determine the scale of WHO's response.

Recommendation 26: WHO may consider reviewing the threshold for notifying the UNSG in the updated ERF 2.1 for Grade 2 Emergencies with provision for activation of Level 3 procedures on a case-to-case assessment of Grade 2 emergencies. (Medium)

[1] IASC refers to Inter Agency Standing Committee.

6.5 Assessment and declaration of public health emergencies of international concern

215. For declaring an event a public health emergency of international concern (PHEIC), following risk assessment of a verified event, the Director-General of WHO may convene an IHR emergency committee (EC) to consider whether the event warrants a PHEIC declaration. Criteria for declaring a PHEIC include events which pose a public health risk to other countries, and potentially requiring a coordinated international response.

216. We found inconsistencies in procedures followed for declaring the PHEIC in the case of sampled emergencies.

- COVID-19: A referral to the EC came after the second RRA on 14 January 2020 despite a previous RRA on 5 January 2020 which indicated high or moderate national/regional risks.
- Mpox: The first RRA did not recommend EC referral despite a high-risk assessment for international spread in Europe. However, the second RRA with the same risk level did recommend referral, leading to a PHEIC declaration by WHO. This happened even though the EC members lacked consensus on the PHEIC advice.
- Multiregion cholera: Despite a very high-risk assessment for geographical spread, none of the RRAs referred the event to the EC.

217. This highlighted the need for a more standardized approach to referring public health emergencies to the EC.

218. We further noted that the EC deliberations on results of risk assessment and how these were applied to the PHEIC criteria of IHR were not documented. The formal minutes of EC deliberations were not available.

219. WHE stated that no formal minutes of EC meetings were taken, but the statement following each of the meetings gives a summary of the proceedings and outcomes.

Recommendation 27: In order to improve transparency and uniformity in procedures leading to determination by the Director-General of an emergency as PHEIC, WHO may consider developing detailed SOP for RRAs for referring an event for review by IHR Emergency Committee in accordance with Article 12 of IHR 2005. (High)

6.6 Incident management system

220. The “no regrets policy” of WHO for emergency response provides that at the onset of all emergencies, WHO will ensure that predictable levels of staff and funds are made available to the WCO, even if it is later realized that less is required, with full support from the Organization and without blame or regret. Further, within 24 hours of grading of acute emergencies, WHO is to activate the IMS.

We noted that the dates of declaration of IMS, emergency grade and the date of grading of various emergencies were as below (**table 9**):

Table 9: IMS activation and emergency grading

Emergency name	IMS activation date	Grade	Date of grading
COVID-19	1 January 2020	Grade 2	14 January 2020
Cholera HQ	13 January 2023	Grade 3	26 January 2023
Cholera (AFRO)	23 January 2023	Grade 3	26 January 2023
Monkeypox	16 May 2022	Grade 2	3 June 2022
GHoA (Food Insecurity and Drought)	No IMST date at HQ	Grade 3	20 May 2022

221. In case of COVID-19, a comparative analysis of the number of staff deployed/assigned for critical functions in the IMSTs in AFRO and WPRO, revealed that of the staff assigned from 1 January to 28 February 2020 for various types of positions,[1] including critical ones, varied widely in the two regions. In case of WHO's response to cholera, we noticed significant delays in the deployment of personnel in four countries, viz., Ethiopia, Zambia, Zimbabwe, and Sudan[2] which were part of priority countries identified by WHO. For Monkeypox, we observed that while IMSTs had been formed in all regions, in EMRO, EURO, and SEARO, only the incident manager had been appointed in the name of IMST. In WPRO, only one person had been assigned/deployed for the function of health operations. Thus, IMSTs as envisaged in ERF 2017 were set up in headquarters and AFRO only. An assessment of human resources assigned in country IMTs for Greater Horn of Africa (food insecurity and drought) showed that the IMTs in Eritrea, Djibouti, Kenya, and South Sudan were not staffed at par with other IMTs. Apart from Sudan, none of the IMTs had an epidemiologist.

222. In response, WHE stated that, for COVID-19, the IMST at headquarters was set up in advance of grading as a coordination platform given the escalating situation. For varying level of human resources deployment in the Western Pacific and African Regions, WHE stated that the assignment of positions is contingent upon several factors, including the complexity, intensity, scale, and specific needs of the emergency response. Additionally, the availability of funding plays a crucial role in determining the approved positions.

223. In case of cholera, WHE stated that given the increasing number of health emergencies to respond and the overstretched capacities at headquarters, almost all if not all persons deployed in respective IMSTs are simultaneously handling other responsibilities apart from their role in the IMST. For the most part, persons deployed retain the responsibilities of their job "in peace time" and in many instances have to take on numerous roles within an IMST.

224. Regarding regional IMST for Greater Horn of Africa (food insecurity and drought), WHE stated that this was a decision to take advantage of working closely with the Nairobi Hub colleagues of AFRO, and to strengthen the regional collaboration and reflect the proximity to the response countries. Regarding the audit observation on non-deployment of all positions in IMTs, WHE stated that that these profiles are very sought after, also by other agencies, so it took time to identify suitable candidates.

225. For Monkeypox WHE stated that it had a global reach, hence it made more sense to have it located at headquarters.

[1] Health operations, infection prevention and control, laboratory technical, clinical management expert.

[2] Sudan has suffered from civil war in recent years.

226. WHO's reply clearly shows that staff and funding constraints resulted in varying levels of deployment of staff in IMST/IMTs. In addition, the IMST/IMTs lacked appropriately skilled staff for providing the interventions required by the member countries.

6.7 Partnerships in the management of vaccines

227. WHO leads and collaborates in global partnerships that aim to improve fair and equitable distribution of vaccines around the world. We examined two such partnerships of WHO.

6.7.1 COVID-19 vaccines through COVAX[1]

228. COVAX was created at the beginning of the pandemic to enable equitable access to potential COVID-19 vaccines. The COVAX doses began to be shipped worldwide in late February 2021.

229. COVAX-secured dose allocation followed the WHO's allocation framework for fair and equitable access to COVID-19 health products. The COVAX facility has delivered almost 2 billion COVID-19 vaccine doses to 154 countries till date (January 2024). In early 2022, as adequate vaccine supplies became available, COVAX moved to a "rolling allocations" model which fulfilled country demands as and when received. On an average, AMC92[2] countries have been able to achieve 57% primary series coverage, and 84% coverage amongst health workers (one of the high priority groups).

230. Thus, even though vaccines became available, vaccination level was low indicating limitation of the ACT-Accelerator[3] model.

231. WHO stated that health system capacity was one of the reasons for low vaccine coverage, as also the political situation, competing national priorities, available workforce, vaccine hesitancy or just a decline in demand as cases began to decrease during 2022.

232. WHO's response reaffirms the observation made earlier in this report on existing gaps in health preparedness among a large number of countries, and insufficiency of the current collaborative models to address the vaccination gap.

6.7.2 Cholera vaccination through ICG partnership

233. Since 2013, the ICG[4] for cholera vaccines has managed the emergency stockpile of Oral Cholera Vaccine (OCVs). Within the ICG framework, WHO is to provide global public health advice, expertise and technical support to countries. During outbreaks, WHO supports all aspects of the multisectoral response. WHO also hosts the secretariat of the ICG.

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[1] COVAX was co-led by the Coalition for Epidemic Preparedness Innovations, UNICEF and WHO. As such WHO was a core partner in COVAX from the outset in April 2020 until it was stood down on 31 December 2023.

[2] AMC92 refers to 92 lower-income countries who were to be provided COVID-19 vaccines free-of-cost.

[3] Accelerator is a global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments and vaccines.

[4] International Coordinating Group on Vaccine Provision (ICG) was established in 1997 by four partners, namely, IFRC, MSF, UNICEF and WHO.

234. As per data provided by WHO, global shortage of OCV vaccines was estimated at 30 million, 35 million and 106 million doses during the years 2021, 2022 and 2023, respectively. The ICG-recommended stockpile size of OCV for emergency response was 5 million doses to be available at all times. In 2023, the ICG received 30 requests from 14 countries for OCV for outbreak response. The strained global supply of cholera vaccines obliged the ICG to temporarily suspend the standard two-dose vaccination regimen in cholera outbreak response campaigns, using instead a single-dose approach.

235. On enquiring into the reasons for not prequalifying more manufacturers to increase the production capacity of cholera vaccines, WHE stated (January 2024) that since the disease affects mostly the resource limited countries, in the absence of guaranteed demand and return on investment, new manufacturers are reluctant to enter the market. A predictable demand could make the market attractive, but projection of demand is a resource intensive work which the affected countries are either reluctant or unable to take up.

236. Though the accountability framework of ICG does not assign the responsibility of vaccine procurement to WHO as the partner in ICG, shortage of vaccines is bound to affect the effectiveness of WHO's emergency response during the outbreak, and preparedness efforts in peacetime. We observed that since the affected countries are those with limited capacity and resources, a multi-agency coordinated mechanism within the Emergency Response Framework of WHO was needed to provide the requisite support to affected countries.

237. WHE stated (January 2024) that despite several appeals, WHO and other partners failed to leverage the funds to respond to such a large crisis, while the situation in Ukraine, Gaza, Iraq earthquake, Haiti or Sudan to mention a few, are already putting a strain on the shrinking resources at global level.

238. The above analyses in case of the two vaccine partnerships of WHO show that while these partnerships have been able to bring together global resources for development and enhanced availability of vaccines, the equitable access to vaccines by all, especially in resource limited countries, is a continuing challenge. The market driven nature of vaccine development and production on one hand and need for achieving equity in universal access to vaccines calls for a leadership role from the WHO as a global health agency.

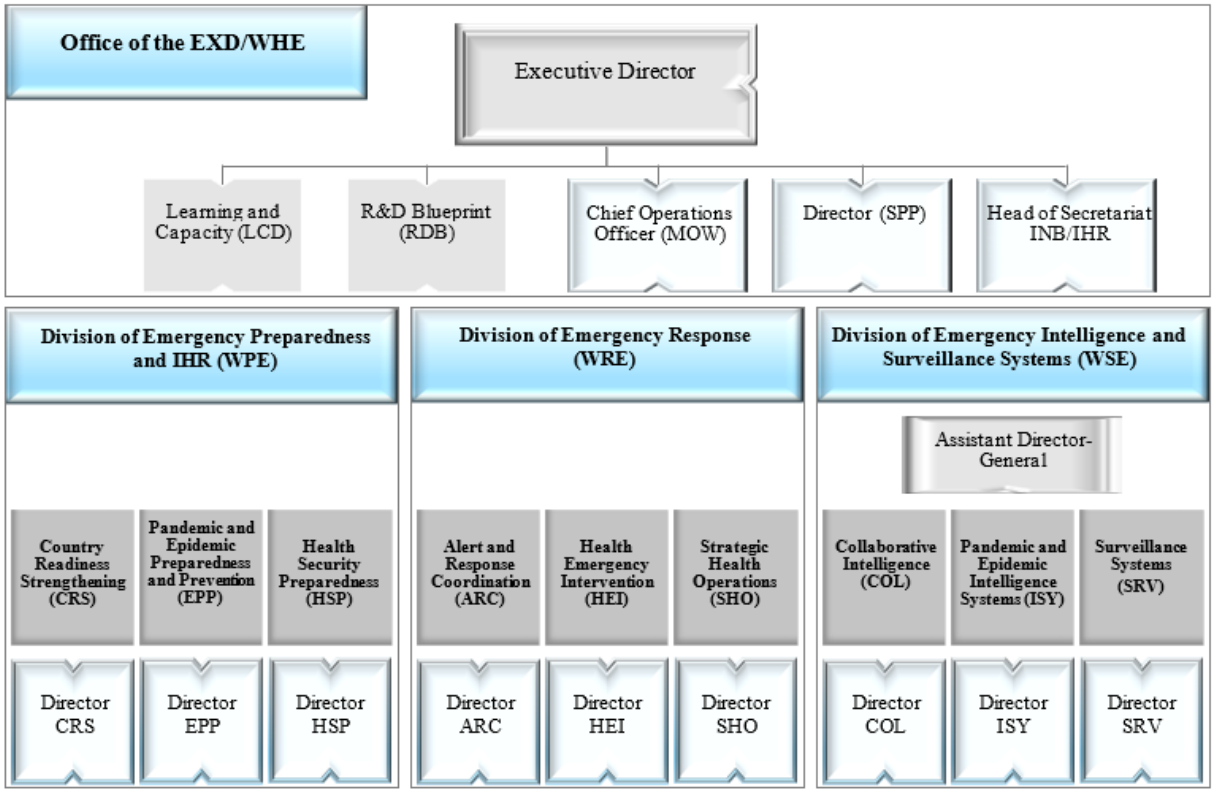
Recommendation 28: We recommend that WHO leads the advocacy for an international network of technical and financial partners (for development of vaccines) cutting across diseases following the principle of One Health. (Medium)

6.8 Changes in Organization Structure of WHE

239. Consequent to WHA decision 69(9) of May 2016, the WHE implemented the Programme through a consistent structure across WHO headquarters and all regional offices to optimize intra-agency coordination, streamline operations, and facilitate the smooth flow of information. At the country level, relevant functions of the Programme were replicated as deemed appropriate, ensuring a cohesive and harmonized approach to health emergencies worldwide.

240. From the organization structure of WHE at headquarters, we noted that the Emergencies Programme at headquarters in Geneva was composed of three divisions, namely, Division of Emergency Preparedness and IHR (WRE), Division of Emergency Response (WPE) and Division of Emergency Intelligence and Surveillance (WSE) (created in September 2021) with nine departments under them (**Fig. 3**).

Fig. 3 Organization Structure of WHE headquarters, 2023



Source: Information provided by WHE, December 2023

241. WHE informed that a revised organizational structure of WHE headquarters was put in place from January 2024. According to the revised organigram, departments under two divisions of WPE and WSE, namely, emergency preparedness and response were reporting directly to the Executive Director (EXD). A new/restructured Division of Intelligence and Surveillance System was put in place in 2022 with a Divisional head at Assistant Director-General level and three departments, namely: Collaborative Intelligence (COL); Pandemic and Epidemic Intelligence System (ISY); and Surveillance Systems (SRV), were reporting to the Divisional Head (**Appendix 5).**

242. A comparative analysis of functions across the nine departments of WHE indicated that many closely linked activities were simultaneously being implemented by different departments. For example, the department of Alert Response and Coordination (ARC) was involved in detection, verification and risk assessment of potential public health events and monitoring of epidemiological trends, public health situation analyses and response, the Systems Surveillance (SRV) department under the division of Intelligence and Surveillance was also entrusted with similar responsibilities like strategies for public health surveillance and intelligence, multi-sectoral engagement and field epidemiology. Surveillance activities, whether for monitoring and situation analyses of acute events, or for developing strategies for public health surveillance stem from a single goal of strengthening the surveillance and intelligence of health systems by WHO. Involvement of two different departments for working on similar responsibilities indicate possible overlap and duplication of functions having risk of injudicious deployment of resources and unclear roles and responsibilities.

243. We further noted that the emergency functions in regional offices were generally organized in line with the three outcomes of WHE under SP2, i.e. preparedness, prevention and emergency response.

For example, we noted from the organigrams of EURO that for the years 2018–2019 to 2022–2023, the WHE division under the regional emergency director (RED) consistently had the following distinct programme areas: (i) country health emergency preparedness and IHR (CPI); (ii) infectious hazard management (IHM); (iii) health emergency information and risk assessment (HIM); (iv) emergency operations (EMO). The former two programme areas were focused on preparedness/prevention, while the latter two were focused on emergency response.

244. The functional reorganization of WHE headquarters division/departments has been undertaken in Jan 2024 without a corresponding change in the structure of regional offices. This could impact the lines of communications of the RO/CO with the relevant headquarters departments, as roles and responsibilities of headquarters departments may not have the required clarity, ultimately impacting the speed and efficiency of WHE's actions during emergency response.

245. WHA's decision of 2016 to create a unified structure, single budget, single staff work plan, and a common results framework across all levels for the Health Emergencies Programme was *raison d'être* of creating WHE. WHO's goal of pursuing the transformation agenda should not compromise the distinct nature of work inherent in the WHE's emergency preparedness and response operations.

246. Consolidation of functions in line with the overall strategic outcomes of WHE, namely health preparedness, prevention and response that represent the core work of WHE would ensure that integrity of the principle of One Programme continues to be maintained.

247. WHE stated that the last approved organigram of the WHE Programme was in December 2019. An update was submitted in 2021 but has not been approved. It is therefore difficult to validate the statistics for WHO headquarters as they refer to a baseline that is from 2019 and does not reflect the current needs.

Recommendation 29: WHE may consider functional restructuring and consolidation of functions and resources on the principle of One Programme. This may be expeditiously done to have an updated and approved organizational structure with consistent strategic objectives in place. (Medium)

E. AUDIT OF DATA MANAGEMENT OF WHO

1. Introduction

248. WHO's constitution (Articles 61 to 65) provides for collection of data on trends in health and health policy and to disseminate that information. GPW 13 ushered a strategic shift that focuses on data (April/May 2018). Accurate and timely data is essential for Member States to achieve health and health-related Sustainable Development Goals (SDG).

249. WHO's transformation agenda (2017) also highlighted an urgent need to reduce data fragmentation and increase efficiencies in WHO's end-to-end data processes. Particular emphasis was placed on the consolidation of health data and assets for external and internal users as well as use of modern technologies, including analytics and visualization methods. This recommendation was reinforced (February 2020) by the Executive Board (EB) where the Independent Expert Oversight Advisory Committee (IEOAC) and the Programme, Budget and Administration Committee (PBAC) report recommended establishing a central state-of-the-art repository for health data. The central data repository sought to:

(a) resolve data fragmentation by consolidating WHO's data repositories, portals and datasets;

(b) reduce data collection burden on countries;

(c) support country capacity in data and health information systems;

(d) track GPW 13 triple billion targets and health-related SDG targets by providing timely, reliable and actionable data.

250. WHO hired Deloitte (November 2018) to assess existing processes for data management and suggest a system for end-to-end data management. Deloitte issued its report on data management assessment, data governance and data process to WHO in February 2019. Subsequently, the Division of Data, Analytics and Delivery for Impact (DDI) was constituted by WHO in March 2019 to bring out a data management platform for WHO. To implement the recommendations, DDI initiated development of a new end-to-end data management platform named World Health Data Hub (WHDH) in 2019. As per the Deloitte report, the platform was expected to be implemented by March 2022. WHDH is expected to assist in securing data exchange between Member States and WHO. The storage of data in a centralized repository would be used by WHO's data managers for analysis, interventions, visualizations and for publishing reports, thereby reducing data fragmentation and increasing efficiencies in WHO's end-to-end data processes.

251. WHDH is expected to assist in securing data exchange between Member States and WHO. The data will be stored centrally in a cloud-based platform, which will be accessible to all the internal stakeholders (headquarters, RO, CO) and can further be leveraged by WHO for carrying out data analytics for monitoring implementation.

2. Audit objectives, scope, and methodology

252. We audited the implementation of the WHDH in October–November 2023 to assess whether:

- governance framework in relation to data management was effective;
- envisioned theme of linking data with digital working was achieved; and
- adequate safeguards were in place for data security and protection of privacy.

3. Audit findings and recommendations

3.1 Implementation of project

3.1.1 Financial resources allocated for the project

253. The Deloitte report (February 2019) was the primary study report for initiation of implementation of the WHDH project. The report envisaged the project to be taken up in three phases, covering solutions for data governance and framework, creation of a data repository, analytics and visualization, and its roll out.

254. The report estimated the project to cost US$ 18.26 million,[1] with cost details for each of the 17 initiatives defined in the report. The report also had a detailed timeline with specific milestones identified.

255. We observed that the project costing model adopted by DDI did not have detailed project timeline with specific milestones and milestone-wise costing.

256. We further noted that DDI prepared a costing model for the project in which the costs were projected for "build" amounting to US$ 10.31 million for 2020–2022 and thereafter an "operate and run" cost of about US$ 11.30 million every year from 2023 to 2027, totalling US$ 66.79 million. The costing was classified under "grow", "manage and run" and "staff costs" components.[2]

257. We also noticed (as of February 2024) that certain components of the WHDH such as Datalake, xMart, Datadot, Data Visualization Engine and Country Portal (Consultations sub-module) have been rolled out. However, other components such as Catalog, Data Activity Calendar, Country Portal (Collections sub-module) are yet to be rolled out. Detailed status of implementation of WHDH modules is given in **Appendix 6**.

258. On reason for delays in completion of the WHDH project, Management stated that the project suffers from financial instability; and owing to lack of continued flow of resources, it has already estimated a time overrun of about 6 to 9 months for modules currently under implementation. It further stated that WHDH project development follows an agile approach, where capacity is allocated, and features are prioritized and developed according to the needs of the Organization and the available resources and the platform would continue to evolve.

259. We noted that the funding support for the project (other than staff cost) includes a significant discretionary component in the form of "in-kind and financial contributions from Donors" valued at approximately US$ 6 million, against a total of US$ 15.36 million spent (as on December 2023) on the project. Given the significance of the project, the project requires prioritized organizational commitment in the form of clear identification of timelines and resources to ensure achievement of the transformation agenda of WHO.

Recommendation 30: WHO may consider committing itself to this significant project by allocating resources; and the progress may be reported on a quarterly basis to an appropriate committee, in a manner compatible with WHO's Project Management Framework. (High)

260. Management accepted the recommendation.

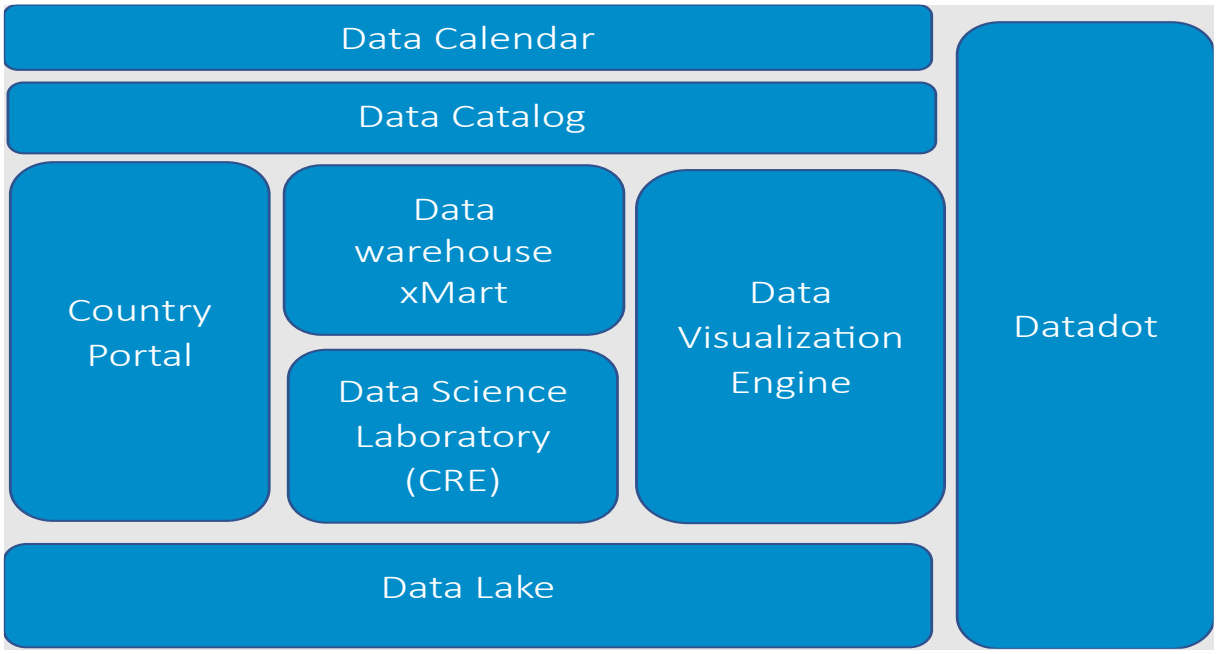
3.2 WHDH Application Modules

261. The WHDH comprises several products, aiming to deliver an end-to-end solution for all health data. The major application components are given in **figure 4**, below:

[1] Development/implementation cost excluding maintenance cost.

[2] The grow component covers flexibility and expansion of the WHDH, while the manage and run component covers delivering the WHDH as infrastructure and services to the whole Organization.

Fig. 4



Source: Write-up provided by DDI

3.2.1 Country Portal

262. The Country Portal is to facilitate two-way secure and digital exchange between Member States and WHO. It aims to support a common framework for Member States consultations ensuring compliance with WHO policies, standardization of tools and processes for Member States data submission requests (collections), addressing feedback loop post-publication by sharing visualized results (profiles), thereby facilitating traceability of WHO data engagements with Member States' including visualization of those engagements for greater coordination and reducing the reporting burden.

263. We observed that the Country Portal has evolved continuously from October 2020 to September 2023, enabling Member State and WHO (three-level) access, standardization of the Member State consultation process (including feedback loop), data submission/file exchange (stored via WHDH: Data Lake), communications (via Chat, email/web notifications, multilingual), data lineage/Member State engagement traceability, and visualization of Member State engagements.

264. We noticed that as of September 2023, a total of 13 technical groups had completed consultations on the Country portal. When enquired about the details of the technical groups which were yet to be onboarded, the DDI stated that the exact number of technical groups pending to be onboarded was not known and there is no notion of "groups to be onboarded" or finite programmes to be onboarded, as consultations and collection exercises are performed continuously by programmes – following a calendar which is specific to them. The Management, however, earlier informed that the Country Portal internally benchmarks onboarding against SDG indicators and that it had engaged with 58% of the SDG indicator focal points, of which 27% are using Country Portal for consultations. The Management stated (April 2024) that they were actively monitoring the engagement.

265. We observed that the collections component of the Country Portal, which contributes to reducing reporting burden of the Member States, is still being implemented. We noticed that when countries were

asked about challenges in June 2022, they highlighted data fragmentation, over-reporting, having too many tools and need for technical capacity-building as priority issues.

266. We noticed that WHO had conducted a study with the help of an external contractor to evaluate the top five commonly used data collection platforms across the Organization, to identify which one would provide the best return on investment. The contractor recommended a product as best suited for WHO's needs. The WHO is yet to assess the pros and cons of the proposed solution and decide on its recommendation.

267. Furthermore, we sought details from Information Management and Technology (IMT)[1] Division regarding the tools/applications used by technical groups for collection of data from countries. We also discussed[2] the data collection mechanism with DDI and technical groups. We observed that technical groups were collecting health data from the Member States using their own distinct tools/applications,[3] outside the tool list provided[4] by IMT. Employing various non-standardized tools may reduce effectiveness of centralized data collection and monitoring systems.

268. We conducted a survey (**Appendix 7**) for technical groups and noticed that 21 out of 121 technical groups were using software/applications/portals such as excel/toolkits/web portal for data collection.

269. We conducted a survey and obtained feedback from focal points of the Member States on the process of data collection. We received 66 responses from focal points of 53 Member States (**Appendix 8**). The focal points of Member States responded that the process of transmitting data was user-friendly. They however mentioned that trainings provided by WHO required improvement. They also highlighted challenges in linking the data provided by them to WHO with subsequent WHO's interventions, insufficient consultation with Member States by WHO before finalizing reports, and multiple requests for the same data from different groups, leading to data inconsistencies. Thus, the objective of reduction of data fragmentation envisaged in the WHO's transformation agenda, planned to be completed by June 2022 by the management, is still in process.

270. Management replied that that there are several initiatives underway to improve data fragmentation and reporting burden on countries. Within the WHDH, the following two distinct, major solutions were under implementation: (i) Country Portal; and (ii) Calendar.[5] Standardizing on Country Portal for communication, data collection and consultation is expected to significantly reduce data-related burden of Member States and WHO regional and country offices and improve timeliness of data availability and accessibility.

Recommendation 31: We recommend that remaining work on the Country Portal for data collection for communications and Data Calendar, which are the major solutions to address data fragmentation and reporting burden of Member States, be expedited. (High)

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[1] Division providing technology and services in WHO.

[2] Based on discussion with Tuberculosis Division, UHC/HEP Division (Nutrition, Food safety, Road safety and Tobacco control), Anti-Microbial Resistance Division (NPM unit and SPC-SEL unit).

[3] Dataform, DHIS2, REDCap, Survey123, Electronic Joint Reporting Form(eJRF), Excel, nutrition data portal, Vitamin and Mineral nutrition information system, Health information systems/portals, etc.

[4] Dataform, DHIS2, REDCap, Survey123, Electronic Joint Reporting Form (eJRF).

[5] Refer to paragraph 27.

271. While accepting the recommendation, management affirmed that the implementation timeline is dependent on identification and commitment of sustained resources.

3.2.2 Data Lake and Data Science Laboratory

272. Data Lake is a central data repository for WHO teams to store and mange structured and unstructured files for data science and advanced analytics. The process involves ingestion of raw data into the WHO data space, store data in native format, eliminate data silos, connect from anywhere using valid credentials, and preserve data version history. It is used to harmonize data through data warehouse (xMart). Data Science Laboratory[1] is a self-contained data analysis workspace, where internal and external stakeholders can collaborate in a shared project workspace in a self-service and secure manner.

273. We observed that the Data-Lake was launched in 2021. It has four quality levels (bronze, silver, gold and platinum) for data classification. The Data Science Laboratory platform was also made functional as a data analysis platform from 2021.

3.2.3 Data Warehouse and xMart

274. The xMart is a central repository of health data in existence since 2012. It is used for harmonization and warehousing for WHO data managers. The xMart-OData application programming interface (API) is available for both internal and external users.

3.2.4 Data Visualization Engine

275. This component has advanced data visualization system with charts, images, etc. It leverages Sitefinity tool for development of visualization engine as well as for public display of data through Datadot.

276. We observed that Data Visualization Engine was in an advanced stage of development with work being done on diagramme/charts and multilingual features. The Data Visualization Engine currently holds charts and visualizations. However, acceleration of the chart rendering process was under development.

3.2.5 Data Catalog and Data Activity Calendar

277. Data Catalog is a comprehensive catalogue of all health data, enabling finding and downloading easily WHO data. Upon completion, the technical groups can use public data/sources independently and make it available for others. Further, WHO publishes mandatory and other reports on periodical basis for submission to Health Assembly such as IHR reporting, World Health Statistics Report etc. The Data Activity Calendar will act as a planning/monitoring tool with tracking features for dependencies on other events/divisions, reducing Member States' reporting burden.

278. We observed that the Data Catalog and Data Activity Calendar were at the conceptualization, requirements-gathering and prototyping stage.

[1] Earlier referred as Collaborative Research Environment

279. Management replied that Data Activity Calendar and Data Catalog have been conceptually merged, but future-oriented data could be shown via a Calendar. Further, delay is partly due to resource constraints.

3.2.6 Datadot (data.who.int)

280. Datadot is a website meant for dynamic data visualization, with search, downloadable, cataloguing and publishing facilities. It is a publicly accessible interface for sharing and enabling visualization of WHO's health data assets.

281. We observed that the data description scheme was launched in May 2022, the country pages in December 2022, visualization engine in December 2022 and indicator pages in May 2023. We however noticed that the data visualization was still in "Beta" stage.

282. We also noted that the contract with the vendor for designing and implementing Datadot platform has expired (September 2023). The DDI's internal reports have identified this as a vendor contracting risk. WHO acknowledged that there was significant risk affiliated with intermittent contract availability. Management replied (April 2024) that the contract was later renewed and that intermittent/short-term funding impacts contract availability and therefore development delivery timelines remain true.

283. In summary, out of the 13 initiatives[1] pertaining to Data, Technology, and People included in the Deloitte report for implementing the WHDH project, one initiative was in proof-of-concept stage, two were pending to be taken up, seven were partly implemented/under development and only three were implemented. The details are given in **Appendix 9**.

284. Management informed us that the Deloitte report was used as an input to be assessed in conjunction with its own needs, constraints and priorities and it was not obliged to implement all the recommendations. On delays in completion of the different components of WHDH, Management replied that it was due to staff instability, short-term contracts, non-availability of resources and lack of sustained funding.

Recommendation 32: We recommend that Project milestones may be set by dovetailing the different components of WHDH, and its implementation monitored by the Data Governance Committee. (Medium)

285. Management accepted the recommendation.

3.2.7 Quality of application data

286. The central pillar of WHO's transformation initiative involves establishment of a robust performance management system underpinned by clearly delineated key performance indicators. As a multilateral organization, WHO has adopted an input-output-outcome model, known as a results framework, for performance management. This framework is designed to align WHO's daily operations with its overarching mission and strategic objectives. Its implementation was integrated into WHO's broader endeavour to develop an impact-focused, data-driven strategy.

[1] Four initiatives are on Process.

287. The performance management system relies heavily on performance indicators, primarily sourced from SDG indicators, with a few formulated following GPW 13. At the core of WHO's objectives lie the triple billion targets, representing the impact, which is intricately linked to outcome and output indicators. These targets are monitored through the triple billion dashboard, intended to provide comprehensive data at the national and regional levels across various indicators over successive periods. Additionally, data is also collated from the WHO Global Health Observatory to augment the information available for analysis and decision-making processes.

288. The GPW 13 calls for promoting strategic disaggregation of data through collection, analysis and reporting based on sex, income, disability, ethnicity and age group categories in surveys, routine data, and other data sources, for achieving health equity and improving programme delivery.

289. We analysed two out of 14 publicly available datasets from the health inequality data repository, pertaining to SDGs and GPW 13[1] for the period 2019 to 2022 and noticed that the number of countries for which indicator information and disaggregated data was available, is outlined in **table 10** below:

Table 10: Availability of disaggregated data for SDG indicators in the health inequality data repository

Year	Number of countries/territories with data available	Total number of indicators in dataset *(max in all years=158)*	Number of countries/territories with disaggregated data for at least 50% of the number of indicators in each year	Number of countries/territories with data for at least 79 indicators *(50% of maximum number of indicators in all years)*
2019	198	142	10	3
2020	198	124	1	0
2021	128	40	0	0
2022	*Data not available*			

Source: Datasets from the health inequality data repository

Table 11: Availability of disaggregated data for GPW 13 indicators in the health inequality data repository

Year	Number of countries/territories with data available	Total number of indicators in dataset *(max in all years=39)*	Number of countries/territories with disaggregated data for at least 50% of the number of indicators in each year	Number of countries/territories with data for at least 20 indicators *(50% of maximum number of indicators in all years)*
2020	195	27	4	2
2021	142	6	7	0
2022	135	2	135	0

Source: Datasets from the health inequality data repository

290. **Table 11** above provides a summary of the availability of data for key indicators related to SDGs and the GPW datasets. As seen therefrom:

[1] Pertaining to the health inequality data repository: https://www.who.int/data/inequality-monitor/data.

(a) in 2019, disaggregated data were available for 198 countries/territories and there were a total of 142 SDG indicators with disaggregated data available for at least one country/territory (out of a maximum of 158 indicators across all years). The number of indicators with disaggregated data available reduced to 124 in 2020 and 40 in 2021. Few/no countries/territories had disaggregated data available for at least 79 indicators (50% of the maximum);

(b) data availability related to 37 GPW 13 indicators followed a similar trend. In 2020, there were 27 indicators with disaggregated data available for at least one country, reducing to 6 in 2021 and 2 in 2022;

(c) disaggregated data availability for both SDG and GPW 13 indicators was hardly available for 2022.

291. We observed that the technical groups, which are the custodians and primary users of this data, were expected to update this data annually. We understand that it may not be possible for countries to possess data pertaining to all the indicators annually. There are some data points for which countries and other agencies collect data with a periodicity of more than one year. We have come to believe that the technical groups do use estimations for the gap data for their internal analysis, as and when required. One of the objectives of the WHDH project is to capture data in a centralized system and resolve data fragmentation. The availability of data used is also expected to provide better inputs to Member States in implementation of their own programmes. The technical groups should leverage the Country Portal module for effective communication with the countries in this regard.

292. As per the WHO risk management strategy,[1] poor data or non-availability of data in health may affect the ability of the WHO and its partners to identify public health needs, respond to them effectively and demonstrate impact against the triple billion targets.

293. Management stated that it was actively advocating for improved collection, analysis, reporting and public sharing of disaggregated data and regularly running training workshops for countries to build capacity. WHO's five-year strategy for health inequality monitoring[2] includes a proposal to produce a global health inequality monitoring atlas, which would be a comprehensive study of country capacity and resources for data disaggregation in all WHO Member States.

Recommendation 33: We recommend that the importance of collecting and providing disaggregated data be advocated to all Member States. (Low)

294. Management accepted the recommendation.

3.3 Utilization of WHDH data in prioritization of WHO interventions

295. WHO embraced the approach of delivery for impact (DFI), as part of its transformation emphasizing translating data, science and evidence into tangible results in countries. To facilitate regular

[1] WHO risk management strategy. Geneva, World Health Organization Office of Compliance, Risk Management and Ethics (CRE); 2022 (https://cdn.who.int/media/docs/default-source/documents/ethics/who-risk-management-strategy.pdf?sfvrsn=12563c32_1&download=true), accessed 18 April 2024.

[2] Inequality Monitoring and Analysis Strategy 2022–2027. Geneva: World Health Organization; 2022 (https://www.who.int/data/inequality-monitor/about/), accessed 18 April 2024.

progress updates and dialogue, DFI convenes stocktakes[1] that provide senior leadership a forum to examine overall progress towards the triple billion targets and assess specific areas against possible acceleration, to identify opportunities for further intervention.

296. Data is analysed to identify trends, countries which are most off-track and need to accelerate progress. This analysis is then aligned with the bottom-up prioritization of the country office through the Programme budget, the Country Cooperation Strategy (CCS) and country support plan. At the country level, the delivery dashboard supports countries to track progress on implementation across high-priority outcomes. Data on progress toward SDG achievement and likelihood of meeting global targets forms the basis of a data-informed prioritization process.

297. The guidance note (November 2022) for developing the Programme budget, read with documents on setting technical priorities at country level, prescribed the principles for developing the Programme budget. It envisaged an iterative approach starting at the country/territory/area office level to ensure maximum alignment with local context and priorities. It was guided by the global and regional strategic directions, as well as available credible data, evidence and trends, especially at the country/territory/area level, and focused on those areas where WHO's added value is recognized.

298. We observed that DDI prepared region and country-wise performance achievement against SDG targets. Also, eight stocktakes[2] were done between 2020 to 2023. DDI prepared accelerated scenarios required for meeting or minimising the gap in attaining the SDG targets by 2030. The DDI provided country and regional-level data views on GPW 13 indicators for data-driven processes in the Programme budget and country support plans. Further, DDI organized two 100-day challenges to create a single prioritization process for country offices (stocktake) in nine countries.

299. We acknowledge the efforts of DDI in identifying the priority areas for WHO intervention based on the available WHDH data. However, we did not find evidence regarding use of this analysis while preparing the Programme budget. We noticed that each Regional Office approached the Programme budget formulation using different tools[3] and processes.

Recommendation 34: We recommend that the inputs of DDI developed through stocktakes may be integrated with the budget preparation activities. (Medium)

300. Management accepted the recommendation.

301. The CCS outlines priorities for a country, which differs based on the country context and needs. We observed that a list of intervention priorities (accelerated scenarios/stocktakes) suggested by WHO for SDG/outcome priorities based on data, and their acceptance or otherwise by Member States were not documented for dissemination and transparency.

[1] Stocktakes focus on the programmatic areas such as climate and health, obesity, tuberculosis, primary health workforce, health emergencies preparedness, and reducing maternal mortality, to identify milestones and outputs to accelerate progress and drive implementation.

[2] For example, in 2022 two stocktakes were held on healthier populations and health emergencies protection.

[3] African Region – AFRO (TAR-2 platform); Region of Americas – AMR/PAHO (PAHO-adapted Hanlon methodology and principles); South-East Asian Region-SEARO (excel based optimization tool); European Region – EURO (Guided by European programme of work (EPW) priorities, Eastern Mediterranean Region – EMRO (development a tool to support the outputs and outcomes prioritization), Western Pacific Region – WPR ("One Team" approach).

302. Management replied that currently they did not have specific intervention priorities within their portfolio, though it could be considered in future in collaboration with technical programmes. It further stated a working group of DDI, PRP, CSS and Transformation are already working to align the process at headquarters.

Recommendation 35: We recommend that a list of intervention priorities (accelerated scenarios/stocktakes) suggested by WHO for SDG/outcome priorities based on the data is provided to WHO Country Offices and Member States to inform prioritization efforts. Final lists of priorities for WHO support decided by countries, including targets and acceleration plans as included in the CCS should be published to provide transparency. (Medium)

303. Management accepted the recommendation.

304. WHO is in the process of implementing a new ERP system, viz., the BMS, which contains the system for programme management (SPM) module for preparation of the budget. We observed that the results of DFI were not yet integrated with BMS.

305. Management replied that a link between the two systems was being considered through which data will be updated at regular intervals.

Recommendation 36: We recommend that integration between the SPM module of BMS and the WHDH, be considered for budget formulation. (Medium)

306. Management accepted the recommendation. The Management further stated that since mid-December 2023, work has started with the SPM team on making key programmatic indicators available.

3.4 Governance framework

3.4.1 Data governance

307. WHO's data governance[1] structure consists of the Data Governance Committee (DGC) and Data Hub & Spoke (H&S) Collaborative. The DGC provides organizational leadership and sets the corporate strategic direction for data strategy and policy. DGC is co-chaired by Deputy Director-General (DDG) and Assistant Director-General (ADG), DDI; and members include all ADGs and, as and when necessary, regional representation, directors, internal or external experts.

308. The H&S structure was technical in scope and the terms of reference was to collaboratively implement data governance across all three levels of the Organization by applying technical and contextual expertise to streamline end-to-end processes. The H&S is chaired by Director, Department of Data Analytics of DDI with co-chairs also being other headquarters department directors or regional focal points. The DDI/regional/country offices represented the Hub, and the technical departments, the spokes.

309. We observed that the H&S collaborative conducted meetings regularly and discussed assigned responsibilities. The DGC was to meet twice annually. However, it met only thrice since 2021 (till

[1] Defined as the necessary standards, solutions, and structures to ensure quality and integrity of WHO's data and health statistics.

September 2023). In the first three DGC meetings, there was no regional representation, and we were informed that they planned to include regional directors, however, there have been delays due to the COVID-19 pandemic.

310. We observed that regional representation in the DGC had not yet been implemented. The last meeting of DGC was held in June 2022. The Office of the Internal Oversight Services (IOS) had also recommended (June 2023) to review and update the membership, define clear scope of responsibilities and decision-making authority, oversight mechanisms of the DGC, and develop a data strategy that was well resourced for achieving WHO's data goals. On H&S, the IOS recommended undertaking a functional review of H&S collaborative, its operational decision-making roles and closer integration with other technical groups. WHO was in the process of implementing the same.

311. Management replied that the data governance white paper was under development with the H&S, and their inputs have been received. Initial efforts have already started in terms of updating the terms of reference for the DGC. The draft data strategy has been shared with the senior leadership in DGC. It also stated DGC will be convened.

Recommendation 37: We recommend WHO consider having regular DGC meetings at senior management level for decision making and advocacy with defined roles and responsibilities. It may have a structure put in place defining the roles and responsibilities, where representation would be inclusive of headquarters as well as regional offices. In such a structure, the role and responsibilities of other departments may also be clearly defined. (High)

312. Management accepted the recommendation.

3.4.2 Internal Governance of WHDH

313. The governance framework for the WHDH project included a WHDH steering committee. The committee is expected to meet bi-monthly and provide strategic decision-making and organizational alignment. The internal governance framework for the project also included a WHDH programme board, programme team, and product sync.

314. We observed that WHDH steering committee has not yet been constituted. The WHDH programme board, programme team, and product sync were formed, and they held meetings periodically.

315. Management replied that DDI had proposed a WHDH steering committee, however it was not formally established. It further stated that WHDH would be strengthened, and they will work towards establishing a new internal governance committee, which will involve more representation from the programme teams and from WHO regions.

Recommendation 38: We recommend that WHO may consider constituting a steering committee with adequate representation from all levels and departments of WHO for decision-making. (Medium)

316. Management accepted the recommendation.

3.4.3 Key performance indicators of WHDH

317. As per WHDH strategy document, the success of the WHDH project was to be measured based on four KPIs, namely: usage, accessibility, efficiency and impact.

318. We noticed that DDI does not currently report on the proposed WHDH strategy KPI metrics as part of active internal governance processes. In the absence of KPIs, the performance of the WHDH project cannot be assessed objectively.

319. Management replied that these were proposed KPIs and therefore were not being formally monitored; and as the Organization's ambition around data evolve, WHDH would need to evolve its KPIs.

Recommendation 39: We recommend that KPIs may be prepared and submitted to the Data Governance Committee for periodical monitoring, and discussed within the Hub and spokes. (Medium)

320. Management accepted the recommendation.

3.5 Security and protection of data

321. In WHO, IMT Division has overall responsibility for cybersecurity, however they refer to DDI for policy regarding protection of personal data in IT systems.

322. DGC approved a data protection policy and resulting terms of reference for the data protection and privacy officer and recommended for resourcing. We observed that the data protection policy is yet to be implemented pending approval from the Director-General. Pending that approval, the decision on identifying resources for implementing the policy has also not been initiated. This aspect was highlighted (May 2023) in the IOS report also (document A76/23).

323. We conducted a survey of technical groups (internal to WHO), in which 21 out of 121 technical groups responded. In the survey, four technical groups responded that they were collecting granular data on personal identification information (PII). Collection of PII by technical groups without implementing the data protection policy and providing resources posed significant risks.

324. Management replied that senior management was being briefed to discuss implementation of the policy and to reconvene the Data Governance Committee.

Recommendation 40: WHO should consider prioritizing the implementation of data protection policy and availability of structure for Data protection and privacy at the earliest. (High)

325. Management accepted the recommendation.

F. WHO REGIONAL OFFICE FOR AFRICA, WHO COUNTRY OFFICE, CONGO AND WHO COUNTRY OFFICE, NIGERIA

1. Audit Scope and Methodology

326. We reviewed the transactions of the WHO Regional Office for Africa (AFRO), and its two country offices, viz., WHO Country Office, Congo (WCO Congo) and WHO Country Office, Nigeria (WCO Nigeria) covering the period 1 January 2023 to 30 September 2023, specifically the processes and transactions relating to programme management, procurement management, travel management, human resource management, cash management and communicating project results to donors.

327. Audit methodology involved understanding AFRO's operating and control environment, testing adequacy and effectiveness of internal controls by requisitions, interviews, etc. It also included holding an entry conference for outlining the broad audit approach indicating our expectations from the management at the beginning of audit.

328. The audit findings include observations noticed during the review of all the three Offices, viz. AFRO, WCO Congo and WCO Nigeria.

2. Audit findings and recommendations

2.1 Budgeting and Implementation of the General Programme of Work

329. WHO prepares a General Programme of Work (GPW), which is a five-year plan for the Organization. GPW 13 covers the five-year period 2019–2023. GPW 13 is focused on three interconnected strategic priorities to ensure healthy lives and promote well-being for all at all ages: achieve universal health coverage (UHC), address health emergencies and promote healthier populations. The priorities of GPW 13 guide decisions pertaining to resource allocation.

330. We reviewed the data on the "WHO Programme budget portal" up to October 2023, in respect of biennium 2022–2023 as detailed in **table 12** below:

Table 12: Budget and funding on the three strategic priorities

		RO Africa	WCO Congo	WCO Nigeria
Universal health coverage	Budget (US$ millions)	523.60	3.80	67.30
	Financing (US$ millions)	432.90	3.40	59.00
Protection from health emergencies	Budget (US$ millions)	377.10	2.60	104.20
	Financing (US$ millions)	318.10	1.90	94.60
Better health and well-being	Budget (US$ millions)	79.00	0.62	3.20
	Financing (US$ millions)	42.90	0.26	0.59

331. As per the Planning Resource Coordination and Performance Monitoring Department (PRP) standard operating procedure,[1] implementation over the course of the biennium should normally average about 4% of planned costs per month and should be monitored against this target, and the manager should monitor workplans in detail for over- and under-spending.

332. We reviewed percentage of expenditure against financing for the three strategic priorities and their outcomes. Details are given in **Appendix 10**. Even though financing was less than budgeted amounts (**Table 12**), funds utilization as on October 2023 was as below vis-à-vis the funding available.

Table 13: Pace of expenditure on the three strategic priorities

Outcomes	Percentage of expenditure against financing		
	RO Africa	WCO Congo	WCO Nigeria
Universal health coverage	72%	82%	63%
Protection from health emergencies	75%	79%	69%
Better health and well-being	73%	60%	68%

333. As per the budget monitoring SOP, to ensure effective utilization of funds, around 88% of available funds should have been utilized by October 2023. We noticed that the pace of utilization of funds was slower than expected in all three strategic priorities. This issue becomes important considering only two months are remaining in the current biennium at the time of audit.

Recommendation 41: Management may strive to ensure financing commensurate to the budget, so that outcomes are realized as envisaged; and may expedite utilization of funds, before the end of biennium 2022–2023, as significant funds are left, in most of the outcomes. (Medium)

334. The recommendation has been accepted by the management.

2.2 Country Cooperation Strategy

335. WHO prepares a Country Cooperation Strategy[2] (CCS) for each country which serves as the strategic plan to guide WHO's work in the country. It is a joint WHO Member State instrument which helps WHO to align its work according to the priorities and needs of a country. WHO's CCS plays a critical role in enabling the Member State concerned and the WHO Secretariat to identify a medium-term vision and joint strategic agenda at the country level. It also defines for each outcome, the indicators to be used to measure progress and impact. WHO country workplans should flow from the CCS in line with the priorities, outcomes and outputs defined in the GPW.

[1] PRP.SOP.II.003 Budget Monitoring PRP/BCR.

[2] A CCS is the strategic basis for the bottom-up planning process, consisting of the identification of a focused and coherent set of priorities responding to country needs. The CCS document includes the Strategic Agenda mapped against the national health policies, strategies, plans and priorities, GPW outcomes, national SDG targets and the United Nations Development Assistance Framework (UNDAF) outcomes. This document is for a biennium (two years).

336. We observed that WHO African Region has valid CCS only with 18 (38%) out of 47 Member States. In respect of the remaining 29 Member States, no CCS exist. We also noted that in respect of 12 Member States (including Congo), the CCS had expired eight or more years back.

337. We further observed that the CCS for WCO Congo had expired in 2013 and a biennial operation strategy was prepared with the cooperation of the Ministry of Health of Congo. For WCO Nigeria, the CCS had expired in 2022 and renewal was under process. For the remaining 27 country offices, the arrangement between country offices and Member States were not made available to us.

338. We are of the view that, the absence of the country-specific arrangements impacts the identification of country specific priorities, cooperation with Member States and alignment with their respective national health polices, and planning and prioritization of resources.

Recommendation 42: Management may put measures in place to ensure that all country offices have a valid Country Cooperation Strategy with Member States. (Medium)

339. The recommendation has been accepted by the management.

2.3 Reporting and monitoring framework

2.3.1 Submission of Reports

340. The WHO e-manual envisages timelines for submitting of technical reports and financial reports (report on certification of expenditure) relating to various agreements, e.g. donor agreement, direct implementation, direct financial cooperation, grant letter of agreement as indicated in **table 14** below:

Table 14

Donor reporting	According to the WHO e-manual on awards reporting, final certified financial statements (FCFS) are to be issued following donor's requirements, normally within three to six months after the award end date. (Section IV 3.5)
Direct implementation	Direct implementation (DI) is used when WHO makes payments to personnel hired by the government to implement activities and a standard direct financial cooperation (DFC) contract cannot be used (either due to a lack of government capacity or because WHO implements an activity directly in collaboration with the government). Under the DI framework, the WHO country offices pay the end recipients directly. According to the WHO e-manual, DI report consists of the funding authorization and certification of expenditure (FACE) and technical report, and must be completed within 3 months of activity completion date (Section XVI 5.2)
Direct financial cooperation	Direct financial corporation (DFC) agreements are signed between WHO and the ministry of health of a Member State to cover cost of items and activities that the country does not have the financial resources for, but are needed to strengthen the government's health development capacity and their ability to participate more effectively or meet their commitments to WHO technical cooperation at country level. According to the WHO e-manual, DFC report also consists of the funding authorization and certification of expenditure (FACE) as well as technical report, both of which must be completed within 3 months of the activity completion date (Section XVI 2.2)
Grant letter of agreement	A grant letter of agreement (LoA) refers to the mechanism under which WHO transfers funds to an external party other than the governments. It is an arrangement under which funds are transferred to a beneficiary to achieve a specific programmatic result in line with WHO's objectives. WHO e-manual states that the grant LoA report is due within 90 days of the activity completion date (Section XVI 3.2)

341. We reviewed the data relating to submission of the above reports for the current biennium (2022–2023) and noticed the following delays:

Table 15: Delays in report submission

RO/CO	Total number of reports in the biennium	Reports submitted	Overdue reports	Report submitted with delay	Range of the delay (in days)
Donor report (submission in six months)					
AFRO	1 509	1 450	59 (4%)	887 (59%)	1 to 474
WCO Congo	26	26	Nil	20 (77%)	3 to 285
WCO Nigeria	303	217	6 (2%)	65(21%)	1 to 474
Direct implementation report (submission in three months)					
AFRO	10 157	8 241	148	1 537(15%)	1 to 407
WCO Congo	180	104	11	69 (38%)	6 to 142
WCO Nigeria	3 473	2 630	1	2 369 (68%)	1 to 408
Direct financial cooperation report (submission in three months)					
AFRO	3 011	2 093	64	647 (21%)	1 to 258
WCO Congo	27	12	10	4 (15%)	61 to 140
Grant letter of agreement report (submission in 90 days)					
AFRO	155	94	8 (5%)	31 (20%)	1 to 266

342. We observed that there were considerable delays in submission of these reports. Timely reporting on the status of implementation of programmes and utilization of funds is essential in maintaining a robust reporting framework and improving confidence of Member States.

Recommendation 43: Management may address the cause of delay or non-submission of Donor, DI, DFC and Grant LoA reports by strengthening regular follow-up. (Medium)

343. The recommendation has been accepted by the management.

2.4 Cash management

344. An imprest account mechanism is used for payment pertaining to operating expenses, usually at the country offices, where a central accounting system cannot be used. The module to record these transactions is referred to as *eImprest* in the GSM (WHO's ERP application).

345. We reviewed the imprest accounts of AFRO and COs in Congo and Nigeria and observed the following:

2.4.1 Closure of inactive imprest accounts

346. Financial SOP (X.002) requires that accounts lying inoperative for 12 months be considered for closure. We, however, noted that 23 inactive imprest accounts (including two in AFRO) were still open beyond 12 months.

2.4.2 Reconciliation status and rating of imprest accounts

347. The WHO eManual[1] requires that bank and cash reconciliations be carried out early, in each subsequent month. Further, the SOP[2] requires a rating to be given to each account subsequent to the reconciliation. We found that out of the 220 imprest accounts, seven accounts were reconciled after 180 days, four accounts between 91–180 days and 40 accounts within 90 days. Further, four imprest accounts did not receive the mandated ratings as they were unreconciled.

2.4.3 Ceiling for Imprest Accounts

348. WHO eManual[3] establishes a ceiling for each imprest bank account at a maximum amount which is considered sufficient to cover general operational costs paid at the local level and payments made on behalf of the Global Service Centre. We noticed that in three Imprest bank accounts operated by CO Nigeria, the bank balances exceeded the approved ceiling limits.

349. WHO e-Manual[4] suggests the assignment of a ceiling to imprest cash accounts although it is not considered mandatory. We noticed that WHO is moving towards assigning ceilings for the imprest cash accounts. Out of 199 imprest cash accounts in WHO, ceilings have been assigned in 103 accounts. We noticed that AFRO management is also gradually reducing the imprest cash balances, however there were four imprest cash accounts which had a balance in excess of US$ 10 000, for which ceilings had not been assigned.

Recommendation 44: Management may strengthen internal control for management of imprest accounts by ensuring timely and regular reconciliation, review of ceiling limits in cash imprest accounts and timely closure of inactive imprest accounts. (Medium)

350. The recommendation has been accepted by the management.

[1] Provision X.3.7.

[2] Provision X.004.

[3] Provision X.3.2.

[4] Provision X.3.2.

G. ACKNOWLEDGEMENT

351. We wish to express our appreciation to WHO, its senior management and its staff for the cooperation and assistance extended to the audit team during the audit.

Sd/-

Girish Chandra Murmu
Comptroller and Auditor General of India

15 April 2024

H. LIST OF ABBREVIATIONS

Abbreviation	Full name
ADG	Assistant Director-General
AFRO	Regional Office for Africa
API	Application programming interface
BCA	Biennial collaborative agreement
BMS	Business management system
BOS	Business Operations
CCS	Country Cooperation Strategy
CFE	Contingency fund for emergencies
CMS	Case management system
CO	Country office
DDG	Deputy Director-General
DDI	Division of Data, Analytics and Delivery for Impact
DFC	Direct financial contribution
DGC	Data Governance Committee
DI	Direct implementation
ERF	Emergency Response Framework
ERP	Enterprise resource planning
EURO	Regional Office for Europe
FACE	Funding authorization and certification of expenditure
FCFS	Final certified financial statement
FENSA	Framework of Engagement with Non-State Actors
GLOA	Grant letter of agreement
GPL	Global Procurement and Logistics
GPW	General programme of work
GSM	Global management system
H&S	Data Hub & Spoke
IAASB	International Auditing and Assurance Standards Board
IASC	Inter-Agency Standing Committee
ICG	International coordination group on vaccine provision
IHR	International Health Regulation
IMS	Incident management system
IMST	Incident management support team
IOS	Internal Oversight Services
IPSAS	International Public Sector Accounting Standards
ISA	International Standards on Auditing
ITB	Invitation to bid
JEE	Joint external evaluations
JSP	Joint strategic plan
KPI	Key performance indicator
LTA	Long-term agreement
MEF	Monitoring and evaluation framework

Abbreviation	Full name
MIS	Management information system
MOU	Memorandum of understanding
NAO	National Audit Office
NAPHS	National actions plan for health security
OCR	Outbreak and crisis response
OCV	Oral cholera vaccine
OSL	Operation Support and Logistic Unit
PAHO	Pan American Health Organization
PFI	Packaging, freight and insurance
PHEIC	Public health emergency of international concern
PO	Purchase order
PR	Purchase requisition
QA	Quality assurance
RFP	Request for proposals
RPI	Regional plan for implementation
RRA	Rapid risk assessment
SCT	Supply chain transformation
SDG	Sustainable Development Goals
SEARO	Regional Office for South-East Asia
SGL	Scan global logistics
SLA	Service level agreement
SOP	Standard operating procedure
SSA	Special service agreement
SUP	Procurement and Supply Services Department
TMS	Transport management system
WHA	World Health Assembly
WHDH	World Health Data Hub
WHE	WHO Health Emergencies Programme
WCO	WHO country office

Appendix 1

STATUS OF IMPLEMENTATION OF RECOMMENDATIONS UP TO THE FINANCIAL PERIOD ENDED 31 DECEMBER 2023

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
1	2020	R001	Encourage the personnel handling procurement processing functions, as well as project approvers at HQ, regional and country offices, to complete the relevant sections of the procurement iLearn curriculum, and to periodically revisit the curricula to refresh themselves and fully appreciate the processes to minimize, if not eliminate, the possible processing errors resulting in the misclassification of the accounts in the financial statements.	SUP has taken significant steps to provide staff training, including category management, sustainable procurement, and Chartered Institute of Procurement and Supply (CIPS) programs for SUP staff. Current training is closely linked to GSM and new training methodologies and approaches will be implemented with BMS. There is a global procurement training strategy, approved in 2019, with an implementation plan focusing on the target audience, curricula for each audience, and specific training modules in procurement. The training was designed in alignment with GSM and tailored to the level of authority and access within GSM. This approach proved highly successful, with 87% of staff requesting GSM procurement requestor responsibility successfully completing the training, while 12% commenced training but did not complete. It's important to note that staff who have not completed the training are not given GSM procurement responsibilities. Additionally, capacity-building is one of the supply chain transformation projects, and further training needs will be explored, particularly as BMS implementation will drive system changes and new training needs.	The recommendation is closed.	Y			
2	2020	R002	Account and report the effects of the prior period errors in accordance with IPSAS 3 to avoid distorting the balance of revenue and ensure fair presentation of the account in the reporting period.	Based on recommendation note 3 has been added to the FR for any future adjustments relating to prior periods. Since, in the last 2 years there have been no such events, we propose to close this recommendation.	The recommendation is closed.	Y			
3	2020	R003	Apply in the newly developed feature in GSM a quality assurance (QA) check up-front to DFCs and DIs, and should be adopted in all regions so that DFC and DI PO requirements are fully adhered to.	Please refer to R003 EMR approach to QA pre-checks (reduced) for update. (FBOR) In EMRO the GSM QA check has not been implemented. As mentioned in the document “EMR approach to quality assurance pre-checks”, an “eWorkflow” tool has been used since 2016 for DFC, DI and Imprest POs. For GLOA POs, the eWorkflow is not used as the GLOA secretariat of the regional	The current response of WHO refers to an absence of GSM QA check in EMRO. Additionally, whether the “eWorkflow” tool addresses all applicable QA checks for			Y	

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
				office reviews the information provided by the initiator (before the presentation to the Grant Review Committee). Please review "EMR approach to quality assurance pre-checks"	entities barring EMRO is not clear. Recommendation may be kept open.				
4	2020	R004	Give importance and strictly follow at the country office level as well as in the GSC level (the unit assigned to process and issue the DFC POs and DI IPOs) the relevant provisions requiring the exceptional approval from the Comptroller.	The requirement is that for DI and DFC, if using a PTAEO that does not belong to the implementing CO is proposed to be used, either DAF or Comptroller approval has to be obtained (not just Comptroller). CO have been reminded of this. There is a reminder "pop-up" in the GSM that reminds the submitter of this requirement. Also since May 2020, an up-front QA check has been put in place for DFC, DI and Grant LOA in all regions (except EMRO, who will be implementing this shortly), which checks that the SOP requirements are fulfilled before the project approvers approve the PRs. If this approval is not attached, the PR is rejected. Therefore instances where no such approval is obtained has reduced to a minimum of cases. 17/09/2023: The document "Exceptional approvals for DFC and DI charged to PTAEO other than the implementing CO" shared by EMRO is still applicable. For DFC, in 2022 and 2023, EMRO did not report any case where activities were funded by a PTAEO that did not belong to the implementing budget centre. in 2022 and 2023, EMRO reported a low number of DI IPOS raised with a PTEAO from a different BC (25 in 2022 and 11 in 2023).	The provision is yet to implemented in EMRO. Recommendation may be kept open.		Y		
5	2020	R008	Conduct a feasibility study or analysis with a view of developing an automated workflow system for the separation payment process that will provide relevant users, both within and outside GSC the necessary functionalities.	The requirement of end-to-end automation of separation process has been provided to BMS – Organization-wide initiative for implementation of new ERP (WorkDay). The end-to-end separation automation is now a part of final process taxonomy of BMS project. The Separation Clearance Workflow will now be delivered as a part of BMS project. We propose to close this recommendation. 7/11/2022: End to end automation of separation workflow has been provided as an input during the BMS requirement gathering phase. Enhanced performance of separation process in terms of turn-around-time and efficiency is one of the identified KPI for BMS project for future system development and monitoring. 2/11/2022: BMS team comments: The analysis will be covered within the context of the implementation of WHO's new Business Management System (GSM replacement project) under the Business Process Optimization (BPO) phase. Along with other HR streams,	The response of WHO can be verified once BMS has been rolled out. The recommendation may be kept open.		Y		

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
				the separation and off-boarding business processes and functionalities will also be reviewed, with a view to develop the required flexible, agile, streamlined and efficient business process within the new system.					
6	2020	R009	Revise the Human Resource Strategy aligning it to the WHO Transformation agenda.	This recommendation will be addressed in 2023 to take advantage of the inputs from the HR-related transformation initiatives that were concluded in 2022, and the outcome of Global Management Meeting to consult on strategic organizational priorities.	Response of WHO refers to the recommendation being addressed in 2023 but the same has not been detailed/updated. It is assessed that we may not close this recommendation. The current WHO response appears incomplete. The recommendation may be kept open.			Y	
7	2020	R010	Revise the Framework for Learning and Development responding to the Transformation as anchored to human resource strategy thus, optimize overall staff capacity and talent.	25/10/2022: This is a long-term project which is being addressed by HR through the Career Management and Development initiative, in coordination with the WHO Academy.	The recommendation is closed.	Y			
8	2020	R012	Review the harmonized selection process to allow further customization of screening questions to improve the utility of the preliminary screening procedure.	12/05/2023: The review of the Harmonized Selection Process guidelines is taking place in 2023, aligned with Workday system development and implementation. In terms of screening questions, HRT has started piloting open text screening questions on some selections, resulting in a better screening process. We therefore propose to close the audit observation. 7/11/2022: The review of the harmonized selection procedures has been shifted to 2023. 2/11/2022: BMS team comments: The review and update of the selection process is planned for 2022. Given the move to Workday and the new BMS system, further changes will be needed in relation to the implementation of Business Process Optimization in some of these areas.	The recommendation is closed.	Y			
9	2020	R015	Establish a registry/coordinator that receives, maintains, refers and will coordinate the staff concerns to the	12/4/2023: Position description for staff relations officer, at least one in each major office, has been prepared. Consultation with major offices and staff associations underway. Expect to roll out in Q4 2023/Q1 2024.	The response of WHO refers to description being prepared for staff relations officer, at least one in		Y		

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
			respective office in the internal justice system.	7/11/2022: On 20 October 2022, Judge Teresa Bravo presented to the Global Staff Management Committee, which included the Director-General, her report on recommended improvements to the internal justice process. Her recommendations included consideration of a "staff relations specialist" with the role of "coordinating the employee-Agency relations activities and for the management of HR processes related to staff grievances, disciplinary cases, appeals and rebuttals." HRT is including this position(s) in the report's implementation plan and report on the status again in 2023.	each Major Office and the consultation with Major Offices and staff associations was mentioned to be underway. Although this position was expected to be rolled out in Q4 2023/Q1 2024, no update on the same is available as of now. Recommendation may be kept open.				
10	2020	R016	Devise a mechanism to monitor the conduct of all the staff survey and the corresponding after-survey activities and initiatives. Moving forward, conduct staff satisfaction survey every other year bench-marking on the UN system practice especially with regards to the policies introduced and revised through the Organization's transformation agenda.	13/4/2023: It is planned to launch the Organization-wide survey in 2023, in line with the UN best practice, and will thus be repeated every two years. HRT will rely on the platform of third-party provider (Agenda Consulting) that include Dashboard and Action Plan module to produce customized report for every business unit. HRT will coordinate the Organization-wide surveys on a bi-annual basis followed by more frequent pulse surveys for selected topics and/or offices to monitor the extent to which progress has been made through the implementation of the bi-annual Survey Response Action Plans. In October 2022, HRT advertised RFP to select provider(s) to support administration of workforce survey for the next 7 years. The policies introduced and revised through the transformation agenda are also reviewed and discussed during annual GSMC events by GSMC members representing administration and staff associations in all regions and HQ locations. Concept Note on survey governance mechanism was submitted to DGO for clearance. Besides regular staff survey schedule this concept note highlights introducing standardized process for organizational surveys (combining survey requirements of several offices into one; introducing standard demographic questions to assess perceptions of women and employees with disabilities; checklist to self-evaluate questionnaire; benchmarking survey outcomes to compare perceptions in preceding years, and with the UN Agencies/public sector). 7/11/2022: Organization-wide survey is being launched in early 2023, in line with the UN best practice, and will thus be repeated	We will await the approval of concept note and initiation of survey. Recommendation may be kept open.		Y		

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
				every two years. HRT will rely on the platform of third-party provider (Agenda Consulting) that include Dashboard and Action Plan module to produce customized report for every business unit. HRT will coordinate the Organization-wide surveys on a bi-annual basis followed by more frequent pulse surveys for selected topics and/or Offices to monitor the extent to which progress has been made through the implementation of the bi-annual Survey Response Action Plans. In October 2022, HRT advertised RFP to select provider/s to support administration of workforce survey for the next 7 years. The policies introduced and revised through the transformation agenda are also reviewed and discussed during annual GSMC events by GSMC members representing administration and staff associations in all regions and HQ locations.					
11	2020	R026	Report to WHA70 – April 2017 Further address inventory issues across the Organization through the evaluation of existing inventory control mechanisms on valuation and reporting, followed by the development of a Global Policy for Supply Chain and Inventory Management which would provide the basis for the development of the Standard Operating Procedure (SOP) on the management of expired inventories (paragraph 32).	12/11/2018: In the past few months supply chain and procurement end-to-end process is being re-designed as a part of business process review of WHO Transformation Initiative, with direct involvement of WHE OSL leadership. The vision and deliverables are outlined in the attached PPT. In the proposed 4 supply chain initiatives, warehouse standard operating procedure is considered one of the building blocks. Specifically, it is planned to define top 10 rules for warehouse standard operating procedures and design change management framework to support implementation. Implementation of these deliverables is anticipated as a part of GPW 13 implementation.	The response of WHO refers to a redesigning of end-to-end process of supply chain and procurement as a part of Business Process Review in 2018. However, it is not clear if this exercise has been completed yet. Further, observations by audit on this area have continued to emerge. Recommendation may be kept open.			Y	
12	2020	R029	Report to WHA72 – 2019 Enforce the timely receipt of the deliverables as well as the completion of Supplier Performance Report on service contracts Agreements for Performance of Work (APWs) and non-grant Letters of Agreement (LOA) above US$ 50 000 00 to properly recognize prepayments and accruals	8/12/2020: We hope to be able to implement the extension of this system to all the Regional Offices and Service contract types in 2021. Implementation could not take place in 2020 due to conflicting priorities. 20/09/2019: In progress an electronic workflow was released in June 2019 to enforce the timely receipt of APWs (to Companies) above US$ 50,000. This eReceipt is currently in use in HQ as a pilot, and it is now stable. We would like to extend its use to other Service types (non-grant LOAs, TSAs, GES) and to all Major Offices earliest in 2020.	From the response of WHO, it appears that the relevant tool regarding this recommendation has not been deployed/operationalized yet. Recommendation may be kept open.			Y	

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				This requires a straightforward set-up of the system (since we designed the functionality for this from the very beginning), as well as change management, communication and maintenance, and will be done in 2020 with the support of IMT and the IT Fund. February 2022: The eWorkflow remains in use in HQ and in the AFRO region. This region had implemented the supplier performance evaluation and electronic eForm process in 2020 with an approval that generates data for KPI and a dashboard for countries/RO (Budget centres) monitoring practices and ranking. This has since been updated using an eAssessment tool which will be deployed in Q1 2022.					
13	2020	R031	Report to WHA72 – 2019 Consider with utmost urgency the immediate development and completion of the contents that are the core of Emergency Operations in the eManual for Health Emergencies (Part XVII), complete with Standard Operating Procedures (SOPs), to ensure transparency, consistency and uniformity in interpretation and application of pertinent policies.	Latest update: 3 November 2021: all OSL SOPs are completed. All eManual sections are filled. This recommendation can be closed.	The recommendation is closed.	Y			
14	2020	R032	Report to WHA72 – 2019 Enhance the current policies on the recruitment and selection process, building on lessons learned, to limit the extension of posting of the Vacancy Notice; reconciliation of the eManual with the related SOPs; requiring on the face of the Selection Report the name and position as well as the signature of the person delegated by the approving authority; disclosure on the Selection Report of the date it was signed by the Selection Panel; and inclusion of a paragraph informing the interviewed applicant on the availability of feedback upon request to HR.	16/05/2023: These recommendations have been provided to the BMS team responsible for development of the recruitment module in Workday and are being taken into account in the design of the new system. We therefore consider that the recommendation can be closed. Previous update: Recommendations are under review and given the limitations of the current Stellis tool, some may only be possible to take into account with the implementation of the new BMS platform and capabilities. The elements have been noted and will be part of the Business Process Optimization discussions taking place towards the end of 2021 and into 2022.	The response of WHO suggests that the relevant functionalities, as recommended by audit, would be incorporated in the BMS. Since the BMS has not been rolled out yet, the recommendation may be kept open.		Y		

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15	2021	R003	We recommend that accumulation of slow-moving and expired inventories may be reduced and optimization of inventory related cost maybe achieved by adopting widely accepted inventory management tools like Economic Order Quantity (EOQ).	05/01/2024: The BMS project for inventory is currently in the final stage of development. It includes supply chain at its heart and will provide technical units with enhanced capabilities in the stock management area. It is proposed to close this old recommendation as the recommendation has already been incorporated into the design process for BMS, including use of a supply chain solution. Once implemented, the audit team may evaluate the effectiveness of the new inventory management system. Further information to permit the closure of this recommendation may be provided by the procurement/supply chain teams of BMS in February 2024.	The response of WHO suggests that the relevant functionalities, as recommended by audit, would be incorporated in the BMS. Since the BMS has not been rolled out yet, the recommendation may be kept open.		Y		
16	2021	R007	WHO should maintain complete documentation of the whole procurement process as laid down in Clause 2.5 of the WHO Procurement Handbook, in order to uphold the principle of transparency and enable the verification of the procurement.	15/02/2024: Between the GSM Electronic Content Management (ECM) system and the UNGM based e-tendering system, In-Tend, it is possible for SUP to maintain complete documentation of a procurement process that the Department has led. ECM is used to store documents relevant for individual purchase order processes, while for all goods and services procurements that are managed by SUP and tendered using In-Tend, the procurement documents are stored in In-Tend. ECM has never offered a full documentation management solution to filing the entire procurement process. The system will also be phased out as BMS comes online. In addition, the decentralized nature of all services procurement means the Organization has delegated the role of document management to the responsible officers in each department. It is anticipated that the procure to pay module for the procurement process in BMS will offer a solution for storing documents; SUP is exploring the possibility whether BMS procure to pay system can have a section where in addition to purchase order documentation, the solicitation documents could also be filed in future. If the new ERP system cannot support document management, then SUP will plan to implement a standard filing system on SharePoint, with the decentralised teams managing their own SharePoint but affording designated officers a view only status of any team's file.	In the response of WHO, it is not clear if the BMS would have functionality to store documents related to procurement process. Inadequacy of documentation has also been pointed out in the Financial and Compliance Audit 2023 and recommendation may be kept open.			Y	
17	2021	R008	WHO should put in place a supply chain system which can be activated to cater for emergency. Modalities for emergency	15/02/2024: In response to the growing need for resilient supply chains in emergencies, several strategic initiatives were launched in 2023 to strengthen our procurement processes. These efforts	A review of policy of emergency procurements is expected in early 2024.			Y	

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			operations along with suitable incentives should be incorporated in the contracts with the suppliers and shipping and logistics contractors.	included review of the policy for emergency procurement (expected to be launched early in 2024), the diversification of supplier networks, quarterly quality assurance assessment of products and processes of our key suppliers, and the development of quality control contingency plans. As a result, we were better prepared to respond to unexpected disruptions and ensure continuity of operations during times of crisis. Shipping and warehousing functions have been developed and launched in the new BMS system, and these new functionalities will help to integrate these essential building blocks in the emergency operations supply chain.	Cases of extensive delays and repeat orders on the same suppliers in spite of past delays have been pointed out in 2023 Compliance and Financial Audit and thus, recommendation may be kept open.				
18	2021	R013	To address the increasing trend of cases of misconduct, WHO should enhance its punitive as well as preventive approach. Delays in investigation and disciplinary action should be reduced so that prompt and proportionate disciplinary action acts as a deterrent.	27/10/2023: HRT has increased its human resources to address the significant increase in IOS investigations submitted to it for follow up actions, including disciplinary proceedings. HRT has also developed an "Investigation and Disciplinary Measures.	The issue of timely completion and closure of investigation activities is still persisting. Recommendation may be kept open.			Y	
19	2021	R014	WHO needs to adopt a risk-based approach to prevention by identifying the offices and units with high risk of misconduct and focus on outreach and strengthening of controls in these offices. Since the largest number of cases pertain to fraud, efforts should be made to increase awareness of fraud and preventive fraud controls. WHO may strengthen preventive measures like checking of antecedents before recruitment, integrity vetting for promotions, and rotation of staff in sensitive positions.	March 2022: It would be helpful if the recommendation could be rephrased to allow for attribution of clear ownership for the recommendation. December 2021: WHO has had an external global compliance review conducted to take stock of its compliance landscape across the three levels of the Organization, through the establishment of a risk-based assurance map across the three levels, also introducing a methodology to identify countries exposed to higher risk levels, including fraud and corruption. The compliance programme would then be tailored to the country's risk profile which would include amongst underlying criteria exposure to fraud and corruption risks.	The WHO response has requested for rephrasing the recommendation. Recommendation offers specific actions to be taken, risk assessment, outreach and strengthening of controls in high-risk offices, increasing awareness and checking of antecedents before employment etc. Ownership over these areas needs to be decided by the management. Therefore, no rephrasing appears necessary. WHO may inform of action taken. The recommendation may be kept open.			Y	

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20	2020	R015	WHO should formulate a new Country Cooperation Strategy for South Sudan at the earliest, in accordance with the new guidelines issued by WHO, HQ.	Agreed. The Process for formulating the new Country Cooperation Strategy (CCS) commenced with evaluation of the expired CCS (2014–2019) in the first quarter of 2020. However, finalization of the evaluation was disrupted by the onset of, and WCO efforts to lead the response to, the COVID-19 pandemic. In August 2020, the WCO revitalized the process of formulating the new CCS, based on the new guidelines issued by HQ. The analysis and strategic prioritization phase have been completed. The WCO is currently undertaking the strategic agenda setting and definition of the impact framework stage. This will be followed by drafting and final consultation/validation. The CCS report has been finalized with expected roll out in April 2022. Propose closing the recommendation.	The recommendation is closed.	Y			
21	2021	R015	WCO Iraq should be prompt in implementation of CCS 2018–23. It should improve awareness on the new CCS through various mechanisms like enhanced staff engagement and involvement, partnership forums, regular stakeholder meetings and enhanced media coverage.	WCO Iraq is looking for the opportunity to finalize the draft CCS 2018–2023 which requires coordination with the Ministry of Health at all levels in a stable environment. Unfortunately, conditions were not yet conducive for developing this work due to high turnover of leadership and management within the Ministry of Health as well as shifting priorities such as the COVID-19 preparedness and response. The latest attempt for initiating work on the CCS was discussed between the incoming WHO Representative and the Minister of Health on 11 February 2021, but priorities of the Ministry shifted into the response to the significant upsurge of COVID-19 cases, and the launching of the vaccination campaign, and yet as of this week the Minister of Health was suspended by the Prime Minister waiting for investigations of responsibilities on the recent Hospital fire that affected Ibn Al Khatib Hospital in Baghdad.	The timeline for implementation of CCS 2018–2023 for WCO Iraq appears to have been overtaken by events.				Y
22	2020	R019	Before starting a limited competitive bidding process, WCO should adopt a formal method for identifying potential vendors by assessing them against a predetermined criterion and duly record it.	We disagree with this recommendation. The WCO has invested in the development of a comprehensive supplier database (refer to attached) to ensure credible suppliers are always engaged. The suppliers in the database were included after a detailed solicitation and vetting process (advertisement in national newspapers and vetting of submitted credentials) and recommendations from other UN agencies with established LTAs. WCO South Sudan will do a review of the current supplier database taking into account the auditor's recommendation but will also combine and in as much as possible do this exercise within the ambit of the UN OMT Procurement Network hence given us a better spread and choice of suppliers.	The recommendation is closed.	Y			

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23	2021	R021	Bid evaluation method to be followed, in terms of whether lump sum or item wise basis will be adopted, should be clearly stated in invitation to bid and consistently adhered to during evaluation	13/03/2023: GSC is part of global procurement department and the response provided is from the Department. In addition, the staff that would have led the procurement activities referred to in the audit are no longer in those roles and the staff member.	The recommendation is closed.	Y			
24	2020	R024	Before starting a limited competitive bidding process, WCO should adopt a formal method for identifying potential vendors by assessing them against a predetermined criterion and duly record it.	Following EMRO SOPs on supplier solicitation, an intensive exercise is undertaken by issuing expression of interest (EOI) through UNGM, newspaper announcements, and email sharing to our list of suppliers, to conduct a market search and enrich the supplier list with competent evaluated suppliers. Three EOIs were announced on 23 February 2021, and closed on 10 March 2021 to cover 3 categories of categories: (1) printing services, (2) IT equipment and services, and (3) medicines and medical equipment. Evaluation is ongoing and due diligence visits will take place before finalization of the new list. Planned to be finalized by end of July 2021. (EOIs – copy attached) After finalization, more categories of supplies will be approached.	The current response mentions of three EOIs closed in March 2021 and the new list was to be finalized by July 2021. No further update. The recommendation mentions adopting a formal method for identifying potential vendors before starting a limited competitive bidding process and the response does not address the recommendation. The recommendation may be kept open.			Y	
25	2021	R031	We recommend that WHO finalizes the GPW 13 Impact Framework, as part of the WHO results framework, on priority basis with defined timelines to enable WHO to describe its contribution to outcomes and impacts.	(blank)	No response, recommendation may be kept open.			Y	
26	2021	R032	We recommend that WHO prescribe timelines for the submission, processing and/or validation of data on triple billion dashboard and ensure adherence to the timelines.	(blank)	No response, recommendation may be kept open.			Y	

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27	2021	R033	We recommend that WHO should review the interaction between the three indices that make up the Health Emergencies Protection Index (HEPI), and recalibrate them to ensure that their impact on the Health Emergencies Protection (HEP) Billion and the HEP index is correlated, to convey a reliable and meaningful information.	(blank)	No response, recommendation may be kept open.			Y	
28	2021	R035	WHO may ensure strengthening of existing processes and introduction of new processes delineated in the update (EB148/27) to ensure improvement of the funding situation and achievement of the projected implementation of the planned expenditure during and by the end of the biennium.	(blank)	No response, recommendation may be kept open.			Y	
29	2021	R002	WHO in consultations with each of the Member States may identify the specific bottlenecks in data collection and persuade the Member States to provide updated data.	06/12/2023: Management has provided their response to this recommendation. Please review the attached PDF "Performance Audit of WHO Transformation – implementation DDI".	The recommendation is closed.	Y			
30	2021	R003	WHO may continue the refinement of the results framework, especially the output score card, to make it more objective, simpler and user friendly.	(blank)	No response, recommendation may be kept open.			Y	
31	2021	R004	WHO may ensure that the Stellis system is configured to capture all key data for the main steps of the recruitment process so as to make the data more useful for tracking, necessary interventions and improvements for the recruitment function.	20/12/2023: Out of 23 recommendations of the audit of WHO recruitment system, conducted by the IOS in 2021, 92 percent of these recommendations were closed by the IOS in 2022–2023, with only 2 recommendations remaining pending the launch of the new ERP (BMS) system. BMS development, including the new Workday recruitment system, will address the issues raised through the audit reports. We therefore propose to close this item.	The implementation part of the recommendation can be checked in BMS only. Recommendation may be kept open		Y		
32	2021	R005	WHO may take steps to provide funding and staffing particularly at regional offices to ensure timely implementation of the transformation of the Norms and Standards activity.	QNS has acted upon this recommendation by engaging in regular discussions with the Regional QNS focal points and facilitating online dialogues to provide technical support across the three levels of WHO. QNS is also providing technical and financial support to support regional offices in the implementation of norms and standards-related activities in the regions and country offices including: regional offices are being supported to implement an	The recommendation is closed.	Y			

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				aligned quality assurance system following common minimum essential standards utilizing WHO handbook for the development of normative products as a pivotal resource for staff at all levels. Regional and country offices are being facilitated on the contextualization and adaptation of normative products for maximum uptake and implementation and also promotes continuous monitoring and evaluation of their impact at country level. QNS has worked with the regional offices to develop coordinated publishing policies, leverage institutional investments in regional journals and improve accessibility of WHO publications. A strong network of over 800 WHO collaborating centres has been established in all regions of WHO to provide equitable access to reliable, relevant, and actionable technical support and evidence to Member States and WHO workforce. Based on the above substantive actions, it is suggested to close this recommendation as it has been adequately addressed.					
33	2021	R006	WHO may address staff and funding constraints for innovation may be addressed at the earliest so as to achieve the benefits envisaged from the initiative.	(blank)	No response, recommendation may be kept open.			Y	
34	2021	R007	WHO may prioritize alignment between concept and process for Strategic Policy Dialogue and other corporate processes and strengthen country health information systems to ensure complete and updated data for the selection of countries for Strategic Policy Dialogue.	(blank)	No response, recommendation may be kept open.			Y	
35	2021	R008	WHO may continue its efforts towards instituting valid Country Cooperation Strategies in all country offices, duly aligned with country support plans, whereby the impact of technical cooperation is objectively measured.	(blank)	No response, recommendation may be kept open.			Y	

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36	2021	R009	WHO may consider completing a reassessment of the value addition of the Strategic Priority Coordination Group (Billion Network), and in the light of the result of the reassessment, an appropriate decision may be taken so that the overall objective of operationalization of new horizontal and vertical networks to support GPW 13 implementation stays on track.	(blank)	No response, recommendation may be kept open.			Y	
37	2021	R010	The Information Management and Technology Steering Committee (IMTSC) may ensure that the tools (e-Workflow and eSignature) are utilized across all the offices and regions.	(blank)	No response, recommendation may be kept open.			Y	
38	2021	R011	WHO needs to prioritize the implementation of initiatives interlinked with the "career pathways" initiative and address the challenges/needs identified to achieve the intended benefits.	27/10/2023: The high-level Career Development Framework with the list of job families has been developed and finalized. The new BMS with the job catalogue concept, which has implications for organizational and job design, recruitment, performance management and career development is yet to be launched.	The implementation part of the recommendation can be checked in BMS only. Recommendation may be kept open.		Y		
39	2021	R012	The revised policy on short-term development assignments may be published and implemented so as to provide WHO staff with opportunities of exposure to different work environments.	27/10/2023: This item has been implemented (please see Information Note 27/2023 issued 27/06/2023).	The recommendation is closed.	Y			
40	2021	R013	WHO may follow up on the last survey of 2020 to assess the level of staff buy-in and cultural change and undertake course correction if required.	20/12/2023: A new Organization-wide culture survey for WHO was developed, and a survey administrator contracted to carry out this survey in 2023; however, the survey launch date was postponed and is expected to be launched in 2024. We propose that the target implementation date is updated to 31 December 2024.	Since the survey is yet to be carried out, recommendation may be kept open.			Y	
41	2023	R001	WHO integrates different systems dealing with in-kind contributions across the Organization, facilitating timely recording, tracking, accounting and reporting of in-kind contributions (High).	(blank)	No response, recommendation may be kept open.			Y	

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42	2023	R002	WHO reviews its policy of applying uniform PFI charges in Inventory Valuation of the vaccines, where handing charges are separately paid by WHO (High).	04/01/2024: This recommendation was implemented for 2023 before the previous audit team departed in March 2023. The proposal was to exceptionally apply a different % for polio stocks only, so as not to digress from the concept of a consistent use of the current WHO policy to apply a uniform % for PFI for all inventory, a policy in force since 2015, and approved by all previous audit teams. Karen will share the evidence of the application of this exception when the audit team arrives in February, 2024 so that the recommendation can be closed.	While it is correct that the recommendation was implemented in 2023, the evidence reflected that the implementation was restricted to inventory acquired in 2023. For the inventory acquired prior to 2023, this issue, as pointed out by audit, remained. The recommendation may be kept open.			Y	
43	2023	R003	WHO reviews the policy of valuation of long-term voluntary contributions receivables, in view of changes in the circumstances on which these estimates are based (High).	(blank)	No response, recommendation may be kept open.			Y	
44	2023	R004	WHO lays down a mechanism to minimize controllable delays in procurements and to ensure at the time of receipt of supplies, adequate available shelf life of medicines and equipment being procured and supplied (Medium).	15/09/2023: We believe the concern is mainly about there being little or no movement in stockpiled polio vaccines, mOPV2 in particular. This is because mOPV2 is no longer the vaccine of choice to respond to vaccine-derived poliovirus outbreaks, in favour of a novel type-2 vaccine, nOPV2. It is necessary to maintain this stockpile as insurance because the preferred vaccine, nOPV2, was provisionally approved under the Emergency Use Listing (EUL) pending more data on safety and efficacy. Should nOPV2 not be fully approved, mOPV2 needs to be on-hand to take its place. Further, even if nOPV2 is fully approved, mOPV2 may be needed in case outbreaks grow faster than expected and demand for vaccine exceeds supply. Regarding avoiding delays in procurement, within the Global Polio Eradication Initiative (GPEI), UNICEF is the procuring arm of the partnership. WHO's role – to identify when, where and how much vaccine is needed, and approving vaccines for use once they are manufactured – is defined in a letter of agreement (LoA) with UNICEF that is being negotiated and will be concluded later in 2023 or early in 2024. The LoA takes into account the audit comments and will address the timeliness of supply, shelf-life and equipment needs.	Stockpile issues were existing in Compliance and Financial Audit of 2023. Recommendation may be kept open.			Y	

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45	2023	R005	WHO strengthens management of inventory for efficient utilization of procured items (Medium).	(blank)	No response, recommendation may be kept open.			Y	
46	2023	R006	WHO accelerates implementation of the envisaged improvements in transfers and grants, including strengthening of the assurance mechanism (Medium).	17/09/2023: In January 2023, the SOP on risk assessment and assurance activities for WHO grants (DFC & GLOA) and direct implementation (DI) was released. In 2023, the implementation of assurance plans agreed with WHO regions on DFC, GLOA and DI (spot-checks and audits) has been monitored by the global assurance hub in Budapest.	There were issues noticed in 2023 audit as well, wherein the assurance plan has not been implemented fully. Recommendation may be kept open.			Y	
47	2023	R007	WHO identifies mechanisms to minimize controllable delays in procurements (Medium).	15/02/2024: Supplier performance evaluation of LTA holders, and continuous engagement with the six largest (by procurement value) suppliers in monthly meetings was implemented during 2023. These meetings target root cause analysis for supplier delays, stakeholder engagement, and supplier performance monitoring, enabling more informed decision-making and improved responsiveness to business needs through greater transparency. This process continues in 2024 to target a wider range of our supply base.	The 2023 Audit has observed cases of extensive delays in finalizing procurement and supplies. Recommendation may be kept open.			Y	
48	2023	R008	WHO strengthens the process of evaluation and award for complex consultancy contracts and also ensures that provisions of procurement manual are complied with at all stages of the procurement process (High).	(blank)	No response, recommendation may be kept open.			Y	
49	2023	R009	WHO implements a system for recording and monitoring of submission of declaration of interests across the Organization; and identifying appropriate level of resources for the ethics function to strengthen the accountability structure in the Organization (High).	(blank)	No response, recommendation may be kept open.			Y	

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50	2023	R010	WHO creates a mechanism for monitoring of action taken on the ethics advice and mitigation actions in a phased manner, starting at the headquarters and regional level and explores feasibility of including this element in the internal control self-assessments of the concerned organization units (High).	(blank)	No response, recommendation may be kept open.			Y	
51	2023	R011	WHO accelerates the implementation of the identified action plan to improve the investigation structure and capacity, as a matter of priority (High).	(blank)	No response, recommendation may be kept open.			Y	
52	2023	R012	WHO establishes a mechanism to record and track status of action taken on investigation reports; and establishment of a formal mechanism, where fact of a case being open for investigation is an input in the separation process of a staff and non-staff member (Medium).	(blank)	No response, recommendation may be kept open.			Y	
53	2023	R013	WHO significantly strengthens the management framework and processes within all organizational units receiving and managing heritage assets, including official gifts (Medium).	December 23: A number of key events have now been completed, in line with the policies and procedures introduced in 2023, which indicates the recommendation may be considered for closure: 1. In HQ, all new gifts received since 2019/20 have now been assessed and the values and locations updated in the gifts database, 2. Recording of new HQ gifts in the database and coordination on a regular basis has now been handed over to AMG, 3. All Regions have conducted a review both in their RO and their countries to record their gift collections. 4. HQ and all Regions have conducted their first annual verification by asset focal points, in coordination with RD staff of their official gifts 5. All Regions with official gifts have conducted an assessment of gifts in 2023 and the results included in their verification returns. Note one exception: In HQ, the DG has kept one gift, and this was not able to be assessed as of 20 December 2023. Work is underway to determine the location of the gift so that its value can be assessed in 2023 to see if it meets the requirement to be classified as an official gift, per WHO policy (US$ 500 or more in value). The documentation enclosed with gift indicated its value at only US$ 10.	The recommendation is closed.	Y			

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				September 2023: The eManual policy on official gifts and heritage assets and the SOP guidelines to implement these policies have now been published and shared with regions. Work on this topic commenced with regions in late 2022 and the discussions and challenges to creating relevant policy and guidelines has been discussed with regional counterparts during the first half of 2023. As a result, policy and procedures have now been implemented.					
54	2022	R015	In view of the design and development of BMS IT application is under progress, a comprehensive consultative approach may be adopted for business process re-engineering to gain efficiency in the other various processes.	12/09/2023: The BOS-BMS directors meeting was held on 10 November 2022 to discuss on the policy and process changes on lump-sum only for statutory travel and other items. As detailed on the attached presentation (pp 7–8) proposal has been made to convert all the statutory travels into lump sum highlighting the background/context for the proposed statutory travel – lump sum and the added advantages of the change. During the meeting the proposal for lump-sum for the HR-related travel-types of appointment, education grant, family visit, home leave, reassignment and repatriation was strongly supported by the BOS directors as an opportunity to optimize business processes and lighten administration. The agreed action points with approval and implementation strategy are documented in the attached meeting minutes. The BMS team has progressed with the redesign of the statutory travel process in the new BMS system. The detailed proposal (ESS statutory travel – proposal lump sum for statutory travel) that shows the status and ongoing discussion is attached. The BMS project is now entering the "end-to-end" testing phase. The solution that has been finalized and will be tested for statutory travel business process will be the "lump-sum" only option, as recommended by the auditors. In light of this, we have successfully implemented the audit recommendation. Therefore, we kindly request the External Auditors to consider closing this recommendation.	The issue can be examined for compliance once BMS has been rolled out completely. Recommendation may be kept open.		Y		
55	2022	R016	GHR may impart training to the staff administering appointment of conference staff, extension of fixed term staff, recognition of child, dependency status of child etc. where achievement of TaT is less.	22/12/2023: GHR agrees and appreciates the comments made by auditors. To address those, GHR is now using WHO training platform iLearn to ensure that such trainings are provided on regular basis. More details are provided under the attached pdf document (GHR iLearn Platform.pdf). External Auditors are therefore kindly requested to close the subject recommendation.	The recommendation is closed.	Y			

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
				13/09/2023: 1. In order to achieve the goal of drastically reducing the SLA compliance for GHR stakeholders, the 2023 PMDS noted a required improvement within one of the mandatory objectives. 2. For comparative analysis purposes, the SLA non-compliance rate for the year 2022 was 38.66% (based on 55 525 HR Cases). As of 12 September 2023, the non-compliance rate improved at 24.04% (based on 39 945 HR cases), an improvement of 14.62%. 3. The GHR Dashboard provides an output of individual-to-team production, allowing Team Leads an overview and visibility of administrator performance against the mandated objectives. 4. To enhance the abilities of GHR's HR Administrators, a dedicated two-month-long training session was conducted, covering 32 training topics. Particular attention was given to ensuring the comprehensive coverage of all transactions and subject areas. The trainers were senior team members who shared their experiences with the team to enhance their abilities and efficiency in addressing customer queries. Please refer to attached documents for more detailed information. We would like to kindly ask auditors to close the recommendation based on the above and attached documents.					
56	2022	R017	GSC may consider adopting and report the benchmarking of GHR and IMT functions. Steps should also be taken for further optimization of processes for achieving the benchmark for GPL and GPAY functions.	08/11/2023: Please find attached a new response (in PDF format) for your review. GSC management thank External Auditors for their valuable support. Noting that the recommendation has now been addressed by GSC, External Auditors are kindly requested to close the recommendation.	The recommendation is closed	Y			
57	2022	R020	GSC to consider a periodic report to be collected from all RO/CO on the cases of LWOP to ensure prompt recovery of excess payment and avoid write offs at a later date.	28/11/2023: For purpose of clarity, external auditors may wish to note that the periodic collection has been established by GPAY for all relevant GSC stakeholders: headquarters, five regional offices and three partnering agencies. Every month, GPAY is collecting cases from those stakeholders, who are providing their inputs to a dedicated e-mail account (salaryhold@who.int) created for this specific purpose and close monitoring. A screenshot of such e-mail account is attached as supporting information (on top of the already provided documents). In view of the above, GPAY has addressed the audit's recommendation and kindly request for its closure.	The recommendation is closed.	Y			

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58	2022	R023	We recommend WHO to develop a procedure to update active supplier data to avoid duplicity and fixation of end-date of ex-employees/employees suppliers who are not engaged with WHO.	28/11/2023: GFI conducts regular reviews of active suppliers to avoid duplication on top of the duplication check already configured in GSM during the creation of suppliers. Attached is one of the examples of efforts done on this regular quality check for supplier-related data in terms of duplication check. This example shows the actions taken, including communication with the responsible officers to review the list of duplicate suppliers extracted and identified from GSM via SQL, and result of deactivation action completed in GSM after confirmation received from the responsible officers. Please find attached relevant supporting documents. Ex-employee status is updated by HR and the data is interfaced from HR to Finance on the standard Oracle HRMS/Finance interface. This interface has not been changed since GSM went live, and no change will be considered given the BMS project underway. For the efforts to avoid duplication and to address duplication demonstrated above, and given the limitations of the GSM system as regards ex-employee data, we therefore request External Auditors to kindly consider closure of this recommendation.	While the part on avoiding data duplicity appears to have been addressed, the fixation of end date of ex-employees/employees suppliers who are not engaged with WHO issue seems to have neither been considered under GSM or BMS. The recommendation may be kept open.		Y		
59	2022	R024	IMT should maintain an inventory of all software applications being used in WHO along with details of services being provided.	08/09/2023: IMT is proposing, via a business case to the Global IT Fund, a solution to enable the application inventory process. There are not enough resources to cover the development using current IMT operational costs and IMT will require increased funding to satisfy this audit recommendation. Implementation date is planned to be end of 2024.	The response is a work in progress and the deliverables against recommendation can only be assessed after the roll out. The recommendation may be kept open.			Y	
60	2022	R025	We recommend to explore the possibility of expanding of new services of GHR to all the ROs/COs to ensure consistency and improvement in HR Management.	02/02/2024: External Auditors may refer to the attached HRT Director's email which was addressed to HR regional counterparts on 7 August 2023. This e-mail confirms the extension of GHR services with regards to step determination, pre-hire, and on-boarding activities from headquarters to regional offices. Further to your comments, dated 26 October 2023, GHR would like to share supporting evidence of the implementation of such decision. Indeed, significant progress has been made in the BMS project to operationalize the centralization of staff on-boarding process across all regional offices, alongside the headquarters. External Auditors may wish to note that the design of the on-	The recommendation is closed.	Y			

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				boarding process (designated as "Pre-Hire Documents Process" under WorkDay) has now been developed. The finalized process flow diagram ("Offer-Staff Process"), dated October 2023, is attached to confirm, and demonstrate that this process falls under the responsibility of GHR under BMS for the entire WHO. In addition to the agreed-upon process for staff appointment, external auditors may also find attached screen captures, dated 31 January 2024, from WorkDay, illustrating tasks received by the GHR step determination specialist. The completed questionnaire is viewable by the GHR administrator on the candidate profile. This demonstrates that the centralization and administration fall under GHR's responsibility under the to-be ERP system. In view of the above, the recommendations made by the External Auditor have been duly adopted and related process design incorporated under BMS architecture. We therefore kindly request External Auditors to close the subject recommendation and do not need to wait for the BMS go-live since all necessary evidence for the implementation has been provided.					
61	2023	R028	We recommend that CEM, SPM and ePQS should be considered a cohesive bundle in the BMS project. The SPM is already part of BMS and given the fact that CEM and ePQS are operational it would need to be integrated to BMS when ready.	(blank)	No response, recommendation may be kept open.			Y	
62	2023	R029	We recommend leveraging Lemon Learning to address capacity-building risks in CEM.	(blank)	No response, recommendation may be kept open.			Y	
63	2023	R030	We recommend the CEM team to undertake a clean-up activity and remove user accounts which are not relevant.	(blank)	No response, recommendation may be kept open.			Y	
64	2023	R031	We recommend the CEM team to extend the CEM platform to hosted entities as well, so that they can also derive the same business transformations that WHO has achieved. Further modalities may be worked out by WHO by collaborating with the hosted entities.	(blank)	No response, recommendation may be kept open.			Y	

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65	2023	R032	We recommend that the CEM team should bring in identified mitigation measures in quality of service for incident resolution before the SLA enforcement starts.	(blank)	No response, recommendation may be kept open.			Y	
66	2023	R033	We recommend that the IT landscape covered under BMS be divided into meaningful business processes, sub-processes and activity.	WHO is building an enterprise capability map for BMS that integrates that high level functionality view with related processes with steps and responsibilities. For example, in case of the core ERP, this documentation is being updated periodically directly.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		
67	2023	R034	We recommend that To-Be process documentation should be created before the configuration/development workshops for the components/phases where the same have not been started. This documentation must be prepared by the BMS team, business owner and SMES in collaboration and published. Any process change must be approved by the business owner before the design of the application is started.	(blank)	No response, recommendation may be kept open.			Y	
68	2023	R035	We recommend that To-Be process documentation for components/phases where design workshops are in progress or completed should be created right away. This documentation must be prepared by the BMS team, business owner and SMES in collaboration and published. Any process change must be approved by the business owner before the design of the application is started.	(blank)	No response, recommendation may be kept open.			Y	
69	2023	R036	We recommend that detailed documentation along the lines of either SRS or user stories need to be created for all modules implemented under Workday.	WHO disagrees with this recommendation as creating separate documentation for WorkDay as up-to-date configuration information is available online from the system itself. User stories etc. are documented as part of the resolution of open design topic discussions, when considered relevant for Workday and SRS type documents are being produced for some of the other BMS components e.g. CEM, Travel, Meetings & Events when agreed as part of that agreed method of working. Hence, reference is made to the business capability documentation referred in recommendation number R007.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		

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70	2023	R037	We recommend that integration dependencies and data migration dependencies may be drawn out based on the To-Be process documentation and gaps in the existing strategy may be filled.	(blank)	No response, recommendation may be kept open.			Y	
71	2023	R038	We recommend that irrespective of the methodology followed, there must be a scope signoff between WHO and the contractor based on the To-Be process documentation. Any additional time taken by the contractor to achieve the To-Be process should be penalized and cost relating to the same should be borne by the contractor.	WHO disagrees with applicability of this recommendation as the contract with WorkDay was signed almost a year before this audit and renegotiating the contract from time-and-materials into fixed price would be a huge task. However, what WHO is currently engaged with the vendors is to scope the wave 4 deliverable in such level of detail that would allow for detailed costing up to the (main) go-live. As stated above, these overall implementation across all components is being captured and monitored holistically through the BMS integrated plan which is currently being updated.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		
72	2023	R039	We recommend that WHO should make efforts to engage with hosted entities periodically.	15/08/2023: Until August 2023 BMS project engaged with the UN entities (IARC, UNAIDS, UNITAID and UNICC) in bimonthly meetings and UNAIDS and IARC also participating in the BMS programme board meetings. We have further enhanced this and since September 2023 BMS project is meeting with the UN entities' programme management biweekly to plan and progress on different workstreams namely testing, data migration, etc. (please see Email BMS deployment for entities – questions from entities for 19 September 2023 meeting.docx for further details).	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		
73	2023	R040	We recommend that an overall solution roadmap needs to be created, considering all the processes holistically instead of component wise.	BMS project is currently performing a detailed analysis of each system sub-component in order to evaluate the realistic timeline for phase 4 implementation. The prepared analysis will be submitted to the programme board for approval.	The results of analysis are awaited. Recommendation may be kept open.			Y	
74	2023	R041	We recommend improving the quality of communication between the BMS team and business team, especially in HCM and Finance module.	WHO has established a steering committee for BMS comprising WHO business owners (directors), BMS management team members as well as WorkDay and ONE Network leads. Steering committee meets monthly. BMS project also has regular meetings with Directors.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		

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75	2023	R042	We recommend that for HCM and Finance module, the business administrators may be identified and leveraged in configuring the rules relating to WHO. This will help in building the capacity of WHO, increasing level of engagement with SMEs and confidence and trust about the component.	(blank)	No response, recommendation may be kept open.			Y	
76	2023	R043	We recommend that crucial project risks need to be identified on a timely basis and formally communicated to the Programme Board.	15/09/2023: Programme board had a special session on risks 29 August 2023 and agreed that in future sessions risks would be closely examined in future meetings (Attachment 2023_28 August_Programme Board meeting.pptx emailed to DIR/EA 15 September 2023 due to confidentiality reasons).	This relates to BMS which is yet to be rolled out. Recommendation may be kept open.		Y		
77	2023	R044	WHO should monitor closely, the risk arising out of two different contracts having been signed with the Core-ERP vendors.	15/09/2023: As presented during the audit WHO has a tri-partite agreement with WorkDay and ONE Network for the project management. Further, as suggested, to monitor the risks systematically, the governance has been enhanced with the vendors specifically with a monthly executive connect (executive sponsors from WHO, WD and ONE) as well as steering committee (business directors, BMS; WD and ONE leads) meetings to monitor progress, unblock issues, address escalations and mitigate risks. (please see attachment SteerCo 31 August 2023 Agenda and Structure.pptx for further details).	This relates to BMS which is yet to be rolled out. Recommendation may be kept open.		Y		
78	2023	R045	The TCO Cost estimate and the project budget expenditure statement, the Recurring Cost (Run period) should be integrated and the overall BMS Project cost and time overrun be unambiguously reported to the Programme Board.	BMS Project is working together with WHO IMT Department, to determine the roles and responsibilities that will take over BMS system day-to-day operations after go-live, and has provided the programme board first estimates of running costs after go-live.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		
79	2023	R046	The perceived high risk of time and cost overrun, in case the project rollout is delayed compared to phases and options presented to the December 2022 Programme Board, be monitored closely and the anticipated time and cost overrun be reported to the Programme Board on a fortnightly basis.	BMS Programme Board has been kept up-to-date with revised project timeline and cost estimates. BMS Project is currently performing a detailed analysis of each sub-component in order to evaluate the realistic timeline and cost estimate for phase 4 implementation. The prepared analysis will be submitted for BMS Programme Board for approval.	The issue needs to be checked once BMS is rolled out completely. Recommendation may be kept open.		Y		

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80	2022	R047	We recommend that the Output Scorecard System may be reviewed to ensure weightages to utilisation of funds against planned costs. We recommend that EURO may explore the possibility of evaluation of the scoring process being peer-reviewed by an independent body to ensure better transparency and measurement of result accountability so that scores are awarded only for the programmes/activities carried out. We recommend that EURO may devise a system to monitor and report the compliance to the outputs mentioned in the Biennial Collaborative Agreements as outputs not executed are escaping review in the present system.	(blank)	No response, we may not close the recommendation.			Y	
81	2022	R048	We recommend that EURO may consider recording the support activities conducted for achieving the results instead of reporting only on the achievements in their future Results Reports (including the mid-term for Programme Budget 2022–2023).	(blank)	No response, recommendation may be kept open.			Y	
82	2022	R049	We recommend that the Award Managers may address the cause for delay of submission of Donor Reports (Financial and Technical) by further strengthening the regular follow-up in order to maintain their commitments towards meeting donor's expectations.	(blank)	No response, recommendation may be kept open.			Y	
83	2022	R050	We recommend that WCO may take steps to arrange Funding for commitments made in the BCA and ensure that funds are utilized in a timely manner for achievement of the strategic priorities as envisaged in the GPW 13.	Action has been taken regarding the audit recommendations. For 2022–2023 in order to assure the achievement of the strategic priorities as envisaged in the GPW 13 and timely utilization of funds, the monitoring reports were generated and provided.	The recommendation is closed.	Y			

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84	2020	R013	Consider the review and moving forward, the acceptable revision of the evaluation parameters comprised in both the preliminary screening and in-depth evaluation steps of the process, with the goal to ensure that redundancy is control.	16/05/2023: The recommendation is to reduce the redundancy in evaluation parameters between the pre-screening and in-depth review of candidates. However, the second in-depth review serves to validate the conclusions from the pre-screening, and to identify the candidates who best meet the criteria defined in the job description. Thus HRT would not agree to strictly segregate these evaluation elements between the 2 stages. The elements should be reviewed at both stages of the process. Accordingly, we recommend that this recommendation be closed.	The recommendation is closed.	Y			
85	2020	R014	Provide feedback of the final selection decision results to SRs and other SP members, and that it be consistently applied and provided for all completed recruitments.	16/05/2023: HRT follows up to ensure that panels are consistently informed of the final outcome of the selection. Importantly, all panel members have access to the Stellis requisition and can see the outcome in Stellis directly. We therefore consider that the recommendation is implemented. This is now being done on a more systematic basis and we will continue to ensure that all recruitment teams are instructed accordingly.	The recommendation is closed.	Y			
86	2021	~~R016~~ R012	WHO should request UNICEF to raise invoice as and when partial deliveries are made and WHO should duly adjust the prepayment.	15/09/2023: Within the Global Polio Eradication Initiative (GPEI), UNICEF is the procuring arm of the partnership. WHO's role – to identify when, where and how much vaccine is needed, and approving vaccines for use once they are manufactured – is defined in a letter of agreement (LoA) with UNICEF that is being negotiated and will be concluded later in 2023 or early in 2024. The LoA takes into account the audit comments.	The recommendation is closed.	Y			
87	2020	R015	WHO should formulate a new Country Cooperation Strategy for Afghanistan at the earliest, in accordance with the new guidelines issued by WHO, HQ	The Country Cooperation Strategy was replaced with Transitional Engagement Framework which was approved by all UN agencies (Copy Attached); also attaching the approval minutes of the UNCT.	The recommendation is closed.	Y			
88	2020	R018	For purchasing several items in bulk price evaluation should be done on the basis of lump sum price and this should be clearly stated upfront in the solicitation of offers. Splitting of orders among the bidders should be undertaken only if the selected vendor does not have the capacity to supply the quantities required.	29/03/2023: Agree with recommendation and request for closure. There is now avoidance with splitting supplies amongst different suppliers solely based on price differential but rather to consider the capacity to deliver within reasonable lead-times. The fact that we can also piggy-back on LTAs from sister agencies help in reducing the need for competitive bidding in most instance for recurring supplies or services.	The recommendation is closed.	Y			

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89	2021	R034	WHO may address the baselines and targets of the programme budget output indicators' on priority.	In May 2022, WHO reported on Programme budget 2020–2021 to the World Health Assembly, including progress made on output indicators (referred to as "leading indicators"). https://apps.who.int/gb/ebwha/pdf_files/WHA75/A75_32-en.pdf The output indicators were reported with baselines, targets and achievements (https://open.who.int/2020-21/indicators). In addition, they contributed to the reporting in 2 ways: 1) assessing the work of the Secretariat as the "results" dimension of the output scorecard (example of outputs leading to outcome 1.1); and 2) identifying key achievements (such as the progress in implementing mandatory policies to prohibit trans fatty acids). In May 2023, a complete set of baselines and targets for output indicators were approved by the WHA as part of the Programme budget 2024–2025 (https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_4Add1-en.pdf) -- along with the mid-term reporting for 2022–2023 (https://open.who.int/2022-23/indicators).	The recommendation is closed.	Y			
90	2021	R017	WHO may consider disclosure of the performance ratings/impact assessment report of each WHO country office as the main aim of transformation is to monitor impact at the country level.	The Secretariat has disclosed the performance ratings/impact assessment report of each WHO country office starting with the end of biennium assessment for 2020–2021. Please see the reporting here: https://www.who.int/about/accountability/results/who-results-report-2020-2021#country-profiles.	The recommendation is closed.	Y			
91	2023	R014	WHO puts in place a robust internal control system over heritage assets, including official gifts, in a time bound manner (Medium).	September 2023: Now implemented. Please refer to R.013 and the policies and procedures now implemented.	The recommendation is closed.	Y			
92	2022	~~R001~~ R018	We recommend carry out cost savings generated on establishment of the GSC for further enhancement of operations at the centre.	13/09/2023: GSC has developed a document highlighting the benefits generated by the establishment of the Global Service Centre (GSC) in response to the recommendation from External Auditors ("The benefit of establishment of the GSC should be assessed under a prescribed time frame") and in line with the decision taken by the GSC Governance Board during its meeting, dated 27 and 28 February 2023. The benefits generated by the establishment in the GSC are described as follows: Cost Avoidance, Harmonization of Services, Quality of Services, Efficiency of Services, Control and Compliance of Services, Benefiting from Malaysian Context.	The recommendation is closed.	Y			

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				Please refer to the full document attached for additional background information and details. In view of the above, the audit recommendation has been implemented. We therefore kindly request External Auditors to close the subject recommendation.					
93	2022	~~R005~~ R019	Steps should be taken for sensitisation of users especially in the area/process where return rates are very high, such that separation processing, personal status change processing, administering emergency salary advance and rental subsidy etc. to avoid multiple iterations causing unnecessary workload.	13/09/2023: GHR has been conducting regular meetings with its regional office and headquarter HR counterparts. During these meetings, we explained all the factors that contribute to delays and/or rejection and clarified what we mean by a "duly completed transaction" that can be accepted for administration. We also provided explanations for transaction rejections. Meeting minutes are maintained and shared, and some of these minutes are attached herewith. In an effort to educate HR counterparts (HR transaction initiators) and staff to further minimize the rate of rejections and returns for corrections, GHR has taken initiatives. We have prepared nine brief and user-friendly videos on the major GHR transactions for the Global HR Community. The aim is to bridge the gap in understanding and interpretation of policies and rules while clarifying the major processes and requirements that need to be fulfilled. To facilitate this initiative, a dedicated "MS Teams" Team named #AskGHR has been formed, and all GHR, RHR, and HQHR staff members are part of this MS Teams group. All audio-visual aids that can be used by initiators are available on this dedicated channel and can be utilized for their knowledge enhancement and support by our HR counterparts. #AskGHR – Global HR Community – All Documents (sharepoint.com) In view of the above, the audit recommendation has been implemented. We therefore kindly request External Auditors to close the subject recommendation.	The recommendation is closed.	Y			
94	2022	~~R012~~ R021	We recommend that dependency verification exercise for the year 2020 should be expedite and thereafter every year this exercise may be completed in a time bound manner followed by prompt recoveries wherever applicable.	08/09/2023: Dependency verification exercise (DVE) for year 2020 was completed on 31 January 2023. Total 3061 staff members are INCLUDED in the verification exercise across all WHO regions and other entities. Dependency verification exercise (DVE) for year 2021 was launched on 6 March 2023, with initial deadline date 31 May 2023. But as per staff member's request it is further extended to 31 July 2023.Total 3161 staff members are INCLUDED in the Verification	The recommendation is closed.	Y			

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				Exercise across all WHO regions and other entities. Total recovery amount for DVE 2021 is US$ 772 000 and DVE 2020 and 2021 closure reports with all the details are attached. We therefore ask External Auditors to kindly close the recommendation.					
95	2022	~~R026~~ R022	WHO may consider including its own requirements or criteria in advance on the new "UN freight forwarding tender" to enable the selection of the best bids for LTAs based on such objective evaluation criteria.	04/09/2023: WHO management, through the Global Procurement and Logistics (GPL) Unit, has already taken action to implement this audit recommendation, as detailed below, and would thus like to suggest that the External Auditor considers it as closed. WHO is highly engaged in the new "United Nations freight forwarding tender" and was nominated as co-lead for the process, alongside UNICEF. The new tender covers the requirements of 14 participating UN Agencies (FAO, IOM, PAHO, UNDP, UNFCCC, UNFPA, UNHCR, UNESCO, UNICEF, UNOPS, UNPD, UNRWA and WHO). Since mid-2022, WHO has been providing input to UNICEF regarding WHO's requirements, collecting and sharing feedback, and through participation in numerous meetings as well as on-line collaboration on documents. This joint work for over a year, led to the development and publication on 10 July 2023 of the request for expression of interest (REOI) of the "The Joint United Nations Tender for Third Party Logistics – Freight Forwarding Services". This tender notice is publicly available and accessible to any potentially interested supplier, it was posted in the United Nations Global Marketplace (UNGM) and circulated to leading freight forwarding service providers. A link to the tender notice is included below and its three key documents (the tender notice as such, a questionnaire and a form) are also hereby attached for ease of reference: https://www.ungm.org/Public/Notice/206344 Importantly, as can be seen in these documents, WHO has ensured that key requirements of the Organization are duly captured, including key criteria that WHO specifically provided on enhanced open book audit requirements, cold chain management capability, the inclusion of freight forwarders ability to accept special carrier conditions, and the ability to comply with industry standard EDI. This REOI and its criteria will enable UN Agencies to shortlist the freight forwarders that will be invited to bid in the subsequent	The recommendation is closed.	Y			

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				Request for Proposals, that will ultimately lead to the establishment of the new LTA contracts by the end of 2024. This time frame covers the project's next stages including tender evaluation, award, contract negotiation, EDI integrations, transition between old and new service providers. As explained above, considering that WHO is a leading part of the process and all its stages, including evaluation and negotiation, and that it has ensured that key WHO requirements are being considered in the already published tender notice, WHO management believes it will be able to select the best bids for the new LTAs based on criteria more geared to its operational needs, thus complying to the audit recommendation.					
96	2022	~~R032~~ R026	Audit acknowledge the added value provided by CRO to GSC and recommends continuing the approach taken to increase the scope of compliance checks of CRO in other functional areas of GHR and GPAY transactions.	11/09/2023: GSC management would like first to thank External Auditors for acknowledging the added value provided by COR to GSC. GSC management also wish to inform External Auditors that GSC Governance Board endorsed the expansion of COR's activities to GHR and GPAY transactions during its last GSC Governance Board meeting, dated 27 and 28 February 2023. Please see below related extract of minutes of meeting: 7.1: External Audit Recommendations: GSC introduced the activities performed by the GSC compliance team for travel claims and procurement & logistics. GSC then presented the following two EA recommendations: (i) expansion of the scope of the compliance team and (ii) communication of recurrent deficiencies identified by the compliance team. In line with the first EA recommendation, GSC proposed to expand the scope of compliance activities to separations, dependency including education grant. GSC explained that the proposal resulted from exchanges held with several stakeholders (including GPAY, GPAY, GFI, Comptroller, CRE). GSC also referred to the perceived risks (for example: manual entry intensity level, complexity, and value of transaction) which were taken into considerations to identify those proposed new transactions to be under compliance scrutiny. Finally, GSC advised that the completion of the recruitment process of the Senior Compliance Officer and two temporary contract staff was also necessary to undertake such scope extension. The COR team has therefore already conducted several working	The recommendation is closed.	Y			

Serial No.	Audit year	WHA Rec ID	Recommendation	WHO response	Audit response	Implemented	Under implementation	Not implemented	Overtaken by events
				sessions with both GHR and GPAY to review existing procedures, especially in the area of separation, dependency and education grant. Some first samples are also being reviewed. External Auditors may wish to note that COR team has also initiated compliance reviews for the hiring of consultants since May 2023 in consultation with HRT. In view of the above, the audit recommendation has been implemented. We therefore kindly request External Auditors to close the subject recommendation.					
97	2022	~~R033~~ R027	Audit recommends for placing a methodology to communicate the recurrent deficiencies observed by COR team to user entities in coordination with GSC functions for bringing efficient validation in the system to avoid such lapses in the system.	11/09/2023: GSC management would like first to thank External Auditors for their advice on the matter. Following EA recommendation, COR has established several mechanisms to regularly communicate deficiencies as follows: In the area of procurement & logistics, COR communicates on monthly and quarterly basis the deficiencies identified during compliance reviews to the Global Procurement & Logistics Unit and copied to the management of Procurement & Supply Services Department. The last monthly and quarterly reports are attached as supporting information. In the area of travel, COR started communicating identified non-compliance cases on quarterly basis to management officers, travel policy unit at headquarters and also budget and Finance officers in major offices/regions. Related e-mails are attached as supporting information. In the area of human resources, COR is also communicating on monthly basis non-compliance cases identified related to the hiring of consultant. The communication of the last monthly report is attached for information. In view of the above, the audit recommendation has been implemented and COR will keep on communicating to support continuous improvement. We therefore kindly request External Auditors to close the subject recommendation.	The recommendation is closed.	Y			
	Total	**97**				**31**	**19**	**46**	**1**
	Percentage of recommendations					**32%**	**20%**	**47%**	**1%**

Appendix 2

LIST OF EXPIRED VACCINES

Sl No	Warehouse	Item Description	Value (US$)
1	AFR-South Sudan, Juba – Tomping	VACCINE RABIES (ChiroRab), lyophilized powder 2.5 IU + solvent 1 ml + syringe	770
2	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, BELGIUM BATCH powder, 25 doses/vial + diluent, vial	0
3	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, DUTCH BATCH powder, 25 doses/vial + diluent, vial	0
4	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, DUTCH BATCH powder, 25 doses/vial + diluent, vial	0
5	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, DUTCH BATCH powder, 25 doses/vial + diluent, vial	0
6	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, DUTCH BATCH powder, 25 doses/vial + diluent, vial	0
7	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, GERMAN BATCH powder, 20 doses/vial + diluent, vial	0
8	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, GERMAN BATCH powder, 20 doses/vial + diluent, vial	0
9	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, RUSSIAN BATCH powder, 20 doses/vial, vial	0
10	OSL-Switzerland, Swiss Confederation	VACCINE, SMALLPOX, ACAM powder, 100 doses/vial, vial	0
11	OSL-Switzerland, Swiss Confederation	(Small pox vaccine) DILUENT for ACAM, 0.6 ml, 100 doses/vial, vial	0
12	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 069.54
13	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	23 217.42
14	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 649.85
15	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 386.32
16	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	240 387.21
17	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 965.73
18	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	236 596.61
19	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 123.68
20	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	235 333.08
21	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	240 545.15

Sl No	Warehouse	Item Description	Value (US$)
22	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 123.68
23	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 281.62
24	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 123.68
25	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 543.37
26	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 070.43
27	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	236 438.67
28	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	86 867.91
29	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	148 465.16
30	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	230 121.00
31	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 859.25
32	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 543.37
33	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 332.18
34	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 648.07
35	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 806.01
36	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 597.50
37	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 439.56
38	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 123.68
39	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	240 071.33
40	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 281.62
41	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 807.79
42	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	240 071.33
43	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 228.38
44	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 439.56
45	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 597.50
46	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 965.73

Sl No	Warehouse	Item Description	Value (US$)
47	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 174.24
48	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 070.43
49	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	236 438.67
50	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 333.97
51	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	235 017.19
52	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 491.91
53	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 702.20
54	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	239 281.62
55	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 491.91
56	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238176.03
57	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 806.01
58	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	227 593.93
59	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	226 646.28
60	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 174.24
61	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	231 226.59
62	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	231 858.36
63	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 544.26
64	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	231 226.59
65	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	231 068.65
66	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	229 489.23
67	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 069.54
68	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	235 648.96
69	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	235 964.84
70	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	238 491.91
71	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 070.43

Sl No	Warehouse	Item Description	Value (US$)
72	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	222 855.68
73	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	235 806.90
74	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	237 070.43
75	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	232 963.95
76	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	109 453.57
77	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	118 456.25
78	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	234 385.43
79	POL-Indonesia, Bandung, Bio Farma Persero	VACCINE POLIO, oral trivalent (tOPV), 20 doses, vial	236 754.55
	Total		**15 346 697.72**

Appendix 3

STATUS OF IMPLEMENTATION OF SCT INITIATIVES

Strategic Goal	Initiative/Project	Current Status	Current Phase	Timeline for Completion
A	Supply chain operating model	60% Complete	Planning	December 2024
	Warehouse management	70% Complete	Planning	December 2024
	Green light	40% Complete	Planning	December 2024
B	Business partnering (SUP/OSL)	50% Complete	Executing	December 2024
	Emergency supplies – demand, inventory and operations planning	20% Complete	Planning	December 2024
	Product catalogue	30% Complete	Planning	December 2024
C	Fraud and corruption prevention	Work started	Initiating	December 2024
	Sustainable procurement accelerator	Work started	Initiating	December 2024
	Capacity development	Work started	Initiating	December 2024
	Procurement policy revision	40% complete	Planning	December 2024
	Category management	60% complete	Executing	December 2024
	Optimization of global shared procurement services	40% complete	Executing	December 2024

Appendix 4

UTILIZATION OF OCR FUNDING IN 115 MEMBER STATES IN US$

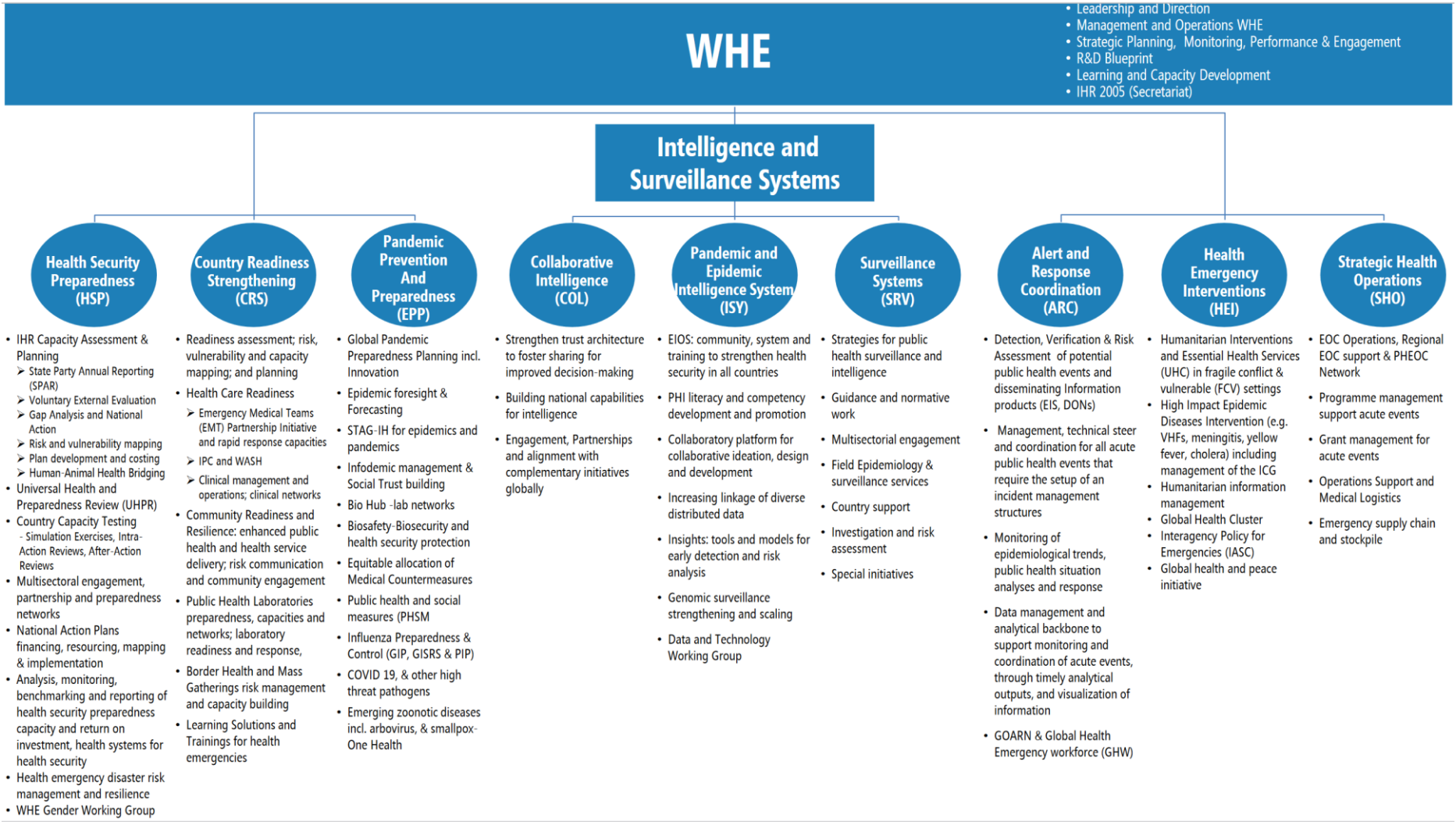
No.	Country	Region	COVID cases	CCPM	OCR funding	% of Total
1	Yemen	EMRO	11 945	370	54,97,06,893	14.901%
2	Afghanistan	EMRO	229 686	5 894	29,17,31,606	7.908%
3	Ukraine	EURO	5 520 483	125 724	18,66,93,639	5.061%
4	Islamic Republic of Iran	EMRO	7 625 160	87 354	16,71,97,219	4.532%
5	Democratic Republic of the Congo	AFRO	99 333	1 070	16,35,80,704	4.434%
6	Syrian Arab Republic	EMRO	57 423	2 764	16,28,88,316	4.416%
7	Türkiye	EURO	17 004 677	202 111	16,09,44,518	4.363%
8	Ethiopia	AFRO	501 117	4 276	12,21,18,409	3.310%
9	Lebanon	EMRO	1 239 904	218 951	11,99,75,854	3.252%
10	Somalia	EMRO	27 334	1 653	10,43,58,234	2.829%
11	Sudan	EMRO	63 993	1 440	10,31,15,157	2.795%
12	Nigeria	AFRO	267 173	1 282	9,05,45,067	2.454%
13	Iraq	EMRO	2 465 545	57 935	8,47,12,231	2.296%
14	Pakistan	EMRO	1 580 631	6 957	7,51,23,985	2.036%
15	South Sudan	AFRO	18 765	1 769	6,94,44,371	1.882%
16	Bangladesh	SEARO	2046165	12 222	6,42,67,318	1.742%
17	India	SEARO	45 004 816	32 229	6,04,51,610	1.639%
18	Libya	EMRO	507 269	76 236	5,69,21,741	1.543%
19	Uganda	AFRO	171 888	3 871	4,94,00,944	1.339%
20	Cameroon	AFRO	125 136	4 724	4,15,08,614	1.125%
21	Republic of Moldova	EURO	628 673	203 794	3,16,53,655	0.858%
22	Egypt	EMRO	516 203	4 803	3,01,95,085	0.819%
23	Mozambique	AFRO	233 731	7 497	2,73,65,258	0.742%
24	Indonesia	SEARO	6 817 154	25 076	2,71,33,628	0.736%
25	Burkina Faso	AFRO	22 106	1 027	2,45,46,060	0.665%
26	Kenya	AFRO	344 094	6 619	2,39,81,642	0.650%
27	Chad	AFRO	7 698	462	2,38,00,573	0.645%
28	Liberia	AFRO	7 930	1 559	2,24,35,691	0.608%
29	Timor-Leste	SEARO	23 460	18 046	2,17,02,986	0.588%
30	Niger	AFRO	9 515	391	2,11,34,478	0.573%
31	Guinea-Bissau	AFRO	9 614	4 769	2,10,91,916	0.572%
32	Malawi	AFRO	89 162	4 601	2,10,00,344	0.569%
33	Nepal	SEARO	1 003 450	34 191	2,08,51,091	0.565%
34	United Republic of Tanzania	AFRO	43 191	700	1,96,95,504	0.534%
35	Poland	EURO	6 590 705	171 506	1,96,00,277	0.531%
36	Jordan	EMRO	1 746 997	159 854	1,94,54,623	0.527%

No.	Country	Region	COVID cases	CCPM	OCR funding	% of Total
37	Philippines	WPRO	4 126 460	36 781	1,90,13,019	0.515%
38	Zimbabwe	AFRO	265 975	16 974	1,89,94,110	0.515%
39	Madagascar	AFRO	68 421	2 424	1,85,99,564	0.504%
40	Guinea	AFRO	38 572	2 921	1,75,17,480	0.475%
41	Sri Lanka	SEARO	672 661	30 977	1,70,19,089	0.461%
42	Lao Peoples Democratic Republic	WPRO	218 903	29 907	1,67,77,348	0.455%
43	Thailand	SEARO	4 761 226	66 613	1,63,30,395	0.443%
44	Uzbekistan	EURO	174 842	5 215	1,41,22,128	0.383%
45	Mongolia	WPRO	1 011 388	307 008	1,40,74,550	0.382%
46	Côte d'Ivoire	AFRO	88 380	3 296	1,37,40,554	0.372%
47	Central African Republic	AFRO	15 440	2 890	1,34,22,228	0.364%
48	South Africa	AFRO	4 072 636	69 260	1,33,98,415	0.363%
49	Tajikistan	EURO	17 786	1 864	1,28,60,475	0.349%
50	Tunisia	EMRO	1 153 361	94 835	1,24,95,159	0.339%
51	Papua New Guinea	WPRO	46 864	4 807	1,23,89,235	0.336%
52	Azerbaijan	EURO	834 241	81 113	1,22,82,310	0.333%
53	Myanmar	SEARO	641 393	12 006	1,17,53,329	0.319%
54	Mali	AFRO	33 162	1 562	1,14,47,584	0.310%
55	Ghana	AFRO	171 834	5 340	1,14,13,835	0.309%
56	Gabon	AFRO	49 051	21 396	1,10,93,491	0.301%
57	Georgia	EURO	1 855 289	492 653	1,10,31,126	0.299%
58	Mauritania	AFRO	63 764	14 174	1,07,36,616	0.291%
59	Equatorial Guinea	AFRO	17 130	10 733	1,06,17,149	0.288%
60	Zambia	AFRO	349 304	18 455	1,05,25,875	0.285%
61	Viet Nam	WPRO	11 624 000	120 271	1,02,35,959	0.277%
62	Sierra Leone	AFRO	7 766	943	1,02,24,206	0.277%
63	Burundi	AFRO	54 394	4 451	1,01,48,775	0.275%
64	Kazakhstan	EURO	1 502 857	79 184	1,01,18,724	0.274%
65	Togo	AFRO	39 527	4 682	93,64,174	0.254%
66	Armenia	EURO	451 272	160 846	89,75,632	0.243%
67	Congo	AFRO	25 213	4 422	86,65,436	0.235%
68	Rwanda	AFRO	133 208	10 133	83,98,978	0.228%
69	Belarus	EURO	994 037	103 183	80,82,516	0.219%
70	Cambodia	WPRO	138 978	8 476	80,18,364	0.217%
71	Benin	AFRO	28 036	2 217	74,57,504	0.202%
72	Senegal	AFRO	89 033	5 417	73,63,577	0.200%
73	Serbia	EURO	2 583 470	351 110	71,03,280	0.193%
74	Maldives	SEARO	186 694	362 909	69,89,441	0.189%
75	Lesotho	AFRO	35 892	15 923	69,74,687	0.189%
76	Angola	AFRO	106 303	3 180	68,95,249	0.187%
77	Comoros	AFRO	9 109	11 299	67,64,690	0.183%

No.	Country	Region	COVID cases	CCPM	OCR funding	% of Total
78	Albania	EURO	334 090	116 536	66,19,665	0.179%
79	Kyrgyzstan	EURO	88 929	13 841	65,58,415	0.178%
80	Namibia	AFRO	172 208	69 185	64,97,454	0.176%
81	Djibouti	EMRO	15 690	14 392	63,33,474	0.172%
82	Bhutan	SEARO	62 697	81 161	63,21,784	0.171%
83	Malaysia	WPRO	5 160 116	155 425	62,39,108	0.169%
84	Sao Tome and Principe	AFRO	6 719	30 731	61,35,025	0.166%
85	Romania	EURO	3 504 870	180 273	58,96,135	0.160%
86	Botswana	AFRO	330 409	129 755	55,91,331	0.152%
87	Bosnia Herzegovina	EURO	403 443	121 577	53,58,289	0.145%
88	Gambia	AFRO	12 626	4 905	51,78,595	0.140%
89	North Macedonia	EURO	349 923	165 756	47,49,565	0.129%
90	Morocco	EMRO	1 278 055	34 835	43,88,990	0.119%
91	Montenegro	EURO	251 280	399 461	40,79,300	0.111%
92	Mauritius	AFRO	315 100	242 790	40,54,174	0.110%
93	Cabo Verde	AFRO	64 474	110 658	36,67,703	0.099%
94	Seychelles	AFRO	51 220	485 360	33,64,142	0.091%
95	Algeria	AFRO	272 010	6 260	31,79,920	0.086%
96	Turkmenistan	EURO		0	31,65,684	0.086%
97	Czech Republic (Czechia)	EURO	4 713 739	447 608	31,38,306	0.085%
98	Eritrea	AFRO	10 189	2 865	30,05,365	0.081%
99	Greece	EURO	5 494 594	522 686	18,04,166	0.049%
100	Slovakia	EURO	1 871 209	342 921	16,94,358	0.046%
101	Oman	EMRO	399 449	87 919	15,80,738	0.043%
102	Democratic People's Republic of Korea	SEARO		0	15,15,023	0.041%
103	Bulgaria	EURO	1 315 421	188 478	11,28,379	0.031%
104	Solomon Islands	WPRO	25 954	37 550	11,19,526	0.030%
105	Italy	EURO	26 433 512	444 256	11,18,722	0.030%
106	Hungary	EURO	2 220 168	227 696	6,95,124	0.019%
107	Samoa	WPRO	16 780	78 072	2,80,000	0.008%
108	Vanuatu	WPRO	12 019	38 561	2,54,222	0.007%
109	China	WPRO	99 321 637	69 703	1,59,919	0.004%
110	Russian Federation	EURO	23 479 653	161 242	1,51,327	0.004%
111	Kuwait	EMRO	666 551	152 863	86,695	0.002%
112	Latvia	EURO	977 068	515 045	46,457	0.001%
113	Lithuania	EURO	1 359 230	481 951	12,430	0.000%
114	Saudi Arabia	EMRO	841 469	23 376	11,309	0.000%
115	Estonia	EURO	604 950	455 040	8,746	0.000%

Source: WHO Global Health Observatory Data: https://www.who.int/data/gho and who country wise data https://www.who.int/ towards Covid Cases, Population, CCPM. The OCR funding utilization from GSM BI Finance Expenditure Type data for country offices.

Appendix 5


WHE
• Leadership and Direction
• Management and Operations WHE
• Strategic Planning, Monitoring, Performance & Engagement
• R&D Blueprint
• Learning and Capacity Development
• IHR 2005 (Secretariat)
Intelligence and Surveillance Systems
Health Security Preparedness (HSP)
• IHR Capacity Assessment & Planning
➢ State Party Annual Reporting (SPAR)
➢ Voluntary External Evaluation
➢ Gap Analysis and National Action
➢ Risk and vulnerability mapping
➢ Plan development and costing
➢ Human-Animal Health Bridging
• Universal Health and Preparedness Review (UHPR)
• Country Capacity Testing - Simulation Exercises, Intra-Action Reviews, After-Action Reviews
• Multisectoral engagement, partnership and preparedness networks
• National Action Plans financing, resourcing, mapping & implementation
• Analysis, monitoring, benchmarking and reporting of health security preparedness capacity and return on investment, health systems for health security
• Health emergency disaster risk management and resilience
• WHE Gender Working Group
Country Readiness Strengthening (CRS)
• Readiness assessment; risk, vulnerability and capacity mapping; and planning
• Health Care Readiness
➢ Emergency Medical Teams (EMT) Partnership Initiative and rapid response capacities
➢ IPC and WASH
➢ Clinical management and operations; clinical networks
• Community Readiness and Resilience: enhanced public health and health service delivery; risk communication and community engagement
• Public Health Laboratories preparedness, capacities and networks; laboratory readiness and response,
• Border Health and Mass Gatherings risk management and capacity building
• Learning Solutions and Trainings for health emergencies
Pandemic Prevention And Preparedness (EPP)
• Global Pandemic Preparedness Planning incl. Innovation
• Epidemic foresight & Forecasting
• STAG-IH for epidemics and pandemics
• Infodemic management & Social Trust building
• Bio Hub -lab networks
• Biosafety-Biosecurity and health security protection
• Equitable allocation of Medical Countermeasures
• Public health and social measures (PHSM
• Influenza Preparedness & Control (GIP, GISRS & PIP)
• COVID 19, & other high threat pathogens
• Emerging zoonotic diseases incl. arbovirus, & smallpox-One Health
Collaborative Intelligence (COL)
• Strengthen trust architecture to foster sharing for improved decision-making
• Building national capabilities for intelligence
• Engagement, Partnerships and alignment with complementary initiatives globally
Pandemic and Epidemic Intelligence System (ISY)
• EIOS: community, system and training to strengthen health security in all countries
• PHI literacy and competency development and promotion
• Collaboratory platform for collaborative ideation, design and development
• Increasing linkage of diverse distributed data
• Insights: tools and models for early detection and risk analysis
• Genomic surveillance strengthening and scaling
• Data and Technology Working Group
Surveillance Systems (SRV)
• Strategies for public health surveillance and intelligence
• Guidance and normative work
• Multisectorial engagement
• Field Epidemiology & surveillance services
• Country support
• Investigation and risk assessment
• Special initiatives
Alert and Response Coordination (ARC)
• Detection, Verification & Risk Assessment of potential public health events and disseminating Information products (EIS, DONs)
• Management, technical steer and coordination for all acute public health events that require the setup of an incident management structures
• Monitoring of epidemiological trends, public health situation analyses and response
• Data management and analytical backbone to support monitoring and coordination of acute events, through timely analytical outputs, and visualization of information
• GOARN & Global Health Emergency workforce (GHW)
Health Emergency Interventions (HEI)
• Humanitarian Interventions and Essential Health Services (UHC) in fragile conflict & vulnerable (FCV) settings
• High Impact Epidemic Diseases Intervention (e.g. VHFs, meningitis, yellow fever, cholera) including management of the ICG
• Humanitarian information management
• Global Health Cluster
• Interagency Policy for Emergencies (IASC)
• Global health and peace initiative
Strategic Health Operations (SHO)
• EOC Operations, Regional EOC support & PHEOC Network
• Programme management support acute events
• Grant management for acute events
• Operations Support and Medical Logistics
• Emergency supply chain and stockpile

Appendix 6

DETAILED STATUS OF IMPLEMENTATION OF WHDH MODULES

Component/module	Function	Status
Country Portal	Facilitates two-way secure and digital exchange between Member States and WHO. It is composed of a framework for Member States for ensuring compliance with WHO policies *(Consultations)* and standardization of tools and processes for data submission by Member States and address feedback look-publication by sharing visualised results *(collections/profiles)*.	**Country Portal (consultations):** • In use. • 58% of the SDG indicator focal points were engaged, of which 27% are using Country Portal for collections. **Country Portal (Collections/profiles):** • File-based collection is working. • A consultant was engaged to study the use of standardised tool for collections. The WHO is yet to assess the pros and cons of the consultant's report.
Data Warehouse and xMart	A central repository (in existence since 2012), which is used for harmonization and warehousing for WHO data managers.	• Functioning. 40 technical teams are using Data Lake. • The xMart-OData application programming interface (API) is available for both internal and external users.
Data Lake	A central data repository for WHO teams to store and mange structured and unstructured files for data science and advanced analytics. The process involved ingestion of raw data, store data easily in native format, eliminate data silos, connect from anywhere using valid credentials, and preserve data version history.	• Data Lake was launched (2021) and has four quality levels (bronze, silver, gold and platinum) for data classification based on quality. • 35 teams were using the Data Lake/Data Science Lab (as at September 2023).
Data Science Laboratory	A self-contained data analysis workspace, where internal and external stakeholders could collaborate in a shared project workspace in a secure manner.	• Functional as a data analysis platform.
Data Activity Calendar	A planning/monitoring tool with tracking features for dependencies on other events and to reduce member states reporting burden.	• Work has started and is in the stage of conceptualisation, requirements gathering and prototyping. Operations yet to start. • Data activity calendar and Data Catalog have conceptually merged.
Data Catalog	Comprehensive catalogue of all health data, which allows users easily to find and download WHO data. Upon completion, the technical groups in WHO could use public data/sources independently and make it available for others.	• Data Catalog was in the stage of conceptualisation, requirements gathering and prototyping.
Data Visualization Engine	This component has advanced data visualization system with charts, texts, audios, images, *etc*.,	• Functional and currently contains charts and visualization. • Acceleration of chart rendering process is under development.
Datadot	Portal meant for dynamic data visualization, with search, download, cataloguing and publishing facilities. It is a publicly accessible interface (data.who.int) for sharing and enabling visualization of WHO's health data assets.	• Website is in "beta stage".

Appendix 7

RESULTS OF SURVEY OF INTERNAL USERS OF DATA

Description	Methodology	Number of users with using the methodology	Total Responses
Type of data collection	Aggregate summarized data	17	21
	Granular data	11	21
	Granular data with personal identifiable information	4	21
	Demographic data	11	21
	GIS data	5	21
Methodology of data collection	By excel sheets in mail	12	21
	By toolkits	6	21
	Through an exclusive web portal (pl. specify)	12	21
Source of Data	Data (directly from Member States)	14	21
	Data from other divisions of WHO	8	21
	Data from other publicly available sources	14	21
	From third party sources	8	21
Actions on the data	Cleaning and transformation	18	21
	Data validation	16	21
	Data exploration and analysis	17	21
	Data visualization	17	21
	Data sharing and collaboration	18	21
	Data interpretation and communication	17	21
Knowledge about data hub	Do you know about the World Health Data Hub?	20	21
	Are you using the Data Hub?	15	21
	If you are using the Data Hub, does it meet your expectations	10	15

Availability of Data Professionals in the Division (21 responses)	Number of divisions
Adequate	7
Inadequate, but we are managing on our own	12
Use services of DNA/Data hub	2

Reasons for not using Data hub (6 responses)	Number of divisions
We do not have adequate information about datahub	2
We internally have adequate expertise within our division for data management	2
Datahub functionalities are not adequate for our division	1
We are working through how/if we can use datahub for our needs	1

Source: Survey of internal users of data.

Appendix 8

RESULTS OF SURVEY OF MEMBER STATES

Sl. No.	Survey Question	Options	No of responses received from Member States
1	On a scale of 1 to 5, how user-friendly do you find the process of transmitting data to WHO? (1 is not user-friendly at all, 3 is neutral, 5 is very user friendly)	Not user friendly	1
		Average	4
		Neutral	28
		Good	25
		User friendly	8
2	How would you rate the capacity building and training effort by WHO for capture, collection, and transmission of data?	Infrastructure was provided for capacity-building, but regular training is not conducted.	10
		No capacity-building/training was provided.	14
		Training and capacity-building by WHO were very good.	9
		Training and capacity-building provided was adequate for our purpose.	25
		Training was provided but related infrastructure was not provided.	8
3	In your assessment, do you think the quality of data transmitted to WHO is good?	I cannot assess the quality of the data.	5
		In my assessment, quality of uploaded data is “average”; there’s room for improvement.	19
		In my assessment, the data quality is below average; significant improvements are necessary.	3
		In my assessment, the quality of the data being uploaded is excellent.	9
		In my assessment, the quality of the data is generally good but could benefit from minor enhancements.	30
4	Do you think that WHO’s intervention in the country is as per the data provided by you?	It is challenging for me to assess the relation between the data and intervention.	30
		There is a clear mismatch between the data I provided and WHO’s intervention.	1
		While there may be minor deviations, the data has played a valuable role in shaping WHO’s actions.	20
		WHO’s intervention in the country aligns with the data I provided.	13
		WHO’s intervention in the country is inconsistent with the data I provided.	2
5	Do you feel that the same data are requested by different programmes/technical divisions of WHO	No, we do not receive multiple requests for the same data as data requests are coordinated by regional offices and there are no duplicate requests.	16
		No, we do not receive multiple requests for the same data. Each division requests different data, and there is minimal overlap.	19
		Yes, there are multiple requests for same data, leading to duplication of efforts and data inconsistencies.	16
		Yes, there are multiple requests for the same data, leading to duplication of efforts but no data inconsistencies.	15

Sl. No.	Survey Question	Options	No of responses received from Member States
6	Have you participated in any consultation process organized by WHO before finalization of reports/estimates to provide feedback on correctness/quality of estimate	No, I have not participated in any consultation process, although I am aware of such processes.	7
		No, I have not participated in any consultation process.	20
		Other	4
		Yes, I have participated in a consultation process to understand the estimates. Feedback was considered by WHO before publishing estimates.	32
		Yes, I have participated in a consultation process. I assume the feedback was not considered before publishing estimates as I received no feedback.	3
7	Have you participated in any consultation process organized by WHO before finalization of reports/estimates to provide feedback on correctness/quality of estimate [Other]	I am yet to receive a confirmation.	1
		WHO already sent us the documents for review.	1
		Yes, I have participated in a consultation process to understand the estimates. Feedback sometimes was not fully considered by WHO before publishing estimates.	1
		Engagement by WHO is far too little and too far apart.	1
		Did not provide an answer	62

Source: Results of survey of focal points of Member States.

Appendix 9

STATUS OF INITIATIVES AS PER DELOITTE MODEL

Sl. No	Initiative	Benefits	Status	Our remarks
1	Define data architecture and tools stack.	Defines future-proof end-to-end data architecture for WHO including a catalogue of vendors and tools for each architecture layer.	Implemented	We noted that WHDH product Stack was established.
2	Harmonise data collection tools.	Streamlines WHO application landscape for data collection, aggregation and validation aiming to build a common data model.	In proof-of-concept stage	Subsequent to a study done in 2021, a proof-of concept was completed integrating Country Portal with a collection tool for Member State data collection but was pending approval.
3	Design and deploy a master data management solution.	Standardizes set of reference data used across the Organization reducing redundancies, inconsistencies and improving cost-effectiveness investments across WHO.	Partly	• A priority list for reference data is created inclusive of external data sources that multiple WHO teams use. • Secondary list to be completed as internal capacity becomes available.
4	Build a data collection and consultation tool.	Sets up a CoE at headquarters and regional level to support programmes with data and analytics initiatives by improving expertise through hiring and training staff when analytics skills are required.	Partly	• Country Portal created for consultations. • Tool for collection of data from Member States yet to be crystallized (refer sl.no.2 in table).
5	Implement a Data Lake across WHO.	Allows to store and process (un)structured data regardless of its source or format increasing flexibility, scalability, and real-time data analysis.	Implemented	• Data lake implemented. • Onboarding on in a "team-by-team" basis.
6	Build and maintain a single data dictionary.	Increases consistency and clarity by documenting indicator's data and metadata definitions ultimately promoting data sharing across WHO.	Partly	• Number of existing data dictionary efforts *viz.*, Indicator Metadata Registry, Digital Health & Innovation. Indicator Working group overseeing harmonisations.
7	Deploy a common code repository.	Ensures clear and structured code documentation is available across WHO enabling code sharing across programmes resulting into better collaboration.	Advanced stage of development	The Data Science Lab can provide Infrastructure for hosting code. Code documentation standards do not exist.
8	Create and maintain a single Data Catalog.	Ensures consistency, visibility and increases productivity by documenting list of available data assets stating their location, owner and systems used.	Pending	Work on the Data Catalog is at the stage of conceptualisation; its requirements are being mapped before development can start.

Sl. No	Initiative	Benefits	Status	Our remarks
9	Select and deploy a holistic end-to-end data lineage solution.	Provides visibility to dataset versions and dependencies throughout the data life cycle improving transparency and traceability.	Partly	Lineage is currently managed via the source information as part of the metadata schema. In the future, this area of work will be supported via the Catalog (tracking of key dataset changes over time).
10	One-stop shop for data.	Puts in place a single data repository for accessing overall WHO health data with a harmonized semantic layer.	Partly	This encompasses the breadth of the WHDH vision. Project components are not fully completed.
11	Modernize data products visualization Solutions.	Provides best-in class tools to visualize data products allowing better informed decisions and consequent action choices.	Partly	Website activated. But features under development (beta stage). The "beta stage" refers predominately to the multilingual features, which use a very different process and are still being monitored for accuracy. WHDH is resolving existing visualization products as the next update is being scheduled.
12	Enable self-service reporting capabilities.	Enhances overall service level and user experience allowing internal/external users to easily access data on a self-service basis for further analysis.	Pending	KPIs of WHDH (self-service statistics are yet to be prepared.
13	Build a stakeholder relationship management platform.	Tracks complete history of interactions with WHO stakeholders (e.g. partners) which ultimately improves WHO's overall effectiveness and efficiency.	Implemented	Separate software platform not built, but Health Data Collaborative and SDG 3 Global Action Plan Data and Digital Accelerator partnerships established.

Appendix 10

BUDGET AND EXPENDITURE OF STRATEGIC PRIORITIES OF AFRO, WCO CONGO AND WCO NIGERIA

Strategic Priorities	Outcomes	Percentage of expenditure against financing till October 2023		
		AFRO	WCO Congo	WCO Nigeria
Universal health coverage	Improved access to quality essential health services irrespective of gender, age or disability	74%	81%	63%
	Reduced number of people suffering financial hardship	81%	67%	77%
	Improved access to essential medicines, vaccines, diagnostics and devices for primary health care (PHC)	54%	96%	35%
	Total	**72%**	**82%**	**63%**
Protection from health emergencies	Countries prepared for health emergencies	76%	79%	75%
	Epidemics and pandemics prevented	73%	113%	68%
	Health emergencies rapidly detected and responded to	78%	71%	76%
	Total	**75%**	**79%**	**69%**
Better health and well-being	Safe and equitable societies through addressing health determinants	73%	NA	24%
	Supportive and empowering societies through addressing health risk factors	74%	60%	70%
	Healthy environments to promote health and sustainable societies	73%	NA	78%
	Total	**73%**	**60%**	**68%**

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