SEVENTY-FOURTH WORLD HEALTH ASSEMBLY **A74/34**
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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-fourth 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 2020 (see Annex).

ANNEX

Office of the Comptroller and Auditor General of India

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

For further information please contact:

Mr. K. Subramaniam
Director of External Audit - WHO
Office of the C&AG of India
E-mail: ksubramaniam@who.int

Audit of the World Health Organization (WHO) for the Financial Year ended 31 December 2020

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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-fourth World Health Assembly.

2. This is the first report to the World Health Assembly by the Comptroller and Auditor General of India, under our mandate as the External Auditor of the WHO from 2020 to 2023.

3. 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

4. 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).

5. We concluded that the financial statements present fairly, in all material respects, the financial position of WHO for the financial year ended 31 December 2020, 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 2020.

6. 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.

7. In addition to the audit of financial statements at WHO headquarters, we also conducted audits of the four WHO country offices (WCOs) – Afghanistan, South Sudan, Ethiopia and Iraq. Moreover, to add value to WHO's financial management and governance, we conducted a performance audit of the triple billion target – health emergencies. The results of the audit on these areas and offices were communicated to WHO management through management letters and are incorporated in this report.

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

9. All the audits were carried out through remote audits from India owing to travel and related restrictions following the coronavirus disease (COVID-19) outbreak.

Audit opinion

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

Key Audit Findings

Financial and compliance audit

(a) WHO did not depict its cash and short-term investments distinctly on its Statement of Financial Position, resulting in incomplete and non-transparent disclosure.

(b) We noted several transgressions in the selection and engagement of a consultancy firm. The firm was assisting WHO in procurement of personal protective equipment (PPE), without due approval, even though it entailed payment of US$2.53 million. Post facto approval was obtained after four months. The firm's role in procurement constituted a conflict of interest as the firm provided assistance to both WHO as well as the supplier.

(c) In the emergency procurement of PPE, we noted deficiencies in quality assurance and technical evaluation.

(d) In the procurement of COVID-19 testing kits, there was lack of objectivity in bid evaluation and selection of suppliers.

(e) The procurement system suffered from inadequate documentation and lack of supplier performance evaluation.

(f) There was an increasing trend of cases of misconduct, especially relating to fraud, harassment, non-compliance to professional standards and sexual misconduct. There were delays in investigation and taking disciplinary action in cases where allegations were substantiated. Efforts on prevention were found to be inadequate.

(g) The results framework, which was the hallmark of the transformative Thirteenth General Programme of Work, 2019–2023 (GPW 13) and was adopted from 2019, was not yet rolled out in any of the four country offices audited by us. In the country offices, we also observed weaknesses in the local procurement process and inventory management.

(h) The triple billion dashboard launched in November 2020 had incomplete data. As against the 64 indicators, data were available for only 38, 23 and one indicators for the years 2018, 2019 and 2020 respectively.

(i) The availability of funds under Contingency Fund for Emergencies (CFE) has remained below its target capitalization of US$ 100 million during the years 2015 to 2020. Further, the utilization of CFE funds for longer periods to fill funding gaps is not in line with the guiding principles.

Main recommendations

11. On the basis of our findings, we recommend that WHO may wish to:

(a) Devise methods for disclosing its own 'cash and cash equivalent' and 'short-term investments' distinctly in the Statement of Financial Position, without compromising the efficiency and advantages of a pooled treasury.

(b) Address the increasing trend of reported cases of misconduct. WHO should enhance its punitive as well as preventive efforts. Delays in investigation and disciplinary action should be reduced so that prompt and proportionate disciplinary action acts as a deterrent.

(c) Ensure that the results framework is completed and implemented across the Organization, and especially at country offices, at the earliest.

(d) Ensure that the WCO in Afghanistan takes urgent and appropriate measures to contain the spread of wild poliovirus and circulating vaccine-derived poliovirus (cVDPV) cases, especially through cross-border transmission.

(e) Address the baselines and targets of the programme budget output indicators on priority

(f) Review its strategies to elicit donor response to ensure sustained funding for health emergency operations to address the funding gaps at critical junctures. The CFE may be utilized for response operations at the onset of the event for a limited period of time, and in response to an escalation of, or a new event within, a protracted crisis, as envisaged in its guiding principles.

A FINANCIAL AUDIT

Mandate

12. 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. Regulations XIV of the Financial Regulations of WHO and the Appendix elaborate on 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.

Scope and objectives

13. 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. The primary objectives of the audit are to provide an independent opinion on whether:

(a) the financial statements present fairly the financial position, the results of financial performance, the changes in net assets/equity, the cash flows, and the comparison of actual amounts and budget of WHO for the financial year ended 31 December 2020 in accordance with IPSAS;

(b) the significant accounting policies set out in Note 2 to the financial statements were applied on a basis consistent with that of the preceding financial period; and

(c) the transactions that have come to our notice or that we have tested as part of the audit, complied in all significant respects with the Financial Regulations and legislative authority.

14. We also carried out a review of WHO operations consistent with Financial Regulation 14.3, which requires the External Auditor 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.

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

16. 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.

Methodology and auditor's responsibilities

17. We conducted our audit in accordance with the ISA. These Standards require that we plan and perform our audit to obtain reasonable assurance that the financial statements are free from material misstatement. The audit included examining on a test basis evidence supporting the amounts and

disclosures in the financial statements. The audit also included assessing the accounting principles used and the significant estimates made by WHO management as well as evaluating the overall presentation of the financial statements.

18. The risk-based audit approach was adopted in the audit of the financial statements. This approach requires the conduct of risk assessment of material misstatements at the financial statements and assertion levels based on an appropriate understanding of the entity and its environment including its internal controls.

19. The External Auditor's responsibility is to express an opinion on the financial statements based on an audit. The audit is performed to obtain reasonable assurance, not absolute assurance, as to whether the financial statements are free of material misstatement caused by fraud or error.

20. 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.

21. During the financial year 2020, aside from the audit of the financial statements at headquarters, we audited the four country offices namely Afghanistan, South Sudan, Ethiopia and Iraq as well as conducted a performance audit of the triple billion target – health emergencies. All the audits were carried out through remote audits from India owing to travel and related restrictions following the coronavirus disease (COVID-19) outbreak.

22. 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 of the United Kingdom. We placed reliance on their audit based on the Comfort Letter dated 1 April 2021. The National Audit Office of the United Kingdom informed us that their audit of 2020, thus far, did not detect any material errors, misstatements or any other matters that will adversely affect the audit opinion on the PAHO financial statements. They further informed us that they can only conclusively give assurance that there are no material misstatements, once the audit of the 2020 financial statements is fully concluded and the 2020 financial statements have been certified. An unmodified audit opinion was also given on the 2020 annual accounts.

23. We coordinated with the Office of Internal Oversight Services (IOS) on the planned audit areas to avoid unnecessary duplication of efforts. We also collaborated with the Independent Expert Oversight Advisory Committee (IEOAC) to further enhance our audit work.

24. We continued to report the audit results to WHO management through audit observation memoranda and management letters containing detailed observations and recommendations. We issued 11 audit management letters to the WHO heads of offices and hosted entities during the financial year 2020. The practice provides a continuing dialogue with WHO management.

AUDIT FINDINGS AND RECOMMENDATIONS

1. Follow-up of previous external audit recommendations

25. There were 32 external audit recommendations outstanding as of 31 December 2020, of which only one has been implemented and others were either pending or under implementation. The External Auditor observes the need for WHO management to improve the pace of implementation of previous

recommendations and make a time-bound action plan to implement the same (External Auditor's comments on the recommendations are given in **Appendix 1**).

2. Financial overview

26. WHO's revenue has been steadily increasing over the last five years, from US$ 2.36 billion in 2016 to US$ 4.29 billion in 2020. Revenue for 2020 saw the steepest rise, an increase of US$ 1.18 billion compared to 2019 (US$ 3.12 billion). This was mainly due to the increase in voluntary contributions by US$ 1.21 billion as compared to 2019.

27. Assessed contributions have shown a declining trend from being 19.88% of the revenue[1] in 2016 to 11% of the revenue in 2020. On the other hand, voluntary contributions have increased steadily from 74% of the revenue in 2016 to 86% of the revenue in 2020.

28. Expenses as a percentage of revenue were at a five-year low in 2020. It was about 83% of revenue in 2020 as compared to 99% in 2019. Staff costs, which constituted the biggest item of expense, showed a slight increase from about 31.8% of the total revenue in 2019 to 32.3% of the total revenue in 2020. However, contractual services, transfers and grants, travel and general operating expenses showed significant decline as compared to 2019. This was primarily due to the slowdown caused by the COVID-19 pandemic. There was an increase of more than 100% on the purchase of medical supplies and materials, due to the large emergency purchase of PPE and other COVID-19-related medical supplies.

29. As at 31 December 2020, the total assets of WHO were US$ 7.13 billion, an increase of US$ 1.5 billion as compared to 31 December 2019. The increase was mainly due to the increase in short-term investments and cash and cash equivalents. The short-term investments increased by US$ 619 million accompanied by an increase of US$ 587 million in cash and cash equivalents; however, as a percentage of the total assets they remained more or less at the same level as the previous year.

30. Accrued staff liabilities which is the biggest item of liability (42.77% of the total liabilities), increased by US$ 695 million. This was primarily due to actuarial valuation of the staff health benefits.

31. The following ratio analysis was used to assess the financial management of WHO.

(a) Short-term solvency

32. We could not calculate the quick and current ratio for WHO as the figures for cash and short-term investments were not distinctly disclosed in the financial statements, as WHO operates a pooled treasury. WHO informed the External Auditor that all of WHO's short-term investments are highly liquid and can be fully liquidated within one to two weeks. All the entities whose funds WHO manages have surplus liquidity.

33. The contribution receivable ratio was used to assess how fast WHO was able to encash its contributions. The ratio for the last four years is shown below:

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

Table 1.

	2020	2019	2018	2017
Contribution received[1] (US$)	4170.17	2982.11	2791.67	2596.02
Average contribution receivables (current)	1244.88	1153.89	1188.51	1069.03
Contribution receivable ratio	3.35	2.58	2.36	2.43
Number of days taken to encash receivables	109	141	155	150

34. The increase in receivable ratio indicates that, in 2020, WHO was able to collect its contributions faster as compared to previous years. The time to collect receivables was 109 days in 2020 as compared to 141 days in 2019 and about 150 days previously. This is further corroborated by the fact that current receivables as on 31 December 2020, have been the lowest in the last four years. Current receivables were 18% of the total assets as compared to 20% in 2019.

35. The inventory turnover ratio indicates how fast the inventory is consumed and days in inventory shows the number of days for which goods remains in inventory. We analysed these ratios for medical supplies and materials for the last four years as shown below:

Table 2.

	2020	2019	2018	2017
Consumptions/Expense of materials (US$)	523.590	259.39	176.69	253.02
Average inventory (US$)	101.753	48.329	40.557	41.598
Inventory turnover ratio	5.15	5.37	4.36	6.08
Days in inventory (days)	**71**	**68**	**84**	**60**

36. Expenditure on medical supplies and materials saw a twofold increase in 2020 as compared to the previous years. This was accompanied by a similar increase in inventory held by WHO as on 31 December 2020. The average number of days for which the materials were in inventory was 71 days in 2020 as compared to 68 days in 2019, indicating a slightly slower movement of materials. This was primarily because of delay in delivery of supplies, as inventory also includes goods in transit. Delay in delivery was attributed to the COVID-19 pandemic. However, the analysis shows that the situation was more or less similar in 2019, and movement of inventory was much slower in 2018.

3. Changes made in the financial statements at the instance of audit

37. Based on audit observations and recommendations necessary amendments were made by WHO in the financial statements. These included adjustments of prepayments valuing US$ 29.80 million, understatement of cash and cash equivalents by US$ 482.80 million due to incorrect mapping of accounts and additional disclosures to enhance transparency.

4. Investment management

38. As on 31 December 2020, total cash and cash equivalents of WHO were US$ 915.95 million (31 December 2019: US$ 328.70 million). Total investments of WHO were US$ 4.02 billion

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

(31 December 2019: US$ 3.39 billion). They comprised short-term investments of US$ 3.88 billion and long-term investments of US$ 136.70 million.

39. The long-term investments are managed by external investment managers while the short-term investments are managed by both treasury and by external investment managers. WHO's objective for the investment of the Organization's funds is preservation of capital, maintenance of sufficient liquidity and optimization of returns as measured over a 12-month period.

(a) Disclosure of cash and investments of WHO

40. WHO operates a pooled treasury system, wherein WHO provides treasury services to the other four non-consolidated entities, the ICC SHI, UNAIDS and Unitaid. WHO treasury manages investments and also makes payments on behalf of these entities. Cash entrusted by all the entities are mingled with WHO funds and invested, while some is held as cash and cash equivalents.

41. We noted that in the Statement of Financial Position of WHO, cash and cash equivalents; and short-term investments of WHO are not depicted distinctly. What is disclosed, is the total mingled cash and short-term investments of all the five entities put together. The Statement of Financial Position of WHO shows cash and cash equivalents of US$ 915.95 million. In Note 4.1 it is clarified that out of this, US$ 198.19 million is held as cash and cash equivalents by the WHO regional offices and headquarters. The remaining US$ 717.76 million (78%) is held as part of the investment portfolios, which includes the investments made on behalf of all the five entities. The Note does not disclose how much of this pertains to WHO and how much to the other entities.

42. Similarly, the Statement of Financial Position discloses short-term investments of US$ 3.88 billion. Note 4.2 states that the total investments shown in the Statement of Financial Position includes US$ 946.23 million invested on behalf of the other four entities. Thus, the short-term investments of WHO are not distinctly disclosed in the financial statements but left to the reader to calculate. Such an obscure depiction of the largest item of the Statement of Financial Position does not meet the standard of complete and transparent disclosure.

43. WHO, in reply to the audit finding, stated that since it also performed disbursement services (payroll and accounts payable) for the hosted entities, its cash is completely mingled with the entities right down to the operational bank account level. Much of the cash in WHO bank accounts is held to fund the disbursements of hosted entities. For example, Unitaid does not have any bank accounts of its own. It is therefore much more difficult to draw definitive lines around the cash and short-term investments and identify which amounts belong to which entities. It would be very difficult to provide an accurate breakdown of the cash and investments figures by entity, unless the funds are no longer mingled, and completely separate bank account structures were implemented for each entity. This would be prohibitively inefficient and expensive to implement.

44. WHO also informed the External Auditor that all of WHO's short-term investments are highly liquid and can be fully liquidated within one to two weeks. All the entities whose funds WHO manages have surplus liquidity. That is why in this context the difference in IPSAS classification between cash and short-term investments is considered to be marginal as a meaningful indicator of the liquidity of each entity.

45. We appreciate the practical difficulties that may be faced by WHO in making an accurate disclosure of these assets, but the basic fact remains that non-disclosure of an organization's materially significant assets, distinctly on its balance sheet constitutes incomplete disclosure. Materiality implies,

usability of the information for decision making by the user of the financial statements. Cash and short-term investments are current assets of WHO that are available to meet its operating needs and therefore the users of the financial statements are entitled to know the value of these assets (para. 23, IPSAS 1).

Recommendation 1: We recommend that WHO should devise some method for disclosing its own 'cash and cash equivalents' and 'short-term investments' distinctly in the Statement of Financial Position, without compromising the efficiency and advantages of a pooled treasury.

46. WHO accepted the recommendation and stated that from 2021 onwards it will disclose these assets distinctly for WHO, as an arithmetic rough estimate of cash and cash investments based on the inter-entity balances. The basis for the calculation of these values will also be disclosed.

(b) SHI long-term funds

47. We noted that Note 4.2 states that WHO's investments include funds managed for other entities. However, we observed that WHO also manages long-term investment portfolios worth US$ 1.17 billion for the SHI Fund but there is no disclosure in this regard in the financial statements.

48. WHO replied that there is a disclosure in the financial report that the SHI is not a consolidated entity. We note that WHO has disclosed that it manages mingled funds on the behalf of other non-consolidated entities like the SHI, UNAIDS, Unitaid etc. WHO needs to, however, specifically disclose that it is managing the SHI's long-term funds worth US$ 1.17 billion in Note 4.2 pertaining to investments.

Recommendation 2: We recommend that disclosure regarding management of SHI long-term funds by WHO should be incorporated in the financial statements for their better understanding.

49. WHO accepted the recommendation

(c) Advisory Investment Committee

50. The Advisory Investment Committee (AIC) functions as an advisory body to the Director-General on investment strategy and investment policy. It also provides oversight on investment matters.

51. The AIC is composed of a minimum of four and maximum of five external members who are selected/appointed by WHO. We noted that from 1 January 2020 to 11 August 2020, the AIC was functioning with only two members as other members had retired/resigned in 2019. A minimum of three members is necessary for quorum. Thus, the AIC functioned for seven months and held one meeting without quorum.

52. WHO replied that the process of recruitment of new AIC members was delayed due to the COVID-19 pandemic. The other two members continued to provide valuable investment oversight and advice during first two quarters.

53. WHO management's reply is to be viewed in the light of the fact that the AIC functioned with only two members in the first two quarters of the year 2020.

(d) Engagement of investment managers

54. According to Clause 7.4 of the Investment Policy, the selection of investment managers should be done through a competitive bidding by issuing a request for proposal (RFP), every five years. We observed that the management of the short-term investment portfolio of WHO and SHI was not submitted to a RFP every five years as required by the policy. The last RFP for WHO mandates was issued in 2011, SHI's equity portfolio was issued in 2012 and its fixed income portfolio was put to a RFP in 2015.

55. WHO replied that considering the performance of the existing investment managers and their fees; and comparing them with the investment managers of other United Nations agencies, it was concluded that a full RFP was not needed and the decision was taken to continue with the same investment managers. WHO replied that issuing a RFP for SHI's fixed income portfolio will be considered in 2021. It was also stated that policy requirement of undertaking a RFP every five years will be revisited.

(e) Asset allocation

(i) Cash balance

56. We observed that the actual cash held by WHO is 13.7%, against the limit of 0–10% stipulated in the Investment Policy. WHO replied that the difficult situation due to COVID-19 had resulted in an increased balance, on account of the extremely large funds inflows related to COVID-19 and the uncertainty about the disbursements of those funds.

57. We acknowledge the situation related to COVID-19. However, we are of the view that necessary corrective action should be initiated to bring the cash balance in the range as specified in the approved asset allocation.

(ii) Staff Health Insurance and terminal payment funds

58. We observed that as per paragraph 2.2 of the Investment Policy, terminal payment funds are held to finance longer term liabilities and these are part of the long-term investment portfolio. However, we noted that 33.50% (US$ 69 million out of US$ 206 million) of terminal payment funds was held in mingled short-term investments. WHO replied that a real estate investment fund has been created and that the selection of the fund manager for the real estate fund was delayed due to COVID-19. Therefore, the earmarked funds were temporarily parked in mingled short-term investments.

5. Inventory management

(a) Expired inventory

59. On examining the inventory reports of all regions for the year 2020, we observed that medicines and medical supplies valuing US$ 5.419 million had expired during 2020. The maximum expired inventory was from the African (27%) and Eastern Mediterranean (50%) regions.

60. WHO replied that the value of expired inventory was US$ 3.9 million and not US$ 5.41 million, as the reports were extracted from Global Inventory Management system (GIMS), which was not fully up-to-date due to the COVID-19 workload. In Bangladesh and Ethiopia, some medicines were issued before their expiry but were updated later in GIMS. WHO also clarified that in some cases, the expiry

date of the medical kits indicated the expiry date of the item in the kit that was expiring at the earliest and did not mean that the whole kit had expired.

61. Explaining the non-use and expiry of medicines, WHO stated that before the COVID-19 pandemic, most of the WHO Health Emergencies Programme emergency stockpiles consisted of medical kits to respond to earthquakes, floods, landslides, cholera etc. However, due to COVID-19, countries are now demanding PPE, diagnostics testing kits and biomedical equipment.

62. We acknowledge the difficulties faced due to COVID-19. However, we are of the view that medical supplies should be procured based on a proper assessment of the requirement and utilized effectively.

(b) Disposal of expired inventory

63. Out of the inventory that expired during 2020 (US$ 3.9 million) inventory valuing US$ 14,289.73 (0.37%) was disposed and 99.63% remained undisposed.

64. We further noted that expired inventory valuing US$ 0.68 million pertaining to the years 2013–2019 was lying undisposed in various warehouses at headquarters and in the African, Eastern Mediterranean and Western Pacific regions. No specific reason regarding the expired inventory being in stock since 2013 was provided.

65. We are of the view that delayed disposal not only involves the risk of inadvertent usage but also involves avoidable carrying cost. It indicates the lack of a stringent disposal monitoring mechanism.

(c) Slow moving and non-moving inventory

66. We noted that 224 items of medicines and chemicals, valuing US$ 1.46 million had not moved during the last one year. This included 73 items worth US$ 1.27 million, where each item costed more than US$ 5000.

67. WHO replied that some items had to be kept in stock for the Ebola virus disease outbreak. In Ethiopia, following the massive cholera outbreaks in 2016–2018, large stocks of cholera kits were procured. However, starting in 2020, cholera cases decreased and the main focus was on COVID-19. Some medicines were procured for programme-specific activities like mass drug administration and vaccination campaigns, which were put on hold or postponed due to COVID-19.

68. We further noticed that three items valued at US$ 1.83 million intended for use in Yemen were expiring by 31 March to May 2021. They had been kept in a Dubai warehouse for more than one year. WHO replied that Yemen had requested to extend the shelf life of the starter interagency emergency health kits to August 2021 by replacing the items expiring in March/May 2021 and that the kits would be shipped thereafter.

69. We acknowledge the fact that some inventory needs to be pre-positioned (stand-by stock) in readiness to respond to the onset of emergencies. However, the level of such buffer or safety stock that needs to be maintained has to be determined on the basis of the target population, rate of consumption and lead time for purchase in accordance with standard inventory management practices. Inventory needs to be optimized to address the risk of both excess stocking and stock out situations.

70. WHO management replied that contingency stocks are necessary and there is always a risk involved in holding them. The quantification and management of contingency stock categories is under review. The functional requirements for the new enterprise resource planning (ERP) project also specifically include better monitoring and flagging of shelf life globally, although this will take time to implement.

71. We noticed in the country offices that despite the very slow movement of some emergency kits, replenishment/delivery of supplies kept happening throughout the year. Since these kits are purchased through long-term agreements from suppliers that have a long-standing relationship with WHO, a suitable mechanism should be established with the suppliers to link the deliveries/supply orders with the movement of inventory.

Recommendation 3: Inventories should be optimized to achieve cost effectiveness by adopting widely accepted inventory management tools like economic order quantity.

Recommendation 4: WHO should ensure that timely, updated and correct information is available in GIMS at any point of time.

6. Contractual services

72. Contractual services represent expenses incurred for suppliers such as experts and service providers who are engaged to support the Organization’s programmatic activities. During 2020, total expenditure on contractual services was US$ 986.13 million which was second highest expense item after staff costs. The main components within contractual services are direct implementation; general contractual services; and consulting and research contracts.

73. Consultancy contracts worth US$ 332.79 million were signed in 2020. Eight contracts with a total value of US$ 11.72 million were placed with one Consulting Firm A, out of which two high value contracts amounting to US$ 5.40 million were selected for detailed scrutiny. These contracts were related to COVID-19 emergency procurements.

(a) Engagement of Consultant A

(i) Engagement from March to October 2020

74. At the start of the pandemic in March 2020, Consultant A offered ‘pro bono’ services to help WHO in procurement and supply of PPE and essential equipment. WHO accepted the offer and engaged Consultant A. According to the offer of Consultant A, the firm was to provide the service for seven months, in different phases as shown in Table 3 below. The total cost of the engagement, as worked out by Consultant A, was US$ 7.30 million, of which 55% (US$ 4.03 million) was to be borne by Consultant A, 35% (US$ 2.53 million) by WHO and about 10% (US$ 0.73 million) by The Bill & Melinda Gates Foundation.

75. The details of the engagement are discussed below:

Table 3

Phase	Start date	End date	Consultant A (pro bono)	WHO (in US$)	The Bill & Melinda Gates Foundation (in US$)	Total (in US$)
Phase 0	27 March 2020	19 April 2020	559 920	0	0	559 920
Phase 1	20 April 2020	14 June 2020	1 474 160	737 080	737 080	2 948 320
Transition	15 June 2020	12 July 2020	197 760	0	0	197 760
Phase 2	13 July 2020	2 Oct 2020	1 800 000	1 800 000	0	3 600 000
Total			**4 031 840**	**2 537 080**	**737 080**	**7 306 000**

76. We are of the view that calling this engagement pro bono is not correct because Consultant A had proposed a project of US$ 7.30 million in which WHO was made to commit US$ 2.53 million. Details of how the pro bono services were valued was not available on record.

77. In phase 1, the purpose of the work was to help WHO develop its supply chain management capabilities. One of the specific deliverables was proof-of-concept for LTAs with suppliers. When asked about the status of the proof-of-concept LTA, WHO replied that the work was shifted to phase 2 as the WHO management was overburdened operationally.

78. We noted that the nature of work done by Consultant A in all the phases was the same which included producing regular pipeline forecasts, monitoring shipments, gathering information about the suppliers and the market, and assisting WHO in all stages of procurement. One of the tasks stated to have been performed by Consultant A was the identification of suppliers of PPE. However, during the same time on 5 May 2020, WHO had entered into a Letter of Agreement (LOA) with Firm C, to help in the sourcing and purchase of PPE.

79. We noted that Consultant A was engaged and started work without due approval of the competent authority, despite the fact that it entailed payment of US$ 2.53 million by WHO. Proposal for approval was initiated almost four months after Consultant A had started their work and after three of the four phases were completed.

80. The proposal seeking post facto approval was submitted to the Contract Review Committee (CRC) in August 2020 stating that: “Consultant A was critical to the success of WHO operations and WHO didn’t have sufficient internal human resources to undertake high value/volume procurement and to continue the services of consultant A for phase 2”. The CRC approved the proposal as a fait accompli and advised that the contract for phase 2 should be strictly for a three-month period, and any further contracts should go through a formal competitive process. The contract between WHO and Consultant A was signed on 14 August 2020. We are of the view that the formal process of approval should have been adopted before accepting the offer of Consultant A and engaging the firm. The delay in getting the approval of the competent authority was not justified.

(ii) Engagement from 1 December 2020 to 31 May 2021

81. In accordance with the CRC recommendation, WHO initiated an open competitive bidding process for further engagement of consultants to "support the long-term vision for WHO supply chain and to build capabilities to execute the long-term supply chain vision". A RFP was posted on the United Nations Global Marketplace portal giving 19 days for firms to respond. About 65 companies had accessed the RFP, but only four consultants submitted bids.

82. It was a two-bid process, with technical and financial evaluation carrying a weight of 70% and 30% respectively. The minimum score for technical qualification was 42 and only two firms – Consultant D and Consultant A – were technically qualified. Consultant D got the highest total score and therefore, the consultancy should have been awarded to Consultant D. However, WHO changed the evaluation criteria and re-evaluated the bids as per which Consultant A scored higher and was awarded the consultancy. According to Clause 3.3 of the RFP (Statement of Work), the work to be done by the consultant was divided under three components: (i) advisory services which included design as one of its items of work; (ii) business process review and production; and (iii) data management and digitization. Consultant A lost out because they had quoted a very high price for the component 'data management and digitization'. Therefore, during financial evaluation WHO removed this component and compared the prices of the two firms. As a result, Consultant A got a higher score and was awarded the contract.

83. The justification given to the CRC was that Consultant D in their financial bid had only estimated a preliminary cost for the 'build' portion of the bid. Whereas, Consultant A had comprehensively bid for the 'build' portion of the information technology (IT)/data management systems. This resulted in the huge price difference between the two bids for the 'build' component. The evaluation committee, therefore, decided to compare the bids only on the design and program management components and exclude the 'build' component.

84. This justification and bid evaluation was not in compliance with the WHO Procurement Manual provisions and violated the norms of public procurement because of the following reasons:

(a) Both the firms were technically qualified having obtained the qualifying scores. For the evaluation committee to state later during the financial evaluation, after discovering that Consultant A had quoted a very high price, that the bid of Consultant A for the 'build' portion was more comprehensive than the bid of Consultant D was not justified. Even after excluding the financial bid for 'build' portion, the difference in the total scores of the two firms was not much. While approving the consultancy, the CRC also noted that the overall score between the two firms did not reflect the actual difference between the firms and further stated that there seemed to be some flaw in the evaluation methodology that should be corrected in the future.

(b) In the RFP, the work was divided into (i) advisory services (which included design as one of its items of work); (ii) business process review and production; and (iii) data management and digitization. However, for bid evaluation, the scope of work was divided into three components – design, programme management and build (building of the IT system) contrary to the specifications of the RFP. Changing the technical requirement or scope of work, from what was stated in the RFP and changing the evaluation criteria at the time of evaluation violates public procurement principles and vitiates the tendering process. It compromises on equity and fair play.

(c) One of the objectives of engaging the consultant (Clause 2.2 of the RFP) was: "To access various assets and expertise, including an end-to-end digital solution". Under Clause 3.3.1 of the

RFP that specifies the deliverables, three of the seven deliverables pertain to development of the digital solution. Programme management implies managing of the whole project including the 'build' portion. Therefore, by removing the building of the IT system or 'data management and digitization' from the scope of consultancy, the objective of the consultancy was compromised. Prudence demands that the building of the IT system is given to the agency that designs the solution and has the programme management contract.

85. In reply, WHO management stated that the main reason for not committing on the build phase was that, WHO was going in for an entirely new ERP which would likely impact the design phase to a high degree. This reply is not tenable because if that was the case then the IT component should not have been included in the RFP in the first place.

86. We noted that Consultant A was involved in the preparation of bid documents and had given inputs to WHO senior management, based on which the RFP was developed. The involvement of Consultant A in the procurement process, in which the firm itself was a bidder is a conflict of interest.

87. The consultancy agreement was signed with Consultant A for US$ 3.6 Million for the duration of 1 December 2020 to 31 May 2021. We noted that the approval of the contract was obtained on 5 January 2021, one month after the start date of the contract. WHO replied that the actual work started only on 6 January 2021, after the approval.

7. Procurement management

88. Procurement of medical supplies and materials is vital for saving lives in emergencies and improving the health of population through programmatic intervention by WHO. Expenditure on medical supplies and materials had seen a twofold increase in 2020 as compared to the previous years. Purchase orders valuing US$ 866.72 million were placed during 2020, out of which, US$ 776.19 million (90%) was emergency procurement. About 82.76% (US$ 717.29 million) of the emergency items purchased were non-catalogue items.

89. Procurement of medical supplies was therefore identified as an area of high risk and was examined in detail using a sample of 26 purchases. The findings have been discussed below with general observations on the procurement system as a whole, followed by observations specific to each procurement category.

90. The overall guiding objective for all WHO procurement is to obtain the best value for money, which means buying the product that best meets the user needs(quality), at the optimum price and the right time. Value for money is assured only if:

- the specifications are clearly framed to truly reflect the user's needs
- all available options in the market are tapped through adequate competition
- the evaluation of offers is done objectively and fairly
- there is competitive price discovery; and
- objectivity, transparency and fair play are maintained at all stages of procurement and are evident in all decision making.

(a) General observations on the WHO procurement system

(i) Price evaluation

91. Verifying the reasonability of the prices quoted by the vendors is an important aspect of price evaluation. Price benchmarks, price estimates or at least a list of prevailing international prices for medical supplies and materials should be maintained by WHO. WHO management agreed that maintaining a price benchmark may be possible for a limited number of high-value strategic supply categories but it may also lead to problems when quotes received are all higher than that benchmark.

(ii) Supplier performance evaluation

92. The evaluation of the supplier's performance is necessary for assuring the supplier's fulfilment of the contractual requirements. It is an essential tool for keeping the suppliers accountable for failure to deliver the specified quality within the specified time, especially when WHO does not include provisions for liquidated damages in its contracts. A supplier performance rating is to be used while selecting vendors for repeat orders or extending LTAs. According to the WHO Procurement Handbook, performance evaluation is mandatory for contracts exceeding US$ 200 000. We could not examine the performance rating of the supplier as they were not available on record. WHO replied that supplier performance evaluations for LTAs are only concluded at the end of the first quarter for purchases of the previous year since WHO needs to wait for majority of orders to be delivered before concluding the evaluation. We did not find any evidence of the performance rating being used in the selection of vendors, while placing repeat orders with them or while extending the framework agreements.

(iii) Bid evaluation

93. While procuring several items that are used together or procuring items in bulk, the best and most efficient method is to invite quotations and evaluate the price on a lump-sum basis rather than comparing item-wise rates and selecting different suppliers for different items. Whether the method of evaluation of bids is lump-sum basis or item-rate basis, should be clearly indicated in the solicitation of offer, i.e. invitation to bid.

94. We noted that in many cases WHO (including country offices) did not adopt the lump sum basis of evaluation of price bids when procuring bulk or sets of related products. The solicitation of offers also did not clarify whether the bids would be evaluated on a lump-sum or item wise basis. Besides leading to subjectivity in selection, it may also lead to the risk of splitting of orders and collusive bidding.

95. In reply, WHO agreed that the method of evaluation would be included in the invitation to bid. It also replied that partial offers are acceptable in some cases like bulk medicines as not all suppliers maintain stock of all medicines.

(iv) Delay in delivery

96. We noted that in 80% of the procurement, the delivery was delayed and in more than 40% cases, the delay was more than 30 days. It was noticed that for COVID-19-related items, there was not much delay in delivery by the vendor to the point of FOB/FCA, which ranged between 4 to 17 days. The main delay was in the transportation of supplies till the point of consumption.

97. Details and status of distribution of supplies to the final delivery point was not provided to us as the information was stated to be with the Operations Support and Logistics unit of the WHO Health Emergencies Programme (WHE/OSL).

98. For the non-COVID-19 related items, there were delays in delivery by the vendor to the point of Free on board/Free carrier (FOB/FCA) and then even transportation from there until the point of distribution. We noticed that in 12 cases, the delay by vendor to FOB/FCA points ranged between 1 and 124 days whereas delay in delivery from FCA/FOB point ranged from 14 to 186 days.

99. WHO management stated that the delay was mainly due to the non-availability of staff in suppliers' production facilities and in getting customs export/import clearances etc. in view of movement control. As there was limited transport available and containers were also blocked at various destinations, COVID-19 supplies were given priority, and as a result, other supplies were delayed.

(v) Documentation

100. In public procurement, objectivity, transparency, equity and fair play should not only be exercised but also evident in each stage of decision making. This can only be ensured through proper documentation. Clause 2.5 of the WHO Procurement Handbook states that, in order to uphold the principle of transparency and enable the audit of WHO procurement activities, every step in the procurement process should be documented and retained in the procurement file (stored in the Global Management System (GSM), the Enterprise Content Management (ECM) and electronic folders). We noted that important documents like the invitation to bid, the technical and financial evaluation report and the purchase order were not placed on record in GSM or more importantly attached to the adjudication reports.

101. WHO management replied that they fully meet the requirements of the WHO Procurement Handbook in terms of uploading documents to GSM. The contract transaction in GSM only contains the documents related to the actual contract and all other documents are stored in electronic folders on the WHO network.

102. We do not fully agree with WHO's contention. The most basic document relating to a purchase is the purchase order. We did not find the purchase order in the contract transaction in GSM, in at least 85% of the cases checked by us. We examined 64% of the PPE purchases and did not find the purchase order in GSM in any of the cases. The external audit was conducted in a fully remote mode and we were only given access to GSM. As most of the procurement documents were not found in GSM, we had to requisition it separately and it was provided to the External Auditor in a piecemeal manner, with some documents being provided on the last day of the audit. If these essential documents were available in the electronic folders on the WHO network as stated by WHO, the External Auditor should have been given access to this folder. In response to the Management Letter, it was stated that these documents were maintained in the contract management on the e-tender portal. However, the External Auditor was not given access to this portal.

103. Inadequate documentation of the procurement process has been pointed out by external auditors for the last 10 years. However, the discrepancy still persists and no substantial improvement has been made by WHO in this regard.

Recommendation 5: WHO should try to maintain a list of international prices of all medicines and medical supplies, that can be used for reference while making purchases.

Recommendation 6: WHO should clarify in the solicitation of offer whether the price bids would be evaluated on a lump-sum or item-wise basis.

Recommendation 7: 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 verification. The External Auditor should be given full access to the electronic folder containing all the procurement documents.

Recommendation 8: WHO should put in place a supply chain system that can be activated to cater for emergencies. Modalities for emergency operations along with suitable incentives should be incorporated into contracts with suppliers and shipping and logistics contractors.

104. WHO management stated that this recommendation is aligned with what they intend to establish in the future and that the vision/design work had already commenced including establishing the partner ecosystem for future pandemic response.

(b) COVID-19 related emergency procurements

105. We acknowledge the fact that 2020 was an abnormal year for the medical sector, which saw disruptions in the market and supply chain due to a surge in demand and shortage of supplies. Logistics was also impacted. As the pandemic unfolded, WHO undertook the onerous task of procuring and stockpiling of COVID-19 emergency items, in spite of its limited capacity. Some of the gaps and deficiencies could be attributed to the challenging and unprecedent situation. These audit findings should, therefore, be used to strengthen the system of emergency procurement and preparedness.

Purchase of personal protective equipment

106. In March 2020, WHO approached Member States that could produce the PPE required for the WHO global stockpile to help front-line health workers in low- and middle-income countries. Only one Member State responded with a list of protective equipment and medical devices that could be purchased through the help of its State-owned Firm C.

107. WHO negotiated with Firm C and signed a non-exclusive LOA on 5 May 2020, wherein the firm was engaged as one of the procurement service agents for sourcing, ordering, delivering, undertaking quality assurance/sample testing and conducting inspections. As the main supplier, Firm C was to identify suitable manufacturers and submit their proposal to WHO for consideration. For all purposes including placing of orders and payments, WHO interacted only with Firm C and not with the manufacturers. The LOA was effective for three years.

108. WHO was to pay a service fee to Firm C, which was 2 to 3% of the value of the goods delivered. During May and June 2020, WHO paid US$ 2.69 million as a service fee to Firm C. The total fee paid to Firm C during 2020 was requested by the External Auditor, but it was not provided.

109. The LOA also required WHO to make an upfront payment of 40% of the purchase order value as an advance, as many manufacturers were demanding full upfront payment.

110. As of 31 December 2020, US$ 158.43 million worth of safety and protective clothing and equipment was procured by WHO of which 76.64% of the procurement was through Firm C.

111. We selected a sample of nine purchase orders valuing US$ 101.31 million for detailed examination. Our sample constituted 64% of the total purchase of PPE. The findings are discussed below.

(i) Quality requirements

Inadequate clarity on technical specifications

112. The initial step in a procurement process is to solicit offers from the vendors by conveying the quality requirements or specifications of the products to be purchased. Specification or quality standards denote the fitness of a product to meet the user's needs and therefore is to be determined by the user/buyer. We noted that qualitative requirements or specifications of the PPE to be purchased were not determined or conveyed by WHO while soliciting offers or before signing the LOA with Firm C. Firm C had offered masks, respirators and gowns with its own standards, which were stated to have been agreed by WHO and specified in the LOA.

113. We noted that during the initial stages, there was ambiguity with regard to the technical specifications of the PPE which impacted the technical evaluation and quality assurance of the procurement. The LOA stated that Firm C was responsible only for the quality standards, which were expressly stated in the LOA. From time to time, Firm C submitted quotations to WHO on behalf of the manufacturing firms who were willing to supply to WHO. The quotations stated the quality standard, quantity offered, price per unit and the lead time for delivery. However, we observed that in six out of nine cases, the quality standard specified in the LOA, the quality standard specified in the offer by Firm C and the quality standard specified by WHO in the purchase orders were different. This is evident from Table 4 below:

Table 4.

Product name	Value of purchase order US$ million	Specification in LOA	Specification in Firm C's offer	Specification in purchase order
Isolation gown	3.36	YY T/0506, GB 38462	Non-sterile	AAMI PB 70 Level 2 Non-sterile
Isolation gown	10.57	YY T/0506, GB 38462	Not given	Not given
N95 masks /Masks	17.20	YY 0469, YY/T 0969, GB 19083	EN149FFP2	EN 149 FFP2
Face shield	15.56	Not given	Ansi Z87.1-2003, GB 32166.1-2016	Ansi Z87.1-2003 GB 32166.1-2016
Medical goggles	5.78	Not given	Safety goggles (GB14866-2006)	Medical goggles (No standards)
Respirator masks	11.43	GB 2626	GB 19083-2010	GB 19083-2010

114. In the case of isolation gowns, the supplier did not specify the quality standards in the quotation and orders were placed for the item in the absence of specifications. The supplier offered safety goggles but orders were placed for medical goggles without specifying any standards.

115. Evidence indicates that establishing equivalence between the supplier's specifications and international specifications known to WHO was a challenging task.

(1) During the procurement of isolation gowns, WHO's procurement wing had to seek repeated clarifications from the manufacturers as to whether the gowns were compliant with AAMI[1] standards.

(2) We noted that the standard for gowns – YY T/0506, which was mentioned in the LOA was applicable to surgical gowns according to the WHO technical specifications for PPE (November 2020) and not isolation gowns (which required more stringent fluid penetration protection). Thus, the isolation gowns procured from Firm C had the specifications of surgical gowns.

116. WHO replied that standards were compared at length to establish equivalencies across known standards and new standards. The main issue with PPE was documentation and the lack of standardization of performance across the regions.

117. With regard to the purchase of isolation gowns using the specifications of surgical gowns, WHO replied that the isolation gowns were qualified on the basis of the relevant standards (ASTM F3352 and AAMI PB70). We are of the view that if the above technical evaluation/ qualification was conducted, it should have been documented as necessitated by the procurement procedure. Moreover, the standard used for qualification should have been specified in the purchase order issued for the purchase of isolation gowns valuing US$ 10.57 million.

118. While acknowledging the problems in the application of standards, we are of the view that for the sake of better quality assurance, the equivalent AAMI/ASTM or EU standards could have been specified in the LOA and the technical evaluation of the PPE procurement well documented.

Delay in adoption of technical specifications

119. We observed that when WHO undertook the procurement of PPE at the start of the pandemic, it did not have its own formulated or adopted specifications for PPE. Technical specifications for PPE were formally adopted only in November 2020 that are specific to COVID-19. Similarly, PPE was not included in the catalogue of items with readily available LTAs so that orders could be immediately placed with the vendors. The critical importance of PPE was known to WHO from the previous outbreaks over the last two decades, including the recent Ebola virus disease outbreak. As part of its preparedness for emergencies, WHO should have adopted specifications for PPE much earlier.

120. WHO replied that WHO standards were established in March 2020, although not formally adopted as specifications until later. In reply to the audit observation, it stated that during the Ebola virus disease outbreak in 2018, WHO had conducted a competitive bidding process and signed three LTAs for PPE in 2019. As the prices increased during COVID-19, the suppliers were not able to honour the LTAs. In its reply to the letter sent to WHO management, WHO contradicted its earlier reply and stated that the LTAs could not be honoured because of a lack of availability and a lack of access due to State intervention; and not because of an increase in price.

121. When we enquired why these specifications used for purchasing PPE during 2018–2019 were not used for purchasing PPE in 2020, WHO stated that these specifications were created in response to Ebola

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[1] Association for the Advancement of Medical Instrumentation is an organization for advancing the development and safe and effective use of medical technology.

virus disease and were different from COVID-19-related specifications. The reply does not fully justify the delay in adoption of PPE specifications as the technical specifications are based on the level of protection and not the type of disease. One has to select the type of protection suitable for a particular outbreak.

122. Unclear product specifications and ad hoc technical validation of requests has also been identified as an "acute" weakness in the procurement system, according to the WHO draft report on supply chain process improvement (dated 11 March 2019) that was based on the study by a consultant firm.

(ii) Technical evaluation

123. Technical evaluation involves comparing the user-specified quality requirement with the specifications offered by the vendor and selecting the product that best meets the user's qualitative requirement. Similarly, financial evaluation involves comparing the offered prices and verifying their reasonability to determine the lowest priced offer. Transparency and objectivity demand that the technical and financial evaluation report is prepared by the evaluation committee and duly placed on record. We did not find the technical and financial evaluation reports on record, for any of these procurements. WHO replied that technical evaluation involved desk review of the supplied documents and their authentication (with the help of a consultant). As stated earlier, we are of the view that if such technical evaluation was conducted then it should have been documented in accordance with the provisions of the WHO Procurement Handbook (para. 8.6). However, we did not find these review reports.

124. We also observed that, initially, there was lack of clarity on the technical evaluation of the offers, which caused delay and confusion. Initially, suppliers were sending samples to WHO headquarters for testing. Later, in September 2020, it was communicated to the main supplier that instead of sample testing, third-party test reports from laboratories accredited by International Laboratory Accreditation Cooperation (ILAC) would be considered for technical evaluation. The LOA between WHO and the main supplier was silent on the criteria or methodology to be used for evaluation of the offers.[1] The LOA should have clearly specified that products will be technically accepted on the basis of test reports from ILAC-accredited laboratories. Without this notification there was no other way for the suppliers to know that they needed to submit such reports.

125. In reply to the audit observation, WHO stated that testing of samples was delayed as courier services delayed the arrival of samples to the laboratories. Waiting for testing would have risked the cancellation of orders by the supplier. Therefore, it was later decided to accept the PPE based on test certificates from ILAC-accredited laboratories closer to manufacturers. Later, in reply to the letter sent to WHO management, it was stated that the WHO's request for ILAC-certified laboratory testing was made early on in March 2020 and not in September 2020. The two replies from WHO during the two stages of audit are contradictory. The later reply is also inconsistent with the fact that in the case of the purchase of isolation gowns, the supplier had sent the sample to WHO for testing on 4 June 2020 and sample testing was going on at WHO headquarters until 23 September 2020.

126. Inadequacy of technical evaluation is borne out by instances of quality problems noticed after placing orders. Orders were placed with Firm V in June 2020 for isolation gowns valuing US$ 4.42 million. One week after placing orders, the main supplier (Firm C) informed WHO that the quality of Firm V was not acceptable and that the Firm was unable to meet the delivery schedule. It took

[1] The WHO webpage on methods and workflow of procurement states that evaluation is done through pre-set criteria, which are clearly indicated on the bidding documents.

more than four months for WHO to cancel this order and place orders with a new firm (Firm U). WHO replied that orders were placed after accepting the third-party test reports. We, however, did not find the technical acceptance or evaluation report on record. The fact remains that the gowns offered by the manufacturer, which were quality cleared by WHO, were subsequently rejected by the main supplier and WHO accepted this rejection.

127. Before issuing the purchase order and while examining the credentials of Firm U, the Firm was asked to give references of its past customers. The Firm initially declined to give the references on grounds of confidentiality. Later the Firm gave the names of three customers. While two customers did not confirm, the third customer did not exist. Further, it was seen that the Firm did not have an export license. Despite these anomalies, orders were placed with the Firm.

128. One of the means of quality assurance is the quality assessment of a firm before its selection. This is done through a technical or quality audit of the firm's production facilities. We noticed that the main supplier had proposed a firm for the supply of isolation gowns but had conducted its quality assessment only after orders were placed with the firm. A quality audit should have been conducted before proposing the firm, selecting the firm and placing orders.

129. Pre-dispatch inspection is quality inspection of the products conducted at the manufacturing facility during production and before they are packed for dispatch. It is an important means of quality assurance, especially when technical evaluation is not fully reliable. Out of the 26 purchases test checked, we found the provision for pre-dispatch inspection in only one purchase order.

130. In the quotation submitted by the main supplier, the manufacturer had quoted for medical surgical masks while it was listed as disposable medical masks in the purchase order. Similarly, in the quotation the firm had quoted for safety goggles (GB14866-2006), while the purchase order listed it as medical goggles (standard not mentioned). The main supplier got the product description changed in the purchase order to what was exactly mentioned in the quotation. In one case, the main supplier also requested a change of the manufacturing firm's name from what was mentioned in the quotation. We noted that in orders valuing US$ 78.05 million the main supplier insisted on changes in the purchase order regarding product name, company name and standards. This indicated ambiguity in the selection of the firms and products.

131. WHO stated that the PPE evaluation process was slowed by counterfeit documents and missing information.

(iii) Approvals

132. We noted that the six purchase orders valuing US$ 72.20 million for isolation gowns, N95 masks, face shields and respiratory masks were issued to the firm, before obtaining the approval of the competent authority. In three other cases of disposable medical masks and goggles, purchase orders valuing US$ 78.05 million were amended after they were issued to the supplier. These amendments were made without obtaining approval from the authority that approved the initial proposal. Further, in respect of respiratory masks and N95 masks, advance payment of US$ 4.57 million was made to the supplier before the approval.

(iv) Role of Consultant A

133. As pointed out earlier, WHO had engaged a consultant (Consultant A) to assist in COVID-19-related emergency procurement. WHO stated that Consultant A had helped in framing and negotiating

the terms of the LOA signed between WHO and the main supplier (Firm C). The Consultant was requested by WHO to also support the main supplier in the supply chain management of WHO purchase orders. One of the tasks of Consultant A was to help identify suppliers. We were informed that a list of 102 suppliers of PPE was provided to the main supplier by Consultant A, out of which 51 suppliers were accepted by the main supplier and orders were placed with nine suppliers in 2020. Consultant A was providing the names of suppliers to the main supplier – Firm C, which then submitted quotations to WHO on behalf of these firms. The Consultant was involved in price negotiations with the suppliers, on behalf of WHO. The Consultant was also assisting WHO in technical evaluation of the offers submitted by the main supplier. We, thus, find that Consultant A was simultaneously assisting both the parties – the buyer as well as the seller. We find this to be a conflict of interest, compromising the integrity of the procurement process.

134. It is also pertinent to note that Consultant A was involved in the procurement of PPE from March to August 2020, without the due approval of the competent authority. Post facto approval was obtained for the engagement of the Consultant four months after the Consultant started work. Such transgression in public procurement is a matter of concern.

(v) Pricing and payment issues

135. The main supplier (Firm C) submitted quotations on behalf of the manufacturing firms and WHO mostly relied on the price quoted by Firm C assuming that it would have negotiated the price and volume with the manufacturers before submitting the quotation to WHO. We noted that in two of the nine purchase orders checked by us, Consultant A had conducted price negotiations on behalf of WHO. In the case of isolation gowns, the price negotiation led to a 20% price reduction. However, as mentioned earlier, the gowns were rejected on quality after the placing of orders. The other case was the purchase of N95 respiratory masks, where the consultant helped negotiate the price and got a reduction of 0.08% i.e US$ 9750. We observed that during the same time another order for N95 masks valuing US$ 31.27 million was placed. The two purchase orders were processed together in the month of May 2020 and approved together. The manufacturers were different, but the main supplier was the same. There was a difference in the unit price of the same masks quoted by the two firms, having a financial impact of US$ 303 200. We noted that Consultant A did not negotiate this price, which had better potential for saving.

136. An advance of US$ 1.77 million was paid to the main supplier against the purchase order placed with the manufacturer in June 2020. The firm was rejected shortly after placing orders and a new firm was selected for replacement, only in October 2020. The advance of US$ 1.77 million remained with the main supplier for four months until the revised purchase order was placed with the new supplier. We are of the view that the advance should have been adjusted against subsequent payments made to the main supplier.

Procurement of COVID-19 testing kits

137. In February 2020, the Foundation for Innovative New Diagnostics (FIND) (one of the partners of WHO in the Access to COVID-19 Tools (ACT) Accelerator) invited expressions of interest from developers of in vitro diagnostics that detect COVID-19 to participate in independent evaluation studies. Over 200 submissions were received, out of which 25 products were shortlisted for evaluation.

138. Evaluation of the offers was done using a comprehensive scoring matrix that evaluated 15 parameters out of a total maximum score of 30. Based on the evaluation, three firms were shortlisted for placing orders – Firms G, H and I. The test kit of Firm G got the highest score of 25, Firm H was

ranked second with a score of 22 and Firm I with a score of 16 was ranked twelfth. We noted that the selection of the firms was not in accordance with the results of the evaluation. The firm that was ranked third should have been the third firm shortlisted, instead of selecting the twelfth ranked firm. Further, the purchase orders placed with the three firms were not in accordance with their ranking in the evaluation. Firm H that was ranked second got the highest orders for US$ 24.00 million, while Firm G that was ranked first got lesser orders for US$ 23.90 million. Firm I got orders for US$ 3.79 million. This defeated the very purpose of using a quantitative evaluation matrix, which is supposed to enhance the objectivity of evaluation.

139. WHO replied that Firm I was selected because it was the first to develop and manufacture simple COVID-19 test kits that became the reference test or "gold standard" to which the newly developed kits were compared. We also noted that the testing protocol had been developed by FIND in collaboration with Firm I. This fact was not reflected in the evaluation results where Firm I was given low scores and ranked twelfth. This could be a result of subjectivity and inconsistency in scoring by the evaluators.

140. Purchase orders were placed with Firm G for the diagnostic kits manufactured by them. However, from the invoice we noted that the disposable sampling kit was made by another firm, Firm J. We also noted that quality specifications were not specified in the purchase order, which would create problems in quality assurance.

141. WHO replied that the quality specification was shared by email prior to procurement so as to ensure that the material was in accordance with the specifications published by WHO. The reply is not tenable because as per procedure, quality specifications should be specified in the purchase order, which is the legal contract document.

Recommendation 9: In all procurements, technical and financial evaluation should be duly documented in accordance with the provisions of the WHO Procurement Handbook and Manual.

(c) Procurement through long-term agreements

142. WHO has to make repeated purchases of medical supplies, both for emergency and non-emergency projects. WHO has therefore adopted the system of framework agreements, wherein suppliers are selected based on competitive bidding and LTAs are signed with them. Orders could then be placed with those suppliers for the selected medical products at predetermined terms and prices, without having to undergo the whole purpose of tendering each time. We examined the establishment of LTAs for six sets of kits, mostly emergency kits.[1]

(i) Solicitation of offers

143. Public procurement principles dictate that framework agreements/LTAs should be established based on full open competition in order to tap all available products and venders in the market and select the offer with the best value for money. WHO resorted to a two-stage competitive selection process. Wholesale distributors and producers wishing to become suppliers were required to complete a prequalification questionnaire, based on which they were prequalified for a broad range of products. For procuring specific medical products, invitation to bid was issued only to the prequalified firms.

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[1] TESK – trauma emergency surgical kit; IEHK – interagency emergency health kit; SAM/PED – severe acute malnutrition kit; NCDK – noncommunicable disease kit; and RRK– rapid response kit.

144. When we enquired about the reason for adopting a two-stage bidding process instead of a single stage open competitive bidding, WHO replied that inviting bids through full open competition and conducting technical and commercial evaluation of all the bids received, would be unduly burdensome. As far as kits are concerned, open tender cannot be followed because producing kits is a very specific process and not all vendors can do it.

(ii) Limited vendor base

145. From the 10 procurements examined by us, we noted that every time invitation to bid was issued to six to 10 preselected vendors and the same four to five firms responded and were technically qualified. The same three to four firms got selected each time. Most of the orders went to the same three firms. For instance, of the total procurement of emergency kits valuing US$ 23.86 million during 2020, orders worth US$ 22 million (92%) were placed with three suppliers. This highlights the need for WHO to enhance competition and broaden its vendor base. Procuring medical supplies through wholesale distributers/aggregators has its advantages; however, given the fact that it is limiting competition and leading to a dominating position for one or two suppliers, WHO should explore the option of procuring directly from the manufacturers to control this undesirable situation.

146. It was replied that WHO fully agrees, however, the kits are comprised of up to 100 items and the kit production process is a niche business and only a few wholesale distributors are able to do it. The infrastructure for kit production is costly.

147. It was agreed that WHO would take the necessary steps to enhance competition.

(iii) Bid evaluation

148. For catalogue procurements, WHO uses the lowest priced technically acceptable (LPTA) method of bid evaluation, wherein the lowest priced bid is selected from among the technically qualified bids. However, we found discrepancy in application of this evaluation method as highlighted by the following case.

149. Bids were invited for the purchase of severe acute malnutrition (SAM)/pediatric (PED) kits. It was a two-bid process where the financial bid of only the technically qualified firms were opened for evaluation. One of the conditions in the invitation to bid was that WHO shall have no obligation to purchase any minimum quantities of goods from the supplier and therefore bids quoting for a minimum order quantity will not be accepted. Firms N and M had quoted for a minimum order quantity and therefore their bids should not have been accepted. Acceptance of their bid was a violation of the invitation to bid stipulation. One of the firms (Firm N) was also allowed to modify its bid by removing the minimum order quantity requirement to enable its acceptance, thereby violating the integrity and fair play of the procurement process.

150. Financial bids of all five technically qualified firms were opened including Firms N and M. Firm M was the lowest priced offer and therefore the contract should have been awarded to the firm. However, Firm N, which was the second lowest, was awarded the contract on the grounds that it was the best value for money as the firm offered faster delivery than Firm M. We observed that this method of evaluation was neither in accordance with the LPTA method nor a value-based method. Having adopted the LPTA method of evaluation, all other non-financial criteria like delivery period should have been applied for the shortlisting of firms, and the final selection should have been based only on price. For this, WHO should specify its minimum requirement for the delivery period and qualify all those firms that meet this requirement, at the technical evaluation stage. Determining the best value for money during price

evaluation, using both price and delivery period as criteria compromises objectivity, unless the weight for the two parameters is predetermined. If WHO wanted to determine value for money in its true sense, it should have adopted a value-based evaluation method where different weights are assigned to different parameters and a scoring matrix is used to select the bid with the highest score.

151. Inconsistency in bid evaluation is borne out by the fact that in the purchase of bulk medicines, a firm that had quoted price for a minimum order quantity in its offer was rejected in technical evaluation. On the contrary, in the above case of purchase of SAM/PED kits, two firms were technically qualified even after quoting minimum order quantity. This indicates that different yardsticks were adopted for evaluation of bids of different firms.

(iv) Splitting of orders among shortlisted firms

152. We had observed that for the same product, orders were split between two or three firms that were shortlisted through the evaluation process. For instance, the orders for rapid response kits were split between Firm K and Firm N. Firm K was the technically qualified lowest bidder. Firm K was awarded 64% of the orders; while Firm N, which was the second lowest, got 36%.

153. When asked about the criteria for splitting the orders, WHO management stated that the criteria adopted for emergency procurements were acceptable shelf life, delivery time and price. For standard procurements, the criteria were acceptable shelf life, price and delivery time. The reply is not acceptable as we did not find these criteria being adopted for this particular allocation and we noticed that quantities were allocated to the different firms based on instructions received through email. Further, all the firms with whom the orders were placed, were selected based on competitive bidding using quality, shelf life, price and timely delivery as the criteria. Accordingly, for a particular product, a particular firm emerges as the lowest bidder (in the case of LPTA evaluation) or the highest scorer (in the case of value-based evaluation). All orders should be placed with this firm unless there is a capacity constraint. In the case of medical supplies where there is a need to maintain more than one supply source, it makes sense to place some orders with the second or third ranking firms also. However, there should be objective and transparent criteria prescribed for such allocation.

(v) Extension of long-term agreements

154. The purpose of framework agreements is to have long-term arrangements with select suppliers so as to avoid repetitive bidding at short intervals. We however noticed that LTAs were signed with suppliers for a short period of one or two years and were then given repeated extensions of one or two years at a time. For the rotavirus kit, laboratory equipment and consumables and noncommunicable disease kits, the LTAs were initially signed for one or two years after which an extension was given three times up to five years. Similarly, 13 LTAs for laboratory equipment and consumables, which were established based on competitive tendering in 2015–2016 were given repeated extensions and continued until 2020.

155. We observed significant delays in the process of extending LTAs and several LTAs were given extensions well after their expiry. This was because actions for extensions were initiated two days before the expiry or even days after the expiry. It also stated that the suppliers' concurrence was received well before the LTA expiry and submission to the CRC was made very close to the expiry date. It was agreed by WHO that extensions would be made well in advance.

156. We noted in respect of rotavirus diagnosis kits, there was ambiguity regarding the effective date of the LTA. Each time the LTA was amended, the dates mentioned in the amended LTA was different

and incorrect. WHO replied to the External Auditor that the validity of the LTA is stated in the header of the contract and in paragraphs 1 and 2, and only these dates are referred to as the validity of the contract and not the date of signature of both parties, which might happen later in some cases. We are of the view that as the LTA is a legal document, efforts need to be made to execute the LTA before the effective date .

(vi) Delay in procurement

157. We noticed that it took more than one year to complete the bidding process and sign the LTA with the shortlisted firms for the trauma emergency surgical kits (TESK). There were delays at various stages. For instance, it took one month to approve the award of the LTA after completion of bidding and submission and it further took more than 30 days to sign the LTA after it was approved by the CRC.

158. We observed significant delays in the delivery of the procurements. For instance, an USAID-funded project was started in 2019 with a duration of 12 months to provide quality essential medicine for humanitarian response in Sudan. Five purchase orders for rapid response kits valuing US$ 3 723 634.5 was placed with Firm K and Firm N. However, the entire supply of kits was delivered after the end of project with three purchase orders delivered five months after the end of the project. WHO replied that due to the COVID-19 pandemic, the suppliers were unable to complete the kit and the transport and green light process were also delayed. It also stated that as the award end date was nearing, it had been agreed that only standard kits would be requested.

Recommendation 10: LTAs should be signed for a longer duration of three years or more. To factor in changes in prices over the years, a suitable price variation clause could be included in the LTA, which is indexed to the market prices of the inputs.

159. WHO management agreed to make the change in standard practice and LTA guidelines to keep LTAs for three years as per the recommendation, and also to modify the LTA template to include price changes linked to price index subject to legal approval.

Recommendation 11: WHO should adopt a transparent and objective criterion for distribution of supply orders among different shortlisted firms.

8. Prepayments

160. Prepayments relate to amounts paid to suppliers in advance, for which goods or services are yet to be delivered. As per the financial statements, prepayments amounting to US$ 108.10 million were outstanding as on 31 December 2020.

161. WHO makes full prepayment for purchase of polio vaccines from UNICEF. We observed that prepayments of US$ 40.85 million made in respect of two purchase orders remained unadjusted despite the partial receipt of materials against these orders. The fact regarding the receipt of materials was confirmed by the procurement unit but was denied by the prepayment unit, reflecting a lack of coordination between the two units. On being pointed out, prepayments were adjusted to reflect the partial supply of material.

162. According to accounting principles, prepayments are expensed as and when the goods are delivered. In the case of partial or staggered deliveries, the prepayments proportionate to the value of deliveries is expensed. WHO stated that UNICEF sends the invoice only after the full delivery is made and therefore prepayments are adjusted after full delivery.

Recommendation 12: WHO should request UNICEF to raise invoices as and when partial deliveries are made and WHO should duly adjust the prepayment.

163. WHO accepted the recommendation regarding applying prepayments on receipt of partial supply and further stated that it will modify the terms of the LOA with UNICEF.

9. Transfers and grants

164. Transfers and grants include grants provided to national counterparts (mainly ministries of health) and LOAs signed with other counterparts to perform activities that are in line with the Organization's objectives. The total expenditure on transfers and grants during the year 2020 was US$ 389.15 million.

(a) Direct financial cooperation

165. Direct financial cooperation (DFC) arrangements are signed with national counterparts (health ministries and other governmental institutions) to perform activities in the field of health. The total expenditure incurred on DFC reduced to US$ 118.74 million in 2020 from US$ 177.24 million in 2019.

166. A DFC report is to be submitted within 180 days of completion of the activity. We noted that DFC reports were delayed in respect of 286 purchase orders amounting to US$ 36.19 million, with 10 reports delayed by more than one year.

(b) Grant letter of agreement

167. A grant letter of agreement (GLOA) describes a non-standard contract between WHO and an external party (not a government entity) to assist the beneficiary reach specific goals in line with WHO's health related objectives. The total expenditure incurred on GLOA reduced to US$ 121.02 million (2020) from US$ 138.65 million (2019).

168. We noted that the GLOA reports were delayed in respect of 129 contracts (37%) involving a value of US$ 71.62 million (45%). Nine reports were delayed by more than one year.

10. Donor reporting

169. As on 31 December 2020, out of 3178 reports, 1547 (49%) were submitted on time, 1115 (35%) were belatedly submitted and there were 516 (16%) overdue reports. Within this total, 39.2% of all reports submitted late were in headquarters, followed by the African Region (24.9%) and the Eastern Mediterranean Region (18.3%). Headquarters accounted for the highest share of overdue reports (57.8%) followed by the African Region (20.2%) and the Eastern Mediterranean Region (11%). WHO stated that in the context of overall reports due, the updated percentages are 48% for headquarters, followed by 18% for the African Region and 15% for the Eastern Mediterranean Region.

170. The WHO management attributed the delays to reporting requests not sent or sent late by the technical units/country offices or close-out requirements not being completely met (open purchase orders, unliquidated encumbrances, small balances, etc.); reports are submitted, but records of submission not updated in GSM; wrong information entered in GSM. About 50% of the donor reports were delayed.

11. Ethics and oversight

171. The IOS of WHO provides investigation services not only to WHO but also the other five hosted entities, namely IARC, ICC, the SHI UNAIDS and Unitaid.

172. IOS receives complaints or 'reports of concern' directly from the staff and various other sources. Complaints from whistle blowers, complaints alleging retaliation and complaints against sexual misconduct may also be initially received by the WHO Office of Compliance, Risk Management and Ethics (CRE) and after review cases which require investigation are forwarded to the IOS for consideration. Cases received through the integrity hotline may also be referred by the CRE to the IOS for investigation.

173. If the allegations are substantiated by the investigation, the report along with its recommendations are forwarded to the administrative authorities concerned to take suitable disciplinary action against the staff involved in the misconduct.

174. Timely investigation accompanied by prompt and proportionate disciplinary action provides a credible deterrent against misconduct. Delays in investigation are unfair to both the innocent as well as the guilty because it prolongs the ignominy of the innocent and delays the punishment of the guilty. Similarly, failure to impose proportionate and prompt punishment on the guilty, not only denies justice but also fails to provide the needed deterrent.

(a) Increasing trend of complaints and reporting of misconduct

175. The number of cases reported in the last five years and their breakdown in terms of the nature of complaints is shown below:

Table 5.

Allegation Group	2016	2017	2018	2019	2020	Total
Corruption	8	14	5	9	7	43
Failure to comply with professional standards	15	4	11	11	13	54
Fraud	32	30	55	61	40	218
Harassment	9	13	25	28	27	102
Other	5	6	27	26	27	91
Recruitment irregularity	5	10	8	14	13	50
Retaliation		1	4	2	2	9
Sexual exploitation and abuse		1	3	5	6	15
Sexual harassment	5	3	10	6	8	32
Total	**79**	**82**	**148**	**162**	**143**	**614**

Source: IOS

NB: The total of 614 includes 73 cases pertaining to the other five entities. It includes 15 cases in 2020, 23 in 2019, 22 in 2018, 3 in 2017 and 10 in 2016.

176. There has been an increasing trend of complaints received, with a steep rise from 2018 onwards. The highest number of cases pertain to fraud (35%), followed by harassment (16%), failure to comply with professional standards (8%) and recruitment irregularity (8%). Allegations of sexual exploitation

and abuse, and sexual harassment are also significant as they constitute about 16% of the total complaints and their rising trend remains a matter of concern. In 2020 the cases of sexual misconduct increased to 14 as compared to 11 in 2019. This included the much-highlighted allegations of widespread sexual exploitation and abuse implicating WHO and other international humanitarian entities in the response to the tenth Ebola virus disease outbreak in the Democratic Republic of the Congo. We were informed that the WHO Director-General has set up an Independent Commission whose role in relation to specific allegations is to establish the facts, identify and support survivors, ensure that any ongoing abuse has ceased, and hold perpetrators to account. The IOS is to provide technical support to the Commission as requested. When we enquired about the progress of the work of the Commission, IOS stated that the Commission was still in its establishment phase, that the contract for the service provider supporting the Commission was still under discussion and hence the field work had yet to be initiated.

177. The number of complaints or reports of misconduct are a reflection of the ethical climate of an organization and its ‘tone at the top’; and therefore, an increasing trend of such complaints should be a cause of concern for the management. The fact that 55% of these allegations are found fit for investigation and in 70% of the investigated cases the allegations are substantiated, further stresses the need for corrective action.

178. This calls for improving the punitive (detection, investigation and disciplinary action) as well as preventive efforts. In WHO, the IOS is responsible for investigation while preventive action is the responsibility of the CRE. We noted that though the CRE has conducted several outreach activities and organized training on harassment and sexual misconduct, more needs to be done to stem the tide of increasing cases. The CRE informed the External Auditor that they were facing resource constraints as they were functioning with a miniscule number of staff.

(b) Time taken to investigate complaints

179. We noted that the IOS has repeatedly reported in the annual report to the World Health Assembly significant delays in the conduct of investigations into allegations of misconduct. The status of the complaints received/detected, the number of cases investigated and the number of cases pending investigation during the three year period from 2018 to 2020 is shown below:

Table 6.

Caseload	2018	2019	2020
Carried over cases	100	167	248
Number of cases received	148	162	143
Total number of allegations for investigation	248	329	391
Number of cases closed	)81(	)81(	)91(
Balance of cases at 31 December	167	248	300
Estimated completion time for open cases in working days	1 646	3 106	3 732

Source: IOS (extract from the Annual Report to the World Health Assembly).

180. In the last three years, the number of complaints received for investigation by the IOS has been increasing. Due to insufficient human resources, the number of cases has been increasing steadily and there are 300 cases pending action as of 31 December 2020. To complete the 300 cases, it would require 3732 working days. This position is not tenable and hampers the cause of justice.

181. According to the prescribed timelines complaints should be closed within nine months of their receipt. We observed that for the 91 cases closed in 2020 the average time taken was 15 months.

182. From the data provided by the IOS, we noted that out of the 300 cases pending as of 31 December 2020, there were 76 high priority cases which were under various stages of investigation. This included 38 cases of fraud and corruption and 15 cases related to sexual exploitation, abuse and sexual harassment. We noted that two cases received in 2017, 18 cases received in 2018, and 24 cases received in 2019 are still under investigation.

183. We observed that out of the 76 high priority cases, 63 pertained to WHO and of these, 37 cases were more than one year old. This shows that in at least 58% of the cases the timeline of nine months could not be achieved. We further noted that nine cases received in 2018 and 2019 were still under preliminary review, even after more than two years.

184. We also noted that, of the cases taken up for investigations, in 70% of cases the allegations were substantiated. This further stresses the point that delays in investigation result in delayed punishment to the guilty, thus diluting the deterrent effect.

185. The primary reason for the piling up of cases and the delay in investigation was that the IOS had only four staff and three consultant investigators, which was not adequate to handle the increasing caseload in a timely manner. According to IOS estimates it would take another 1372 work days to close the 76 open high priority cases that are at various stages of investigation.

186. The IOS stated that in February 2021 a plan was approved to strengthen both the fixed term and temporary resources to address the backlog. The plan is being implemented.

(c) Disciplinary action on substantiated cases

187. The responsibility for implementing the recommendations of the investigation reports where the allegations have been substantiated, rests with the Executive i.e. the Director-General at headquarters and the respective Regional Directors for the cases pertaining to country and regional offices.

188. The status of investigation from 2018 to 2020 as provided by IOS is set out below. It shows that 78 investigation were completed, out of which 56 cases were substantiated.

Table 7.

	2018	2019	2020
Number of investigation reports issued	28	21	29
Number of cases substantiated	19	17	20

189. When enquired by audit about the status of disciplinary action on the cases substantiated during 2018 to 2020, IOS furnished the following information. IOS stated that there was some delay in updating the status due to a lower prioritization of the update of the feedback from decision makers in the TeamMate platform (available resources were focused on case investigation) and to some extent the recent migration to the new cloud-based TeamMate+ platform).

Table 8.

Category of implementation	2019	2020	2021	Total
Closed/Verified	4	0	0	**4**
Implemented	29	8	2	**39**
In progress	1	2	0	**1**
Not started	6	8	19	**33**
Total	**40**	**18**	**21**	**77**

190. It may be seen that of the 40[1] recommendations (cases substantiated) that were due for disciplinary action in 2019, disciplinary action was completed in 29 cases (75%) and was in progress in one case. In six cases disciplinary action was yet to be initiated. Similarly, out of the 18 cases due for disciplinary action in 2020, action was completed in eight cases and action was yet to be completed in 10 cases. As on 30 March 2021, out of the 77 cases in which allegations were substantiated, disciplinary action has been completed in 39 cases (50%). Action taken is yet to be communicated in 42% of the cases (33 cases).

191. The IOS also stated that of the six cases on which action was due in 2019, but no action was initiated, four cases related to a special situation at UNAIDS.

(d) Concerns reported through the integrity hotline

192. One of the tools offered by WHO to enable its staff and others to raise concerns of inappropriate behaviour and possible abusive conduct is the integrity hotline. Cases can be reported to the hotline via telephone or email, confidentially, and where preferred by the individual, anonymously. The hotline is managed by a professional company selected competitively by WHO. Reports are then considered by the CRE, and may be referred to the Executive for remedial action or to the IOS for investigations.

193. The number and nature of reports received by the integrity hotline from 2018 to 2020 are shown below:

Table 9

Category of reports	2020	2019	2018
Breaches of the WHO Code of Ethics and Professional Conduct/conflict of interest/discrimination or favouritism	50	13	17
Human resources issues and/or breaches of WHO staff rules and regulations	25	28	22
Issues of potential fraud/corruption/bribery	22	8	6
Abuse of authority/harassment	11	14	5
Concerns of sexual harassment and sexual exploitation and abuse	9	3	8
Total[2]	**117**	**66**	**58**
Cases referred to the IOS	25 (21%)	15 (22%)	14 (24%)

[1] Some 19 cases substantiated in 2018 and 21 cases substantiated prior to 2018.

[2] One of the categories, 'Concerns of substantial danger to public health and personal safety', was not considered for analysis because this number was very high for the year 2020 because of the COVID-19 pandemic. It would have given a distorted picture.

194. Reports of breaches of the WHO Code of Ethics, conflicts of interest, and discrimination saw a steep increase in 2020, more than double the cases reported in previous years. Reports on potential fraud/corruption/bribery also saw an increase of about three times in 2020 as compared to the previous years. As pointed out earlier in paragraph 163, the largest number of cases handled by the IOS pertained to fraud (35%). This is a cause for concern and WHO needs to address the issue.

195. We noted that about 22% of the cases received through the integrity hotline were referred to IOS for investigation.

196. The CRE informed the External Auditor that 20 cases concerning retaliation were raised in 2020, of which three were referred to the IOS for investigation.

(e) Issues raised with the Ombudsman

197. The Office of the Ombudsman and Mediation Services (OMB) is another key component of the ethics framework of WHO. The OMB provides confidential assistance to staff members who voluntarily approach the office. Based on those confidential conversations, the Ombudsman monitors trends to enable the early detection of issues of potential relevance, provides feedback to WHO management, and advises the top leadership on appropriate remedial and preventive action. Ultimately, the Ombudsman aims to foster a better working environment and ethical culture.

198. The number of staff utilizing the services of the OMB or the number of issues raised by the staff is a reflection of the issues faced or perceived by them at the workplace. Analysis of the number of cases and issues handled by the OMB, for the WHO, in the last three years is shown below.

Table 10.

	2020	**2019**	**2018**
Number of cases/visitors	323	329	336
Number of issues raised	937	805	787
Utilization rate	12 %	13%	14%
Reports under the category of 'Legal, regulatory, financial and compliance'	12%	12%	15%
Cases of retaliation	19	7	13
Cases of sexual harassment	2	6	10

199. The number of staff who approached the OMB saw a slight decline; however, the number of issues raised, saw an increase from 787 issues in 2018 to 937 issues in 2020. Each case or visitor received by the OMB may raise several issues. The utilization rate, which denotes the ratio of the overall number of staff to the number of cases received, saw a decline from 14% in 2018 to 12% in 2020. However, according to the Ombudsman this rate of utilization was higher as compared to similar institutions which had utilization rates of 1 to 5%.

200. The issues raised by WHO staff are classified according to the categories developed by the International Ombudsman Association (IOA). The category, 'Legal, regulatory, financial and compliance issues' also includes issues of harassment (excluding sexual harassment), discrimination and retaliation. We noted that cases under this category remained at 12% of the total cases received in 2019 and 2020. However, we noted a significant increase in the number of cases of retaliation reported to the OMB, from seven cases in 2019 to 19 cases in 2020. It is pertinent to mention that in 2020 the CRE also received 20 complaints of retaliation. This increase in complaints of retaliation is a cause of concern and WHO needs to analyse the causes and take suitable remedial measures.

Recommendation 13: 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.

Recommendation 14: WHO needs to adopt a risk-based approach to prevention by identifying the offices and units with a 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 should strengthen preventive measures like checking of antecedents before recruitment, integrity vetting for promotions, and rotation of staff in sensitive positions.

B. AUDIT FINDINGS ON COUNTRY OFFICES

201. We audited four WHO country offices (WCOs) – Afghanistan, South Sudan, Ethiopia and Iraq, and the findings are discussed below.

12. Strategic planning

(a) Country cooperation strategy

202. WHO prepares a country cooperation strategy (CCS) for each country that serves as the strategic plan to guide WHO's work in the country. It is a joint WHO–Member State instrument that helps WHO align its work according to the priorities and needs of a country. Under WHO's transformed operating model, the Thirteenth General Programme of Work, 2019–2023 (GPW 13) and the Programme budget 2020–2021 are to be driven by CCSs, which contain clear actions, results and performance metrics. WHO issued guidelines for the preparation of CCSs in 2020 for implementing the GPW 13.

203. We observed that the CCS for Afghanistan was not revised/updated in accordance with the new operating model that is based on the triple billion targets. There was a CCS for 2009–2013, and then there was a strategy brief for 2018.

204. In South Sudan also, we observed that the CCS for 2014–2019 was not revised/updated in accordance with the new operating model that is based on the triple billion targets.

205. We observed that though the WCO in Ethiopia has initiated the development of the new CCS for 2021–2025, there was delay in the process due to delays in the finalization of the other related development plans for Ethiopia.

206. The WCO in Ethiopia stated that there is already a draft document ready for discussion prior to adoption.

207. Although the WCO in Iraq had commenced the development of a new CCS for 2019–2023 in line with the GPW 13, there was a considerable delay in finalizing the strategy.

Recommendation 15: We recommend that WHO ensures the formulation of new CCSs for Afghanistan, South Sudan, Ethiopia and Iraq at the earliest in accordance with the new guidelines issued.

(a) Results framework

208. The new operating model and GPW13 shift the whole focus of WHO's work to enhancing the impact at the country level. The Programme budget 2020–2021 also demonstrates the new approach by significantly increasing the budget at the country level. The hallmark of WHO's new model is its focus on measuring the outcomes and impact of all of WHO's work, including that of the Secretariat. For this purpose, a detailed results framework has been developed that links the input resources to outputs in a verifiable and measurable way. The impact expressed in terms of the three triple billion targets have been broken down into 10 outcomes and 42 outputs, with specific indices and performance indicators.

209. Upon inquiry about the outputs and outcomes achieved, in terms of the prescribed results framework indicators, the WCOs in Afghanistan, South Sudan, Ethiopia and Iraq responded as follows:

- The WCO in Afghanistan stated that the technical achievement and analysis of output and outcome is done at the end of each year, with the final review being done at the end of the biennium.

- The WCO in South Sudan stated that to implement the results framework, the African Region is in the process of developing key performance indicators (KPIs) to be selected and reported against by each country office in the region. South Sudan had in September 2020 selected the relevant KPIs to be used for measuring its outputs and outcomes. Commencement of the measurements of achievements of the selected KPIs would commence during the first quarter of 2021.

- The WCO in Ethiopia is still in the process of defining its KPIs and its implementation is yet to commence. The WCO in Ethiopia stated that there is already a draft document ready for discussion prior to adoption.

- The WCO in Iraq was in the process of defining its KPIs and its implementation was yet to commence.

Recommendation 16: We recommend that WHO ensures that the results framework is completed and implemented at the WCOs in Afghanistan, South Sudan, Ethiopia and Iraq at the earliest.

13. Human resources management

(a) Vacancy of positions

210. Out of a total 131 positions at the WCO in Afghanistan, 26 positions (19.85%) were vacant as at the end of September 2020. Out of these 26 vacant positions, 17 positions (65.38%) were vacant for more than six months. We further observed that 13 vacant positions were in the professional category, and eight of these positions were vacant for more than six months.

211. In the WCO in South Sudan, out of total 88 positions, 18 positions (20.45%) were vacant as at the end of October 2020. Further, out of these 18 vacant positions, two positions were vacant for more than six months. The WCO in South Sudan stated that there was very limited impact of the vacant positions on their operations in the short term.

212. In the WCO in Iraq, we noted that there are 29 vacancies at various levels, half of them have existed for more than six months as per the new human resources plan. Out of these vacancies, only 13 positions are temporary while the remaining 16 positions are long term. All of the 16 newly created positions are currently lying vacant. The WCO in Iraq stated that recruitment to fill vacant positions had been affected by a shortage of funds.

Recommendation 17: We recommend that country offices make extra efforts to minimize the number of vacancies, especially those which have been vacant for more than six months, and take necessary actions to avoid funding gaps in this regard.

(b) Gender equity

213. The goal set by the United Nations General Assembly is to achieve 50:50 gender distribution by 2000 in all posts in the professional category and above, overall and at each level including posts at the D1 level and above.

214. During the audit of the four WCOs (Afghanistan, Ethiopia, Iraq and South Sudan), we reviewed the status of staff in position and observed an adverse gender representation in the country offices as indicated in the table below:

Table 11.

Country office	Total staff in position	Male staff	Female staff
Afghanistan	105	96 (91.43%)	9 (8.57%)
Ethiopia	131	100 (76.33%)	31 (23.67%)
Iraq	61	44 (72.13%)	17 (27.87%)
South Sudan	70	58 (82.86%)	12 (17.14%)

215. The WCO in South Sudan stated that being a non-family duty station and the prevailing security situation, a smaller number of women were in international positions.

(c) Recruitment in the WCO in Iraq

216. The WHO eManual III 4.1 states that so far as practicable, selection shall be made on a competitive basis. A consistent and transparent selection process is essential to ensure the best qualified candidate gets selected.

217. During the audit of the WCO in Iraq, we were provided with documentation of the special service agreement (SSA) recruitments done by the WCO for the positions of Public Health Officer, Data Management Assistant, Fleet Management and Administrative Assistant. We noticed that:

- For all SSA recruitments, no master scorecard for rating candidates on essential and desirable qualifications was prepared.
- No combined scoresheet of candidates was prepared for shortlisting them for the interview.
- Interview scoring was not at all clearly evolved or documented. How a candidate is finally selected after interviewing all shortlisted candidates, is not objectively recorded anywhere.

218. Some specific deviations from a neutral and fair selection process were observed as follows:

(i) Public Health Officer, WCO in Iraq

219. Though an interview scoresheet was prepared, no rating sheet for shortlisting the candidates for interview was prepared.

220. One candidate was added later to the four other shortlisted ones and was not subjected to screening as others and was finally selected in interview. One screened and shortlisted candidate was dropped before interview, despite possessing all the essential and desired qualifications as per the vacancy notice.

221. The WCO in Iraq replied that in this case, after reviewing the candidates the hiring manager recommended that another candidate be added and the human resources pre-screening is not the final shortlist. The hiring manager always reviews the candidates to come up with the final shortlist. For the candidate who was dropped the reasons are clearly stated. He was above the retirement age.

222. We observed that nowhere were reasons clearly stated for adding and deleting candidates from the pre-interview screening. If the candidate was over-age, he should not have made it to shortlist in first place. Also, the addition of a candidate to the list of already shortlisted candidates was without assigning any reason except that the hiring manager felt the candidate was suitable as per the emails enclosed. This shows that the whole process of screening and shortlisting was subjective.

(ii) Administrative Assistant, WCO in Iraq

223. We observed that five candidates were shortlisted without any scoresheet. Midway through the selection process, a few candidates were added to the shortlisted pool of screened and shortlisted candidates. Recruitment emails show how reverse engineering was resorted to, to shortlist certain candidates when they did not make it to final list. Final selection documents were not shared with the External Auditor.

224. The WCO in Iraq replied that the selection panel has the latitude to decide at which point to limit the number of candidates who will be retained for assessment. Therefore, a shortlist may go through several iterations before coming up with the final list.

225. We observed that not selecting criteria for shortlisting of candidates leads to subjectivity in selection and may lead to selectors' bias. Insufficient transparency and inconsistency in the selection process may harm the image of the WCO in Iraq, and WHO as a whole.

226. Given the sensitivity of the recruitment process at the WCO in Iraq, we recommend that the scoring criteria, matrix etc. should be more clearly evolved and firmly recorded prior to initiation of the screening process, without any departure.

14. Procurement management

(a) Delays in the delivery of goods

227. We observed significant delay in the delivery of goods in the WCOs in Afghanistan and South Sudan. In the case of the WCOs in Afghanistan and South Sudan, about 50% of the delayed supplies are emergency purchases.

228. In the WCO in Afghanistan, the delay in delivery of goods ranged from one to 174 days. Timely delivery was noticed only in 10% of total purchases.

229. We observed in the WCO in Iraq that out of a total of 60 emergency purchase orders related to COVID-19, five orders in which the date of delivery was 16 January 2021 were yet to be delivered (March 2021). Further, in respect of 16 of these 60 purchase orders, there was a delay in delivery of more than 30 days, the average delay being 140 days.

230. The reasons for delay was stated to be: (a) global supply chain disruption due to COVID-19; and (b) shipments that were not COVID-19-related suffered the additional delay of obtaining green light procedures before shipping.

231. We acknowledge the delays experienced due to COVID-19. However, we emphasize that the timely delivery of goods especially those flagged as emergency goods is critical in the implementation of the projects of the WCOs towards the achievement of the deliverables of WHO within the planned timeline.

(b) Delayed procurement of cholera emergency kits in Ethiopia

232. We observed that Epidemiological Bulletin 32 (3–9 August, 2020) published by the Ethiopian Public Health Institute indicated that floods, which were caused by the overflow of the Awash river, displaced more than 67 885 people. As a result, cholera outbreaks continued in several regions during the reporting week (3–9 August 2020).

233. A procurement request for interagency emergency health kits was made by the WCO in Ethiopia in September 2020. Approval for the procurement of 32 components of emergency health kits for US$ 1.68 million was given on 23 September 2020.

234. It is evident from the above that the flooding and resultant cholera outbreak had occurred before 3 August 2020, but the procurement of emergency health kits was initiated nearly two months later and the purchase order was issued on 9 October 2020. The material was actually delivered much later, i.e. between October 2020 to February 2021 by which time the threat of cholera had completely subsided. No useful purpose can be served if supplies to deal with acute health emergencies are delivered so late.

235. The delayed response of the WCO to the cholera outbreak and the receipt of the emergency health kits after the threat had subsided has the potential of not producing the desired result on the situation of cholera and on the lives of people.

236. The WHO management replied that they had medical kits in place before the above orders were initiated and that the above procurements of kits were made to ensure that the stock of medical kits for cholera was replenished. Cholera is a recurrent problem in Ethiopia and the emergency team have this in mind every year.

237. We acknowledge the fact that medical kits may have been available in stock, but the fact remains that the procurement of emergency health kits was made on an emergency basis as a response to the acute cholera outbreak and not as a routine replenishment of stock.

(c) Local procurement

WCO in South Sudan

238. We examined six local procurements undertaken by the WCO in South Sudan and our observations are detailed below:

Procurement of laboratory supplies for rapid diagnostic test support activities in the WCO in South Sudan

239. The WHO programme funding under the European Community Humanitarian Office is geared towards strengthening the detection, early warning and response to outbreaks. Procurement of medical supplies valuing US$ 45 810 was approved for this programme. We examined one case of procurements consisting of rapid diagnostic test kits and other laboratory supplies. Our observations are discussed in subsequent paragraphs.

240. A request for quotation (RFQ) was issued to four firms for the supply of 15 items with three days to respond. Only two vendors responded by the deadline. We observed that there was inadequate competition in the procurement, as quotes were invited from only four vendors, of which only two responded. According to the WHO Procurement Handbook preselection of suppliers for solicitation of bids should be done through a formal method of assessing suppliers against predetermined criteria. Only suppliers who meet established criteria are invited to bid. We noticed that the WCO in South Sudan did not adopt any such formal process before shortlisting the four vendors for issue of a RFQ.

241. We observed indications of collusive bidding by the two vendors who participated in the bidding. The commercial evaluation comparative statement shows that for 10 items one bidder either quoted very high prices or did not quote at all, which enabled the other bidder to obtain the orders for these 10 items. Similarly, for the remaining five items the same practice was adopted. Thus, the due diligence for verifying the reasonability of the quoted prices was not done.

242. The main reason for such collusive bidding was limited competition and splitting the quantities between two bids, instead of adopting the practice of evaluating and awarding contracts for such bulk supplies on a lump-sum basis. The WCO stated that it is well aware of the risk of collusive bidding by vendors which is why the WCO has invested in the development of a comprehensive supplier database to ensure credible suppliers are always engaged. The suppliers in the database were included after a detailed solicitation and vetting process and through recommendations from other United Nations agencies with established LTAs. To increase competition, the WCO always solicited quotations from three or more suppliers. Splitting of supplies is done for cost-saving purposes since suppliers most often quote different prices for different items (mostly because of different makes and models). We note that soliciting quotations from three or more suppliers is not a substitute for open competition, especially when the shortlisting of vendors is not transparent. If it is stated upfront in the invitation to bid/RFP that the evaluation would be on a lump-sum basis, suppliers will rationalize their pricing accordingly. Further, the contention of the WCO was not borne out by the cases examined by the External Auditor.

Recommendation 18: For purchasing several items in bulk, price evaluation should be done on the basis of a lump-sum price and this may 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.

Recommendation 19: The WCO should adopt open tendering in all cases and in exceptional situations if limited tendering is resorted to, the potential vendors should be identified using a predetermined criterion which is duly recorded.

WCO in Ethiopia

Procurement of 70 satellite phones and accessories

243. The WCO in Ethiopia took up the procurement of 70 satellite phones and accessories for WHO vehicles in 2020. These included four items, namely satellite phone terminals, vehicle docking adapters (to attach the phone to the vehicle), carrying cases and pre-paid service vouchers for 50 units. In the initial proposal the reason for purchase was stated as the heightened security risks due to the political developments in Ethiopia. However, the adjudication report stated "COVID-19 preparedness" as the reason for procurement of the equipment on an emergency basis.

244. Bids were invited for the supply of the four items from three firms – MLK, IECT and DXT. Bids were invited for a particular brand name (Thuraya) of phone and its accessories in violation of public procurement principles and WHO procedure. Justification for procuring a particular brand was not on record.

245. All three firms were technically qualified despite the fact that the firm DXT did not quote for the carry cases.

246. Prices evaluation and selection is based either on a lump-sum basis, i.e. the lowest bid for all the four items put together, or item-wise, i.e. lowest bid for each item. Whatever criteria is adopted it should be stated in the invitation to bid and adhered to during evaluation. The norm of procurement is that while procuring interrelated sets of items, i.e. items to be used together, the price evaluation and selection should be done on a lump-sum basis.

247. On the basis of a lump-sum evaluation, the firm MLK was the lowest with US$ 91 770. If the evaluation was conducted on an item basis, then item one should have been awarded to IECT, item two to IECT, item three to MLK and item four to MLK. The total cost if awarded on an item basis would have been US$ 86 446. We noted that the WCO in Ethiopia neither followed the lump-sum basis nor the item basis of price evaluation.

248. IECT quoted the lowest price for items one and two and it was awarded these contracts accordingly. MLK quoted the lowest price for item three (vehicle docking adaptor). However, instead of selecting MLK, the third lowest offer of DXT was accepted reportedly on the ground that it had quoted for the requested model and that the model was preferred by the project. The price of DXT was 97.7% higher (US$ 23 940 higher) in comparison to the lowest bid.

249. The technical specifications of the vehicle docking adaptor as requested by the project was clearly mentioned in the RFP issued to the three bidders. The bid evaluation tabulation sheet shows that MLK met the specification and therefore it was technically accepted. According to the LPTA evaluation method adopted by WHO, lowest bid which has been technically accepted has to be selected. Not accepting the lowest bid was therefore a serious transgression.

250. The WHO management replied that the brand of the equipment did not match the request. We observe that as mentioned earlier the use of brand name is not permitted in public procurement.

251. For item four (Thuraya pre-paid service vouchers), MLK quoted the lowest price but the contract was awarded to IEC Telecom which was selected for items 1 and 2. This was stated to have been done to avoid splitting the order among too many suppliers. This reply is self-contradictory because by adopting the item wise price comparison method, the WCO has already decided to split the orders. Having adopted this method, it should have adhered to it consistently. But instead, firms were selected arbitrarily on a pick and chose basis. As a result, the total cost of procurement was US$ 110 590 which was much higher than what would have been paid if the lump-sum or item-wise evaluation method had been followed. Some US$ 24 144 could have been saved if the lowest bid was accepted for each of the four items.

Recommendation 20: Use of brand name for procurement should not be permitted.

Recommendation 21: The bid evaluation method to be followed, in terms of whether to adopt a lump-sum or item-wise approach, should be clearly stated in the invitation to bid and consistently adhered to during evaluation.

WCO in Afghanistan

Procurement of medical supplies and personal protective equipment

252. In response to the request of the Afghanistan Government (10 February 2020), WHO initiated the procurement of 30 000 personal protective equipment (PPE) and other medical supplies. An invitation to bid was issued to 10 firms (ITB/AFG/03/02/2020) on 3 March, inviting offers for medical supplies and PPE. The bid closing date was 22 March. On 21 March another invitation to bid (ITB/AFG/03/06/2020) was issued to four different firms for 30 000 PPE kits, with a closing date of 24 March. There was no recorded justification for starting another bidding process for the same requirement/items when the first bidding process was still in process.

253. We found that the bids were opened on the same day (24 March) for both bidding processes. Further, the second bidding process, which was started 18 days after the first bidding process, was completed before the first bidding. The adjudication report for the first bidding (ITB/AFG/03/02/2020) was submitted on 5 April and approved by the Regional Director on 8 April. The adjudication report for the second bidding (ITB/AFG/03/06/2020) was submitted on 1 April and approved by the Regional Director on 5 April.

254. In the second bidding (ITB/AFG/03/06/2020), the bid of M/s SHL was not opened because according to the bid opening report: “there was no WHO reference number on the envelope”. We noted that the firm was referred to WHO by the Ministry of Health of Afghanistan and the firm had confirmed that it had around 19 000 imported PPE kits in stock. Its price was also the lowest on many items. We consider the rejection of the bid to be unjustified as the ground for rejection was not materially significant.

255. In the second bid, according to the adjudication report, the samples provided by all the four firms were rejected stating that they were of substandard quality. Only the coveralls (Dupont) offered by the firm M/s NSF was accepted and 30 000 coveralls were purchased from the firm. The comparative analysis report stated that the Technical Review Committee selected only the coverall of M/s NSF, which had the lowest price, and decided to procure the rest of the items through the ongoing first bid. This again raises the question of the need for starting the second bidding. We did not find an objective and verifiable technical evaluation report to substantiate the rejection of the samples of the bidders on grounds of quality.

256. Technical evaluation primarily involves a comparison of the required specifications conveyed in the invitation to bid with the specifications of the products offered. The compliance or the non-compliance of the offered products to the required specifications should be clearly recorded in the technical evaluation report.

257. The total projected requirement of PPE was 30 000. However, in addition to the 30 000 coveralls procured from M/s NSF another 17 000 coveralls were purchased through the first bidding (ITB/AFG/03/02/2020) from M/s QAL. The unit price of the coveralls offered by M/s NSF was lower than that offered by M/s QAL. If 17 000 more coveralls were required, the orders could have been placed with M/s NSF which was the lowest priced acceptable quality.

258. Under the second bidding process M/s NSF had quoted a price of US$ 14.5 for each PPE kit consisting of five items. The same set of items were procured from four different vendors for US$ 40.26 each through the first bidding process. In this context, recording the specific reasons for technical rejection of the samples offered by the vendors becomes very important to assure the integrity of the bidding process. The estimated international price of these items that were available with the WCO in Afghanistan was much lower.[1] The comparison is tabulated below:

Table 12. Prices in US$

PPE item	Price per unit NSF	Price per unit under the first bid	International price per unit
Coverall	12	12.41	Not available
Surgical mask	Not available	11.76	1.93
Examination gloves	Not available	8.49	6.50
Goggles	Not available	5.23	0.98
Shoes cover	Not available	2.72	Not available
Total	**14.5**	**40.26**	

Price comparison of other items

Table 13.

Item	WHO purchase price per unit	International estimated price per unit
N95 mask	4.60	1.93
Body bag	45.34	1.03
Nebulizer	28.50	45.25

259. Financial evaluation of bids implies verifying the reasonability of the quoted prices against a benchmark. There is no evidence that the WCO in Afghanistan verified the reasonability of the prices quoted by the suppliers against this benchmark of international prices.

260. The invitation to bid dated 3 March 2020 (ITB/AFG/03/02/2020) required the vendors to submit their offer for 20 items of medical supplies. Clause 14 stated that WHO reserved the right to accept only part of the items quoted for or offered. Using this clause, WHO split the whole order among the four

[1] These estimated international prices were conveyed by the WCO in Afghanistan to another WHO staff member via email on 30 March.

firms, instead of evaluating and placing orders on the single LPTA bid on a lump-sum cost basis. According to the comparative analysis statement, different items of different vendors were selected by the Technical Review Committee based on the assessment of the samples provided by the vendors. We could not find any evidence to derive assurance that the technical acceptance or rejection of the items was done in an objective and verifiable manner. This becomes all the more significant given the fact that for majority of the items the lowest price bid was not accepted. The good practice of procurement requires that in such bulk procurement, bid evaluation and selection is done on a lump-sum basis, rather than item-wise. This ensures efficiency and better vendor management. Splitting of orders between the bidders is justified only if a single vendor does not have the capacity to supply the required quantities. It is pertinent to mention that in the second bidding (ITB/AFG/03/06/2020), all the four suppliers had quoted lump-sum price for the whole PPE kit without quoting item-wise rates.

261. The WCO in Afghanistan had adopted limited competitive bidding rather than open competitive bidding in all the cases noticed in audit. According to the WHO Procurement Handbook preselection of suppliers for solicitation of bids should be done through a formal method of assessing suppliers against predetermined criteria. Only suppliers who meet established criteria are invited to bid. We did not find any such formal process having been adopted by the WCO in Afghanistan for the shortlisting of vendors for solicitation of bids.

Recommendation 22: Technical evaluation reports should record the specific reasons for acceptance or rejection of offered products in an objective and verifiable manner. Technical evaluation should be done strictly with reference to the specifications and criteria conveyed in the invitation to bid.

Recommendation 23: Price evaluation should be done either on the basis of lump-sum prices or item-wise rates. Whatever method is adopted, it should be clearly stated upfront in the invitation to bid and not be left to be decided during the evaluation.

Recommendation 24: The WCO should adopt open tendering in all cases, and in exceptional situations if limited tendering is resorted to, the potential vendors should be identified using predetermined criteria which are duly recorded.

15. Information security policy

262. We reviewed the information security policies of the WCOs in Ethiopia and Iraq along with their disaster recovery and business continuity plan preparedness. The results of the review are detailed below:

263. Ethiopia: The information security policy and its various components have not been updated for the last five to 10 years. Formal programs to assess the vulnerability of ICT assets and applications were not found. There was a disaster recovery plan (April 2020) but no disaster recovery tests conducted in 2020. In response, the WCO in Ethiopia stated that the IT security policy is global and not decentralized at the WCO level.

264. Iraq: We are concerned to note that no information security policies were developed locally. We also noted that the business operations policy for IT was last updated in December 2011. There was no formal program to assess the vulnerability of ICT assets and applications. The details of disaster recovery plan tests conducted in 2020 were not provided to audit. It does not have a formal information security incident management program in place in compliance with the professional best practices adopted by the United Nations Secretariat/WHO headquarters.

Recommendation 25: The WCOs with the help of their regional offices and headquarters' IT department, may update their information security policy from time to time, conduct periodic disaster recovery drills and assess the vulnerability of ICT assets and applications.

265. The WCOs agreed with the recommendation.

16. Observations on specific country offices

(a) WCO in Afghanistan

Overdue donor reports

266. As 97% of WHO funding is through voluntary contributions, timely and effective donor reporting is critical to ensure flow of funds in future. Timely reporting also demonstrates accountability to the donors.

267. On analysis of the donor reports due between 2012 and 2019 on the GSM BI dashboard, we observed that there were 54 outstanding reports during this period, and of these, 14 reports were due for more than five years, 26 reports for more than three years, seven reports for more than two years, five reports for more than one year and two reports for less than one year. These included both technical reports and financial reports.

268. The WCO in Afghanistan furnished multiple reasons for delays such as reports not being processed because of encumbrances due to international procurements and some financial reports to be reviewed/cleared by the regional office/headquarters.

Polio eradication and transition plans

269. Polio eradication and transition plans are one of the major and top priority programmes of the WCO in Afghanistan which also has the highest budgetary allocation in the year 2020. Since the beginning of 2018, the polio programme in Afghanistan has provided close to 114 million doses of oral polio vaccines to children through campaigns. The objectives of the polio programme run by the WCO in Afghanistan are to: (i) eliminate all wild and vaccine related poliovirus; (ii) safeguard polio eradication in the rest of the world and prevent any spread out of Afghanistan; and (iii) maintain sensitive polio surveillance to guide vaccination strategies and to prove the absence of poliovirus in the post-eradication phase.

Budget and utilization

270. The budget and utilization of polio eradication and transition plans are given below:

Table 14. Budget and utilization of polio eradication and transition plans (in US$)

Year	Activity budget	Utilization	Amount paid through the direct disbursement mechanism	Amount paid through non-direct disbursement mechanism payments	Share of non-direct disbursement mechanism payments in %
2020	29 900 988	16 203 466	4 247 338	11 956 128	73.78
2019	40 593 512	31 804 341	7 090 524	24 713 817	77.70

271. We observed that less than 30% of the amount spent was paid through the direct disbursement mechanism (DDM) in 2019 and 2020. Likewise, payments for 56% of districts covered in the polio programme was done through the DDM while the remaining 44% was through non-DDM.

272. As the oral vaccination campaigns involve large number of front-line workers such as vaccinators, supervisors etc., non-DDM payment is not only inconvenient both for the payers and receivers, it is also susceptible to the risks of leakages and of not reaching the intended beneficiaries. While we acknowledge the efforts made by the WCO in this regard, its proportion of payments through DDM needs to be increased.

273. The WCO stated that there is a new project for DDM payments that started in November 2017, where they tied up with Azizi Bank on a pilot basis in two districts, which has now expanded to many other districts. It further highlighted context-specific challenges like the penetration of banking services, availability of national identification cards, high turnover of front-line workers, cultural aspects etc.

Programme targets and achievements

274. To effectively eradicate polio, routine immunization services (services delivered at fixed health facilities) are supplemented by supplementary immunization activities (SIAs). SIAs are mass vaccination campaigns during which health workers and volunteers undertake additional outreach service or go door-to-door to offer immunizations to all members of a target population, irrespective of previous vaccination status. Polio SIAs may be conducted nationwide (through national immunization days (NIDs)) or may target specific districts/regions through subnational immunization days (SNID). They supplement routine immunization services and are provided in two ways. First, SIAs help to achieve the oral polio vaccine (OPV) schedule for children not fully vaccinated through routine immunization. Second, they also provide additional OPV doses to children who have completed the routine OPV schedule. SIAs may significantly contribute to herd immunity against poliovirus infection in local communities by delivering a large number of OPV doses in a short period. Therefore, high SIA coverage plays a key role in fighting polio, especially in countries where routine immunization coverage may be low.

275. We examined the SIAs undertaken in 2020. The objective was to fully cover the target population. The coverage of the targeted population, extent of post-campaign monitoring and the quality of the immunization drive is shown in Table 15 below. The targeted coverage for monitoring i.e. post-campaign monitoring was 95% of the population covered in the immunization drive. The extent of coverage of immunization was assessed using the statistical method of lot quality assessment survey, wherein the population was divided into homogenous lots on the basis of village, municipal ward or locality. Samples were selected and tested for quality and coverage of immunization. The whole lot was rejected if the defect/shortfall in the sample was more than the threshold limit (10%).

Table 15. Targeted outputs and outcomes for SIAs

SIAs)NID/SNID or any other(	Target population)in millions(	Achieved population)in millions(	Achieved population)in %(	Percent of lots passed in quality
January NID	9.9	6.9	69.7	76 %
February SNID	6.8	5.1	75	77%
July case response	1.1	1.06	96.4	91%
August case response	3.3	3.16	95.8	83%
September SNID	6.1	4.31	70.7	83 %
September case response	2.0	1.33	66.5	59 %

276. We observed significant shortfall in the coverage of the targeted population in four out of the six immunization campaigns undertaken during the year. Except for the campaigns undertaken in July and August (where the coverage was 95 to 96%), the coverage during the other four campaigns ranged from 66% to 75%. We also observed that except in July, where 91% lots had passed, during the other campaigns, 59% to 77% of the lots had passed the quality test. The above statistics indicate that in four out of six immunization campaigns there was 34% to 30% shortfall in coverage of the targeted population. This was compounded by the fact that, of the population covered, 17% to 41% of the population lots failed in the post campaign assessment.

277. The Technical Advisory Group on Polio Eradication in Afghanistan in its June 2020 meeting suggested to recruit at least one female member in all the teams for effective SIAs. However, the percentages of female front-line workers are very low varying between one% in the south-east to 32% in the north.

278. The WCO stated that efforts such as the hiring of an international consultant, transport incentives, etc. were taken up to increase the female workforce for the November SNID

279. We appreciate the efforts being taken up by the WCO to hire female members in teams, as increasing women’s meaningful and equal participation at all levels of the programme is crucial for its success.

Wild poliovirus outbreak

280. Afghanistan saw higher incidences of wild poliovirus type 1(WPV1) cases during 2020 with 53 cases reported between 1 January and 25 October 2020, compared to 20 cases for the same period in 2019, which is a 165% increase. Similarly, there was sudden increase in circulating vaccine-derived poliovirus (cVDPV) cases also to 101 in 2020 from zero in 2019 indicating geographic spread from areas bordering Pakistan to interior districts of Afghanistan.

281. The WCO stated that to reduce international spread, permanent vaccination teams are stationed at main crossing points like Torkham etc., airports, passport offices and meetings on the polio programme were held with Pakistan at the national and regional levels in addition to issuing early notification of outbreaks in the bordering areas.

282. We appreciate the efforts being taken and acknowledge the immense challenges under which the WCO operates in Afghanistan. However, the increasing trend in WPV1 and cVDPV cases is a cause for alarm and indicates the need to address the gaps in WHO’s response strategy.

283. The WCO agreed that there are gaps and highlighted that the journey is not straightforward in the country context.

Recommendation 26: We recommended and the WCO agreed, to make efforts to reduce the share of non-DDM payments.

Recommendation 27: We also recommend that efforts are made to improve the coverage and quality of the SIAs so as to expedite the eradication of polio and prevent any resurgence of the virus.

Recommendation 28: WHO also needs to take urgent and appropriate measures to contain the spread of WPV1 and cVDPV cases, especially through cross border transmission.

(b) WCO in Ethiopia

Inventory management

Slow moving inventory

284. One of the locations had an opening inventory of US$ 1.32 million as on 1 January 2020. It received 100 items of cholera, malaria, and emergency kits valuing US$ 2.52 million during the year. However, only six items related to malaria, cholera and trauma were issued during 2020 which valued US$ 50 706. Thus, despite very slow movement of inventory, delivery of supplies/additional purchases kept happening throughout the year. This is not an efficient supply chain management Since these kits are purchased through LTAs from suppliers having long-term relationships with WHO, a suitable mechanism should be established with the suppliers to link the deliveries/supply orders with the movement of inventory.

Inventories without expiry dates

285. All the inventories were categorized as medicines, vaccines and humanitarian supplies. As such each item included in the inventory should contain an expiry date. We observed inventory valuing US$ 546 121 did not have any expiry dates.

Expired inventories

286. We observed that inventory valuing US$ 1.14 million had expired.

Recommendation 29: The WCO in Ethiopia should ensure that all medical inventories have expiry dates mentioned with the ultimate aim of having no items without expiry dates in the inventory.

287. The WCO in Ethiopia agreed with the recommendations and stated that transitioning to the use of GIMS would enable better monitoring and data entry on the supplies side.

Internet connectivity and the infrastructure upgrade plan

288. The requirement of reliable internet connectivity becomes even more critical for organizations like WHO for quick dissemination of information to a widely spread population especially in times of health emergencies like COVID-19.

289. In the WCO in Ethiopia, we observed that there were nine incidences of breakdowns in internet connectivity reported in 2020, which is quite a high figure and has the potential to disrupt the digital operations of the WCO. To tackle the problem, the WCO had prepared an infrastructure upgrade action plan that was to be implemented by 30 June 2019. We noted that the upgrade work has not yet been completed.

(c) WCO in Iraq

Health care services for Sulaimanyah

290. The WCO in Iraq entered into (April 2020) an agreement with Heevie Organisation (grantee) for providing financial support of US$ 224 773.50 towards implementation of the project entitled: "Providing access to the quality health care services for vulnerable population in Sulaimanyah". As per the agreed terms, payment of US$ 179 818.80 was released in April 2020 by the WCO to Heevie Organisation. The project was to be executed between 16 February 2020 and 30 September 2020. The balance payment of US$ 44 954.70 was made in November 2020. As per the budget proposal, primary health care services were to be provided in Heevie Static clinics at the Ashti Internally Displaced Persons Camp (US$ 200 597.25) and the Internally Displaced Persons Camp in Arbat (US$ 24 176.25). We reviewed the related records and observed the following.

291. Out of the total grant of US$ 224 773.50, the grantee had spent amount of US$ 200 597.24 and the balance amount of US$ 24 176.26 remained unspent due to the fact that the primary health service at the Arbat Internally Displaced Persons Camp was not provided. The reasons for the same were not found on record.

292. As per the agreement, the second instalment of US$ 44 954.70 was to be paid after the completion of the project and after the receipt of final technical report and financial statement. However, the WCO released the entire amount without deducting the unspent amount due to non-setting up of the service at the Arbat Internally Displaced Persons Camp.

Recommendation 30: We recommend that the WCO should consider putting in place a mechanism to monitor the utilization of funds by the grantee in order to ensure that expenditure has been incurred in accordance with the agreed terms. The WHO management needs to exercise greater due diligence before releasing the payments in favour of the grantee.

Indiscriminate use of WHO emblem

293. It is clearly mentioned in the Manual that in no case shall a non-State actor use the name or emblem of WHO, or any abbreviation thereof, in relation to its business or activities, the project, or otherwise. In that regard, the entity shall be made aware that any use of WHO's name or emblem requires an explicit written authorization by the Director General of WHO. Unless such an authorization was obtained, the entity should be urged to remove WHO's emblem. We noted that several NGOs were using the WHO emblem on their mobile clinics, in their annual reports and on t-shirts. It is not clear how the WCO is monitoring the use of the mobile vans it handed over to the Department of Health which in turn handed them over to non-State actors.

Lack of assurance activities

294. In all purchase orders provided by the WCO in Iraq, there were no records of any assurance activity undertaken by the WCO. There were no field visits, no site reports by WCO officials, no travel records or interim spot check notes. The WCO has completely relied on the report given by non-State actors without any of the checks that were mentioned in the agreements or clearance letters. There were no verification audits as well. Assurance activities are important to ensure that actual expenditure and reporting are in accordance with WHO rules and procedures. Otherwise there is a risk of misuse of grants including fraud and corruption.

C. PERFORMANCE AUDIT OF TRIPLE BILLION TARGET – HEALTH EMERGENCIES

Introduction

295. Under the new approach adopted by WHO and as reflected in its Thirteenth General Programme of Work (GPW 13), three strategic targets are to be achieved by 2023 – called the triple billion targets. These are:

- One billion more people benefiting from universal health coverage

- One billion more people better protected from health emergencies

- One billion more people enjoying better health and well-being

296. In this audit, we assessed the work done to achieve the second triple billion target, one billion better protected from health emergencies. For the assessment we tried to use the results framework developed by WHO which specified the outputs and outcome indicators to measure WHOs performance. We also aimed to assess the actions of WHO, including actions of State Parties, in response to COVID-19 pandemic in terms of the International Health Regulations, 2005 (IHR) for response to health emergencies. We examined the records and data pertaining to implementation of the triple billion targets as well as the Programme budget 2020–2021.

Audit findings and recommendations

17. Results framework for the triple billion targets

297. In May 2018, the GPW 13 of WHO was approved by the World Health Assembly. It is the blueprint of the work to be done by WHO during the five-year period from 2019 to 2023. The hallmark of WHO's new model is its focus on measuring outcomes and impact of all of WHO's work, including that of the Secretariat. It aims at increasing accountability through measurement. For this purpose, a results framework has been developed that links the input resources to outputs in a verifiable and measurable way. The impact expressed in terms of the three triple billion targets have been broken down into 10 outcomes and 42 outputs, with specific indices and performance indicators for each. There are 40 programmatic milestones linked to the 46 indicators in the GPW 13 Impact Framework. Each milestone is tracked by a single or multiple indicator.

298. Formulation of the GPW 13 was started in August 2017. A technical expert reference group (ERG) was established by the Director-General in November 2017 to develop a methodology along with

indicators for measuring the impact, outcomes and outputs for the triple billion targets. The ERG was expected to produce a final report by February 2018. However, it only submitted an interim report in January 2018. Thereafter, the ERG created a task force with a mandate to produce a concise report on the methodology of the triple billion targets. The task force submitted a preliminary report in May 2018. Approval of the World Health Assembly was sought based on this preliminary report. The ERG is yet to submit its final report as of March 2021, even after three years of its target date.

299. The Director-General submitted a report on the GPW 13 Impact Framework to the World Health Assembly in May 2019 which stated that the development of the Impact Framework was being undertaken in two stages. In the first stage, the indicators were to be incorporated into the Programme budget 2020–2021. In the second stage to be taken up in 2019–2020, the indicators would be further developed and finalized.

300. We sought the status of the second stage of the development of the WHO Impact Framework. WHO replied that the development of the results framework was still a work in progress. It stated that the work on indicators' development, the rationale, methods and data availability was ongoing and that it would be presented to the governing bodies in 2022 for consideration.

301. From the reply of WHO, it is evident that the WHO Impact Framework is likely to be presented to the governing bodies in the year 2022, with less than one reporting cycle left in the GPW 13 period.

302. The target of one billion more people protected from health emergencies also referred to as the health emergencies protection billion (HEP billion) target is measured using an index built from three indicators:

- **Emergency prepare indicator** that measures country preparedness for emergencies in terms of a country's ability to identify and respond to a range of emergency situations.

- **Emergency prevent indicator** that measures efforts to prevent health emergencies via vaccination, especially for the priority infectious hazards: yellow fever, meningitis and cholera, measles and polio. It was also stated that the indicator can be adapted to include other mass vaccination campaigns that are needed (e.g. pandemic influenza, Ebola virus disease, COVID-19).

- **Emergency detect and respond indicator** that measures whether public health emergencies are detected, notified and responded to in a timely fashion.

303. Regarding the progress of development of the results framework for the HEP billion target, WHO stated that country specific targets are completed for the prepare and prevent capacities for each of the five pathogens. For detect, notify and respond, as this is a new indicator, WHO is using the emerging trends to establish appropriate targets.

304. WHO had brought out a report entitled "Methods for impact measurement" in April 2020 that also presented the limitations of the triple billion methods, some of which are summarized below:

(a) Indicators: Some of the indicators, which are sustainable development goal indicators are not fully representative of relevant health issues and risks, while other obvious key indicators are missing.

(b) Data availability: There are many gaps in data availability of the indicators, even for sustainable development goal data sets.

(c) Supporting information: There is a lack of supporting information on how data sets of component indicators are correlated and how change in indicators fit together.

(d) Time lag: The work done during the GPW 13 may not produce effects quickly enough to be measured by 2023.

305. Even after the finalization of the WHO Impact Framework, the reported outcomes and impacts would suffer from the limitations presented in the preceding paragraph. While we do appreciate the need for continuous improvement and refinement of the indicators, we also note the need for a settled set of indicators and a framework to actually measure outcomes and impact in a timely manner, to be of utility. Given the emphasis placed on the measurement of impact and outcomes as a distinguishing feature of the GPW 13, the delay in finalization of the Impact Framework, even two years after the start of the GPW 13 period, is a point of serious concern.

Recommendation 31: We recommend that the WHO finalizes the GPW 13 Impact Framework, as part of the WHO results framework, on a priority basis with defined timelines to enable WHO to ascertain its contribution to outcomes and impacts.

306. WHO replied that the Impact Framework has been finalized and consists of healthy life expectancy, the triple billion targets and the 46 outcome indicators. Progress on these is being regularly tracked and reported. Additional indicators for important public health priorities would be added as better data become available. This is in progress and the governing bodies would be regularly updated in this regard.

18. Triple billion dashboard

307. WHO launched the triple billion dashboard during the World Health Assembly in November 2020. The triple billion dashboard is an interactive and dynamic tool to track progress and deliver impact towards the triple billion targets at the country, region and global levels. The dashboard sources data mainly from the WHO's Global Health Observatory (GHO) databases, which contain official statistics prepared in consultation with Member States.

308. The triple billion dashboard provides 64 indicators related to the GPW 13 outcomes. These 64 indicators cover all the 46 outcome indicators related to the triple billion targets.

309. We noted that the dashboard had the data in respect of only 38 of the 64 indicators for the year 2018. Further, the number of countries for which the data was available in the dashboard for the year 2018 ranged from two to 194 with the data for 13 indicators being available for less than 50 countries. It is pertinent to note that the dashboard data covered only 25 of the 46 outcome indicators related to triple billion targets.

310. In 2019, the dashboard provided the data in respect of 23 of the 64 indicators. Moreover, countries in respect of which data was available ranged between two and 194, with the data in respect of 11 of the indicators being available for less than 50 countries. We also noted that dashboard data covered only 17 of the 46 output indicators related to triple billion targets. Further, for the year 2020, the dashboard had the data in respect of only one indicator, namely, the number of cases of poliomyelitis caused by wild poliovirus.

311. In respect of the triple billion target, one billion more people better protected from health emergencies, we observed that all the five outcome indicators have been included in the triple billion dashboard. However, no data are available in respect of one of the indicators, namely, proportion of vulnerable people in fragile settings provided with essential health service, for any of the past three years, i.e., 2018, 2019 and 2020. For 2020, data are available for only one indicator, namely, the number of cases of poliomyelitis caused by wild poliovirus.

312. WHO responded that for most indicators, the dashboard is dependent on the data available in the GHO database. The non-availability of data on indicators is because data are not available, data are being validated by the technical programmes, or the programmes have not yet submitted the updates to GHO. The rigorous process followed from the moment data are received to the moment data are published on GHO takes time. However, more updated data will be published at the end of March.

313. We acknowledge WHO's response and appreciate their efforts. At the same time, the fact remains that the triple billion dashboard is still incomplete and will be of limited use until complete data are available

> **Recommendation 32: We recommend that WHO prescribe timelines for the submission, processing and/or validation of data on the triple billion dashboard and ensure adherence to the timelines.**

314. WHO accepted the recommendation and mentioned that the process is currently on to collate a calendar of updates for each indicator in the triple billion dashboard. Major updates would be made to the dashboard twice a year based on this collation and this will be announced on the dashboard pointing to the updated indicators.

19. Health emergencies protection billion

315. The health emergencies protection index (HEPI) is the measure of the extent to which a State Party is protected from health emergencies. It is an average of the three subindices – the preparedness index, the preventive index and the response index. We noted that in the triple billion dashboard for the health emergencies protection target, the figures of the HEPI for 2018 and 2019 have been presented in addition to the number of people better protected from emergencies as of 2019. However, in respect of 29 countries, we noted that the number of people better protected had increased, while the HEPI had decreased from 2018 to 2019 and vice versa. For instance, for one country, the HEPI in 2018 was 65.5, which decreased to 57.8 in 2019. However, the number of people better protected was shown to have increased by 1.5 million. Likewise, in the case of another country, the HEPI had increased from 79.8 to 91.5 from 2018 to 2019, but the number of people better protected was shown to have decreased by 2.5 million.

316. WHO explained that the data in the dashboard would be updated in March 2021. It further explained that the increase in the number of people protected, despite a decrease in the index could be due to the use of other covariates in the model.

317. We are of the view that if the measure of the number of people protected is impacted by other covariates, then the index should be suitably modified to factor in this impact. Otherwise the index would be misleading.

> **Recommendation 33: We recommend that WHO should review the interaction between the three indices that make up to the HEPI, and recalibrate them to ensure that their impact on**

the HEP billion target and the HEPI is correlated to convey reliable and meaningful information.

318. While accepting the recommendation, WHO stated that the methods for the HEPI are under discussion especially with regard to the detect and respond indicator. The methods report would be updated with descriptions of the methods for setting baselines and for the projections

20. Programme budget 2020–2021

(a) Indicators and targets of programme budget outputs

319. In the approved Programme budget 2020–2021, the triple billion targets are categorized into nine outcomes and 29 outputs with 46 outcome indicators as indicated in the following table:

Table 16. Outcome indicators for the triple billion targets

Strategic priority	No. of outcomes	No. of outputs	No. of indicators
One billion more people benefiting from universal health coverage	3	13	21
One billion more people better protected from health emergencies	3	10	5
One billion more people enjoying health and well-being	3	6	20

320. In order to assess the performance against the triple billion target of one billion more people better protected from health emergencies, we sought indicator values at the end of the 2020 as well as the baseline data for the indicators. WHO responded that the programme budget output indicators' baselines and targets are now being addressed through the Organization-wide mid-term review process coordinated by the Planning, Resource Coordination and Performance Monitoring (PRP) unit.

321. We observed that WHO had brought out draft GPW 13 WHO Impact Framework metadata in January 2019, which provided the metadata for the 46 indicators including the definition, method of estimation, calculation and data sources. Hence, we sought the reasons for not addressing the baselines and targets even after the completion of two years of the GPW 13 period of 2019–2023.

322. WHO replied that the WHO Health Emergencies Programme developed the indices for the GPW 13 and that indicators were being regularly reviewed and refined on a continuous basis. WHO further informed the External Auditor that a technical group has been working on the methodology for estimating baselines and projections for all indicators, which is yet to be finalized.

323. We observed that a delay in the finalization of the baseline and targets of the programme budget output indicators' is likely to deprive WHO of evidence for identifying and addressing deficiencies in the implementation of the programme budget and the GPW 13. Such a delay would also adversely impact the ability of WHO to demonstrate impact to strengthen the case for investing resources over and above the assessed contributions.

Recommendation 34: We recommend that WHO should address the baselines and targets of the programme budget output indicators as a priority.

324. WHO did not respond to the above recommendation.

325. The Programme budget 2020–2021 was the first programme budget developed under the GPW 13 and hence a vital element in ensuring the implementation of the strategy set forth in the GPW 13.

326. The Programme budget 2020–2021 amounts to US$ 4840.4 million (excluding emergency operations and appeals), including base programmes (US$ 3768.7 million), the polio eradication programme (US$ 863 million) and the special programmes (US$ 208.7 million). The programme budget represents an increase of 9% compared with the total Programme budget 2018–2019. The base component of the Programme budget 2020–2021 has increased by 11% compared with the Programme budget 2018–2019, which was stated to be reflecting the need for strategic investments in several major areas in line with the objectives of the GPW 13. The base budget provided for four strategic priorities, namely, the three strategic priorities of the GPW 13 and 'more effective and efficient WHO providing better support to countries'.

327. In this audit, we focused on strategic priority 2, i. e., one billion more people better protected from health emergencies. This strategic priority was divided into three outcomes and ten outputs as indicated in Appendix 2. The three outcomes and the budget allocation for each of the outcomes for the biennium is presented in the following table.

Table 17. Approved budget for the biennium 2020–2021 in respect of strategic priority 2 (in US$ millions)

Outcome	Outcome description	Country offices	Regional offices	Headquarters	Total
1	Countries prepared for health emergencies	112.7	60.8	57.5	231.0
2.	Epidemics and pandemics prevented	219.5	67.6	93.3	380.4
3.	Health emergencies rapidly detected and responded to	131.1	74.0	72.3	277.4
	Total	**463.3**	**202.4**	**223.1**	**888.8**

328. From the information provided by WHO, we observed that the expenditure incurred on strategic priority 2 during 2020 was about 34% of the planned cost; and only around 31% of the approved programme budget. Please refer to Table 18 below.

Table 18. Expenditure (including encumbrances) incurred in respect of strategic priority 2 in the year 2020 (in US$ millions)

Outcome	Outcome description	Approved budget	Planned cost (Note 1)	Funding (Note 2)	Expenditure (including encumbrances) (Note 3)
1.	Countries prepared for health emergencies	231.1	214.7 (92.9)	113.6)49.2(	73.6 (34.3)
2.	Epidemics and pandemics prevented	380.4	337.6 (88.7)	213.1)56.0(	125.3 (37.1)
3.	Health emergencies rapidly detected and responded to	277.3	253.4 (91.4)	156.8)56.5(	77.1 (30.4)
	Total	**888.8**	**805.7 (89.5)**	**483.5)54.4(**	**276 (34.3) (31.1) (Note 4)**

Note 1: The figures in the parenthesis indicate the planned cost as a percentage of the approved budget.

Note 2: The figures in the parenthesis indicate the funding as a percentage of the approved budget.

Note 3: The figures in the parenthesis indicate the expenditure as a percentage of the planned cost.

Note 4: The figures in the parenthesis indicate the percentage of expenditure to the approved budget.

329. From the above, it can be seen that WHO had planned for more than 88% of the approved budget for all the three outcomes. However, the expenditure incurred (including encumbrances) ranged between 30.4% and 37.1% of the planned cost only. Moreover, when compared to the approved programme budget, the expenditure incurred during 2020 works out to only around 31%, which necessitates that nearly 69% of the approved budget needs to be expended in 2021, the second year in the biennium.

330. We noted that in the programme budget of the previous biennium 2018–2019, expenditure on the WHO Health Emergencies Programme was around 76% of the approved budget. The expenditure during 2018 and 2019 was 35% and 41% of the approved budget, respectively. The outputs for the WHO Health Emergencies Programme during 2018–2019 are fully mapped into the outputs of the Programme budget 2020–2021 for triple billion target of health emergency protection. Considering that expenditure during the first year of the biennium 2020–2021 is in the same range as the expenditure during the first year of the biennium 2018–2019, there is a very real possibility that less than 80% of the approved budget would be expended during the biennium 2020–2021. This may adversely impact the achievement of the outputs and the outcomes of the programme budget.

331. We also observed that the funding against the approved budget for the biennium 2020–2021 was only US$ 483.5 million or around 54% of the approved budget. Without the approved budget being fully funded, the outcomes and outputs delineated in the programme budget cannot be achieved.

332. In its response, WHO stated that in 2018–2019, although the expenditure was 76% of the programme budget, it was 93% of the funds available. During 2018–2019, the WHO Health Emergencies Programme had US$456 million available, which was 82% of the programme budget. WHO, further attributed the reduced expenditure to the fact that WHO had to respond to the Ebola virus disease outbreak in 2018–2019. We do not find this reply tenable because an emergency like the Ebola virus disease outbreak should result in increased expenditure.

333. To further justify the lower expenditure, WHO added that it was the first full biennium for the then newly created WHO Health Emergencies Programme which required time and resources to establish staffing across the three levels of the Organization and to expand its operations. It also stated that it was always prudent and necessary to have an opening balance of funds available at the beginning

of a biennium, to ensure continuity of operations while resources are mobilized towards the implementation of the new programme budget.

334. In respect of the audit observation regarding the low level of funding vis-à-vis the approved budget, WHO stated that against the budget of US$666 million[1] for the triple billion target of health emergency, it is expecting fully flexible corporate funding of US$ 155 million, of which the Director-General has released US$ 132 million so far. The remainder of the budget needs to be funded through voluntary contributions from donors. The largest part of the WHO Health Emergencies Programme's COVID-19 preparedness and response work in 2020 is financed through contributions received under the outbreak and crisis response (OCR) fund and its implementation is also accounted for in the OCR segment of the programme budget. This is also reflected by lower funding and implementation levels in the base budget segment.

335. From the above, we noted that the funding of the programme budgets is a concern, that needs to be addressed to achieve the full utilization of the programme budgets. While having an opening balance at the beginning of the biennium may be prudent, we are of the opinion that such a balance needs to be ensured through adequate funding and not by reducing or delaying expenditure. This approach was also endorsed by the World Health Assembly at its Sixty-sixth session.

336. In response to our observation, WHO expressed apprehension that it would not be able to take any action on the issue of funding beyond discussions facilitated by the Secretariat as ultimately it requires the action of Member States and other donors.

337. We observed from the Director General's report on the financing and implementation of the Programme budget 2020–2021, that as at September 2020, over US$ 3000 million has been allocated for emergency operations and appeals, as against the approved budget of US$ 1000 million. This was to fund the emergency operations in response to the COVID-19 pandemic. The report acknowledges that the base budget for WHO Health Emergencies Programme is so far quite sparsely funded, as was the trend in previous bienniums. It was also stated that in absolute terms, implementation of the base budget remains strong vis-à-vis the corresponding period of the previous biennium. It is further stated in the report that in 2020–2021, existing processes are being strengthened and several new processes would be put in place, enabling timely implementation of the approved programme budget. The report adds that according to the Organization-wide review, with these adjustments between 80 to 85% of the plans are projected to be implemented by the end of the biennium.

338. We appreciate the plans delineated by WHO to improve the funding situation and while acknowledging the impact of COVID-19 on the delivery of the biennial plans, we reiterate the need to ensure projected implementation of at least 80 to 85% by the end of the biennium. We also note that WHO has not contested the facts and figures pointing to significantly less expenditure vis-à-vis the approved budget and the planned expenditure during the bienniums, more pronounced, at the end of first year of the biennium.

Recommendation 35: We recommend that WHO should ensure the strengthening of existing processes and the introduction of new processes delineated in the update (document 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.

[1] Excluding poliovirus.

339. WHO accepted the recommendation.

21. Measuring Secretariat contribution

340. One of the strategic priorities aimed to be implemented by the Programme budget 2020–2021, as already noted in the preceding paragraphs, was one billion more people better protected from health emergencies, which was divided into three outcomes and 10 outputs.

341. One of the hallmarks of the new results framework adopted by WHO is its "new and more robust approach to measuring and reporting on Secretariat accountability".[1] In each of the outputs under the triple billion targets, how the WHO Secretariat proposes to contribute to the achievement of the outputs is defined. Each output has separate section entitled "How will the Secretariat deliver?" that specifies the commitments of the Secretariat. The output scorecard roll-out guidance for the Programme budget 2020–2021 directs the budget centres to list out five main achievements for each output.

342. We sought information on the measurement and achievement of these commitments as at the end of 2020. In response WHO stated that at the end of each biennium, WHO performs an Organization-wide assessment of its achievements against the commitments to deliver results in the biennial programme budget. In addition, mid-term review is conducted midway through the biennium. The mid-term reporting, along with the scorecard for the major office level was expected to be completed by March 2021 and the three billion targets outcome data was expected to be completed in the middle of March 2021.

343. We do appreciate the existence of and adherence to the organizational processes of mid-term review and end of biennium assessment of results. However, in the absence of information on the actions taken, plans made and progress achieved against each of the outputs, we are not in a position to assess the performance of the WHO Secretariat against the commitment made for each of the outputs.

344. We note that the guidance on the mid-term review process for the Programme budget 2018–2019 had directed the budget centres to review the contribution to the outputs and outcomes. However, the mid-term report for the Programme budget 2018–2019 did not present the outputs in its report in spite of the guidance issued. We also draw attention to the report of the External Auditor for the year ended 31 December 2019 wherein the then External Auditor had noted that the mid-term report did not present the status of the outputs that were financed out of the programme budget. Thus the Organization's accountability for the implementation of the programme budget and how it contributed towards the desired outcomes was not apparent. The then External Auditor recommended that WHO include outputs reporting in its mid-term report.

345. WHO responded that outputs have always been reported in the past in the mid-term report and at the end of the biennium for 2018–2019. We note from the mid-term report that the outputs have not been reported in spite of the guidance in this regard. For instance, in respect of category 4 – health systems in the Programme budget 2018–2019, there are four outcomes with five outcome indicators and 12 outputs with 13 output indicators. The mid-term review report for the biennium 2018–2019 provided the details of the budget, funds available and the expenditure by major office and by programme as also the details of the top 10 voluntary contributors. While sporadic information has been provided about a few of the indicators, the report did not provide the details of the achievements against outcome

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[1] Programme budget 2020–2021.

indicators and output indicators systematically. We would like to emphasize the need for reporting all the results as per the guidance for the preparation of the mid-term report.

Recommendation 36: We recommend that WHO should ensure that the instructions in the roll-out guidance for mid-term reporting on the Programme budget 2020–2021 are fully adhered to in order to ensure better transparency and measurement of results accountability.

346. WHO accepted the recommendation.

22. Contingency Fund for Emergencies

347. The Contingency Fund for Emergencies (CFE) with an initial target capitalization of US$ 100 million was established by the World Health Assembly in May 2015. The CFE provides WHO the resources to respond rapidly to disease outbreaks and health emergencies – often in 24 hours or less. WHO's ambitious triple billion target of one billion more people better protected from health emergencies is interwoven with the CFE.

348. The CFE functions like a revolving fund with costs initially incurred against CFE allocations being reimbursed through donor contributions outside of the WHO Health Emergencies Programme core budget either directly to the CFE or through reimbursement from donations against country response plans.

349. During the years 2015 to 2020, WHO received US$ 159.46 million in contributions for the CFE and released more than US$ 200 million from the CFE in response to many emergencies which includes disease outbreaks, natural disasters and complex humanitarian crises. We noted that reimbursements during these years remained between 30 to 50% per year. The availability of funds under the CFE during the years 2015 to 2020 remained between US$ 14–14.5 million which was well below the targeted amount of US$ 100 million.

Table 19. CFE position during the years 2015–2020

	)US$ in thousands(					
	2015	**2016**	**2017**	**2018**	**2019**	**2020[1]**
Opening budget)as on 1 January(	0	14 265	17 077	18 294	40 532	32 326
Revenue	14 296	18 090	12 988	39 985	51 265	22 849
Expenditure	31	15 278	11 771	17 747	59 471	24 230
Closing budget)as on 31 December(	14 265	17 077	18 294	40 532	32 326	30 945

Source : WHO's audited financial statements

350. The availability of funds under the CFE as on 31 December 2019 was US$ 32.32 million. WHO released US$ 12.90 million[2] during the year 2020 for COVID-19 responses. The allocations were made over a span of 11 months, out of which US$ 8.90 million was released in January–February 2020 and the remaining US$ 4.00 million was released in November 2020. In response to the audit, WHO informed the External Auditor that US$ 4.00 million was released for the renewal of contracts for staff and consultants in 2021 to ensure operational continuity. The use of the CFE for the renewal of staff and consultant contracts during the COVID-19 response was not in line with the objectives of the Fund However, this amount constituted a temporary loan and will be fully refunded.

351. WHO also acknowledged that multiple allocations totalling US$ 102 million were made between September 2018 and April 2020 for the Ebola virus disease response in North Kivu, which were outside the original ambit of the CFE but this was done due to insufficient donor funding for the response.

352. We opine that:

(a) The availability of funds under the CFE has remained far below its initially envisaged target capitalization of US$ 100 million during the years 2015 to 2020, whereas, frequent emergencies faced by the world are a reminder that a sufficient and sustainable CFE is necessary for responding rapidly to disease outbreaks and health emergencies.

(b) The CFE is meant to provide rapid funding in the initial response phase of disease outbreaks and health emergencies and in response to an escalation of, or a new event within, a protracted crisis. Its utilization for longer periods to fill funding gaps in ongoing emergency operations is not in sync with the CFE guiding principles.

353. WHO in its response accepted that the CFE has been used to finance operations over the longer term, which is outside of its original scope. The CFE was used to bridge funding gaps at critical junctures to ensure the continuity of operations. WHO also stated that the US$ 100 million capitalization target initially envisaged by Member States has proved to be unrealistic. Furthermore, it was not clear if this was originally intended to be a minimum balance to be held in a fund. Instead of a funding target of US$ 100 million, experience of deploying the CFE suggests consideration should be given to maintaining a minimum balance based, for example, on average annual allocations. This would be supported via a mix of available funding, and potentially a drawdown mechanism, funding guarantees or multi-year commitments from key donors.

[1] The figures for the year 2020 have been taken from unaudited financial statements.

[2] January 2020: US$ 1.8 million; February 2020: US$ 7.1 million; and November 2020: US$ 4 million.

354. The use of the CFE to bridge funding gaps in responses lasting for longer periods is indicative of WHO's inability to raise sustainable and reliable source of funding and put in place a planned response to protracted and longer term health emergencies.

Recommendation 37: WHO should review its strategies to elicit donor response to ensure sustained funding for health emergency operations and to address the funding gaps at critical junctures. The CFE should be utilized for response operations at the onset of the event for a limited period of time, and in response to an escalation of, or a new event within, a protracted crisis, as envisaged in its guiding principles.

D. ACKNOWLEDGEMENTS

355. 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.

Girish Chandra Murmu
Comptroller and Auditor General of India

30 April 2021

Appendix 1

STATUS OF PREVIOUS RECOMMENDATIONS OF EXTERNAL AUDITORS

STATUS OF IMPLEMENTATION OF RECOMMENDATIONS FOR THE FINANCIAL PERIOD ENDED 2020

					Status after verification			
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
1	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;	So far, all personnel holding "Procurement Requestor" role in GSM are requested to take the Administrative curriculum training to retain this responsibility. The enforcement was slightly delayed due to Covid-19 crisis, but an Admin Note is pending ADG's approval and will set the new final deadline for completion to 30.09.2020. As regards the other functions (Technical / Responsible Officers, Quality Check / Project Approvers 1 and Managers / Project Approvers 2-6), dedicated curricula are ready and fully available in the corporate platform iLearn. Supply submitted a request to make the completion of the different curricula mandatory for staff members holding or requesting the corresponding roles in GSM. Further	The recommendation is under implementation stage as the completion of the different curricula have not yet been made mandatory for staff members holding or requesting the corresponding roles in GSM. The details of personnel holding "Procurement Requestor" role in GSM, who had taken the administrative curriculum training were called for but not made available. Copy of the approved ADG's Admin note regarding the deadline for completion of this training was requested but was not made available. As of now, the recommendation is under implementation stage.		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
			discussions will be held with ADG/BOS regarding implementation. It is important to flag that the Supply Department alone cannot make those trainings mandatory. It has to come from Senior Management					
2	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.	WHO's reply is pending.	As reply is pending, the recommendation is not implemented.			X	
3	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.	The up-front QA check was enabled in December 2019, when it was implemented in HQ. All the regions except EMRO implemented the QA check during the first half of 2020 (see attached emails). EMRO will be implementing the QA check before the end of the year. The QA check is for DFC, Grant LOA and IPO including DI IPO.	The status of implementation of recommendation in EMRO was not furnished. As of now, the recommendation is under implementation stage.		X		
4	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	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	The status of implementation of recommendation in EMRO was not furnished. As of now, the recommendation is under implementation stage.		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
		requiring the exceptional approval from the Comptroller.	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.					
5	R005	Ensure that the country offices follow the policy requirement on refund processing provided under FIN.SOP.XVI.001.	BFOs have been reminded through regular monitoring reports about the correct way to record refunds; BFOs have been reminded at BFO (VC) meetings to ensure that the country offices use the correct method to record receivables. Pls see attached latest DFC monitoring report, under findings and recommendations.	**As seen from DFC monitoring report refund of US$ 337 716 was received by WHO and BFOs were asked to remind COs to record DFC refunds as described in the policy. May be considered as Implemented and closed, after review by DEA**	X			

				Status after verification			
SI No.	Recommendation ID	Recommendation of the External Auditors	Action reported by the management	External Auditors' assessment	Implemented	Under implementation	Not implemented	Overtaken by events
6	R007	Establish a robust performance tracking system within the Global Procurement & Logistics and Global Finance for a comprehensive picture of the performance of key services that would provide insights for management to make more informed decisions and identification of key areas for improvement and further improve the quality and timely delivery of the services to the WHO and partner organizations.	In line with this recommendation from the external auditor and the similar recommendation from the internal auditor, GFI, in coordination with GPL and IMT, has assessed the case for an electronic tracking of SLA. A business case was prepared and is being finalized for management consideration. The Business case was submitted for management consideration. The recommendation is proposed for closure.	It was noticed from the communication on Business case that considering the implementation cost and proposal for new ERP system, the recommendation was not implemented. As the new ERP is yet to be established, the status of implementation may be assessed during next audit.		X		
7	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	WHOs reply is pending.	As reply is pending, the recommendation is not implemented		X		
8	R009	Revise the Human Resource Strategy aligning it to the WHO Transformation agenda.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented		X		

				Status after verification			
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9	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.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented		X		
10	R011	Facilitate the mobility policy implementation by prioritizing the establishment of the MAB and CIB and drafting its corresponding Terms of Reference (ToR).	With regards to this recommendation the preliminary analysis and plan was reviewed during 2019 by a global mobility taskforce, that was established in the context of the WHO transformation. The taskforce prepared mobility guidelines, which were shared with the Human Resources Department and has resulted in a revised WHO Mobility Policy. The policy was shared with WHO senior management in February 2020 and included an implementation plan, which was recommended for testing in the form of a simulation exercise. As a result of the global pandemic, the simulation exercise was launched in August 2020. Feedback from the exercise will be used to finalize the mobility policy and the	As the MAB and CIB is yet to be established, and TORs are not finalized, the recommendation is under implementation.		X		

				Status after verification				
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			implementation plan. The MAB and CIB will be established, and TORs finalized, through this process.					
11	R012	Review the harmonized selection process to allow further customization of screening questions to improve the utility of the preliminary screening procedure.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
12	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.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
13	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.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
14	R015	Establish a registry/coordinator that receives, maintains, refers and will coordinate the staff concerns to the respective office in the internal justice system.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		

					Status after verification			
SI No.	Recommendation ID	Recommendation of the External Auditors	Action reported by the management	External Auditors' assessment	Implemented	Under implementation	Not implemented	Overtaken by events
15	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.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
16	R017	Clarify and streamline programme accountabilities and coordination in relation to its transformation initiative as it transitions into the new General Programme of Work and Programme Budget, to ensure that programme outputs are delivered as planned and support programme results reporting.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
17	R018	Include outputs reporting in its MTR as these are the results that the WHO has full accountability in the implementation of the PB, for better transparency and measurement of results accountability.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
18	R019	Enhance the PB implementation performance reporting by providing more focus on progress of outputs delivery and ensuring that related activities are closely monitored to exact better accountabilities and improve PB implementation reporting process.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
19	R020	To harmonize programme-level monitoring mechanisms to establish specific responsibilities and mechanisms to track and monitor programme deliveries for more streamlined information management in support of organizational learning and future decisions.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented		X		
20	R021	Re-define its overall fraud risk governance structure and provide specific roles and responsibilities to its key players to better clarify fraud risk management accountabilities and set the tone for future fraud-related policies.	The fraud risk governance arrangements will be reviewed in the context of the broader Enterprise Risk Governance arrangements needed to implement an enhanced risk management approach serving GPW13 implementation (including its related risk appetite approach), under the leadership of the WHO risk management committee.	As the fraud risk governance arrangements is yet to be reviewed, the recommendation is under implementation.		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
21	R022	Conduct a concrete and formally-documented fraud risk assessment exercise, through the CRE, at periodic intervals and at appropriate levels to obtain better traction in forwarding the Organization's commitment to manage its fraud vulnerabilities.	The institutionalization and operationalization fraud risk assessments will be started once the necessary updates to the fraud related governance and policies arrangements are in place and approved/supported by the WHO risk management committee.	As the institutionalization and operationalization of the fraud risk assessments is yet to be started, the recommendation is under implementation.		X		
22	R023	Include in the fraud risk management policy, the mandatory training requirement for all staff on fraud awareness and prevention, and for the HRD to include the same in its mandatory training programme; and monitor staff compliance with the Declaration of Interest and to systematically conduct exit interviews taking interest on fraud-related issues that may arise.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		

				Status after verification				
SI No.	Recommendation ID	Recommendation of the External Auditors	Action reported by the management	External Auditors' assessment	Implemented	Under implementation	Not implemented	Overtaken by events
23	R024	Streamline its fraud reporting mechanisms and coordination in support of the creation of a central repository for all reported fraud allegations and complaints to ensure that the IOS case data include those reported through the Integrity Hotline and other mechanisms, all to enhance the fraud deterrence value of the Organization's fraud response.	WHOs reply is pending.	As reply is pending, the recommendation is not implemented.		X		
24	R025	Undertake a comprehensive monitoring of the application of its Fraud Prevention Policy and Fraud Awareness Guidelines and related policies, to establish the right precursors in the enhancement of its fraud risk management mechanisms and further improve the Organization's risk aware culture.	This will be addressed through the fraud related governance mechanisms and through the work planned around risk appetite aimed at further embedding risk management with processes (including internal controls and other operational indicators)	In view of the reply, the recommendation is still under Implementation.		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
25	R026	Report to WHA 70 – 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).	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.	In view of the reply that this recommendation will be implemented as a part of GPW 13,as of now, the recommendation is still under Implementation.		X		

					Status after verification			
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
26	R027	Report to WHA 70 – 2017 Formalize the control frameworks on the critical processes of IT management, giving priority to (i) outsourcing arrangements, (ii) criteria for classification of critical IT assets, and (iii) IT Performance Management Framework, and ensure that these control frameworks are documented and shared across the Organization for effective management and monitoring. Also align the control frameworks with the risk identification activities that need to be enhanced focusing on the defined key result areas (paragraph 126).	**In Progress** As already reported in 2020, the outsourcing arrangements have already been addressed and are actively managed. This was already addressed. Due to covid-19 pandemic, the efforts have been focused on getting new services, products and projects up. During Q4 of 2020, the Project Management Office started discussions on how to address IT Performance Management and got the small team trained on COBIT 2019. We have outlined a framework by which the IT processes are going to be assessed and measured. In the last departmental meeting, it was announced that IT Performance Management will be a key area to push for and work with different areas/teams will start this year to discuss key priorities areas for measurement and improvement.	As the IT performance management framework is under discussion, the recommendation is under implementation		X		

27	R028	Report to WHA71 – 2018 Enhance WHO's end-user IT equipment management, through the Department of Information Management and Technology (IMT), AMG and the Corporate Procurement and Policy Coordination (CPPC) by: incorporating a requirement for justification and IMT approval for IT equipment procured outside of the standards set for better transparency and accountability; providing regular updates to business units on the age of IT equipment to support acquisition planning and decisions on IT replacement and purchases; standardizing the global software desktop configurations which shall be done at the manufacturer`s site to further speed up the acquisition to delivery cycle time; and providing AMG with access to IMT mobile device management tools such as the System Center Configuration Manager (SCCM) and AirWatch to speed up the equipment verification.	Since mid-2020, the process to request and deliver personal computers has been changed. IMT now purchases and maintains a central stock with periodic replenishment. Users request mobile devices and personal computers from IMT service catalogue. This has done away with business units having to order directly with external supplier, thus, improving the overall process. Loading WHO configuration at PC manufacture's site has been kept on hold due to security concerns around the need to extend trusted WHO network to manufacturer's premises. In its place, the configuration process on site has been optimized and further assisted by the central purchase of stocks ready for delivery on demand from service catalogue requests. The remaining action is to code the review of justifications for non-standard purchases into a formal policy and publish it in the eManual to speed up verification Business units are provided updates on aging equipment to plan purchases.	As the review of justifications for non-standard purchases into a formal policy is yet to be codified and published in the eManual, the recommendation is under implementation.		X		
28	R029	Report to WHA72 – 2019 Enforce the timely receipt of the deliverables as well as the completion of Supplier Performance	We hope to be able to implement the extension of this system to all the Regional Offices and Service contract types in 2021.	As the electronic workflow for ensuring timely receipt of deliverables was not extended in all		X		

				Status after verification				
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
		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.	Implementation could not take place in 2020 due to conflicting priorities.	regional offices, the recommendation is under implementation.				
29	R030	Report to WHA72 – 2019 Adopt a change management strategy to support the implementation of the redesigned resource mobilization process and related systems along with the organizational structure to ensure effective delivery of the new Resource Mobilization (RM) model.	**Ongoing** The CEM system along with related RM process is currently in project status and the project will be going live in March 2021 with roll out to HQ and AFRO offices first and then roll out to all other offices by May-June 2021.	As the CEM system is yet to be rolled out in all other offices, the recommendation is under implementation.		X		
30	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 (SOP) s, to ensure transparency, consistency and uniformity in interpretation and application of pertinent policies.	Proposed for closure. Critical eManual sections have been completed.	17 March 2021 As per the reply, some sections are in final draft form and would be published in upcoming weeks. As of now, the recommendation is under implementation stage.		X		

				Status after verification			
SI No.	**Recommendation ID**	**Recommendation of the External Auditors**	**Action reported by the management**	**External Auditors' assessment**	**Implemented**	**Under implementation**	**Not implemented**	**Overtaken by events**
31	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.	WHO's reply is pending.	As reply is pending, the recommendation is not implemented.		X		

32	R033	Report to WHA72 – 2019 Intensify the ongoing Contingency Fund for Emergencies (CFE) financing campaign and strengthen support from donors so that resource mobilization shall be a continuous process, and also strengthen the resource mobilization efforts at country level to sustain reimbursements to the CFE through donor contributions.	**In progress** Progress has been made in broadening support to the Fund. Contributions averaged US$15 million per year from 2015–2017 from 11 Member States. This jumped to US$ 37 million in 2018 and US$ 54 million in 2019, with the overall donor base doubling to 22. Nearly US$ 18.5 million has been pledged/contributed in 2020 (as at 24 Mar 2020). Despite this success, the current replenishment model is heavily dependent on contributions from a few traditional donors. WHE is undertaking a review to look at ways to deepen existing partnerships, widen the pool of Member State donors, and explore alternative sources of funding, including the private sector, foundations and internal sources of revenue. In this regard a draft set of recommendations has been produced following a recent first round of internal consultations. Next steps would be to agree on these recommendations; explore their potential and the feasibility of adopting them and presenting a short road map/stragegy towards a strengthened CFE to WHE senior management by the time of the World Health Assembly.	As the strategy towards strengthening the Contingency Fund for Emergencies (CFE) is ongoing, the recommendation is under implementation.		X		
	Total				**1**	**30**	**1**	**0**
	Percentage of total number of recommendations				**3.12**	**93.76**	**3.12**	**0**

Appendix 2

OUTCOMES AND OUTPUTS OF STRATEGIC PRIORITY 2 – ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES

Outcome 1 – Countries prepared for health emergencies

Output 1.1 All-hazards emergency preparedness capacities in countries assessed and reported

Output 1.2 Capacities for emergency preparedness strengthened in all countries

Output 1.3 Countries operationally ready to assess and manage identified risks and vulnerabilities

Outcome 2 – Epidemics and pandemics prevented

Output 2.1 Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards

Output 2.2 Proven prevention strategies for priority pandemic-/epidemic-prone diseases implemented at scale

Output 2.3 Mitigate the risk of the emergence and re-emergence of high-threat pathogens

Output 2.4 Polio eradication and transition plans implemented in partnership with the Global Polio Eradication Initiative

Outcome 3 – Health emergencies rapidly detected and responded to

Output 3.1 Potential health emergencies rapidly detected, and risks assessed and communicated

Output 3.2 Acute health emergencies rapidly responded to, leveraging relevant national and international capacities

Output 3.3 Essential health services and systems maintained and strengthened in fragile, conflict and vulnerable settings

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