
Internal control framework: implementation update, including proposals on direct financial cooperation

Report by the Secretariat

1. WHO's updated internal control framework has been finalized, and a summary report was noted by the Programme, Budget and Administration Committee of the Executive Board at its nineteenth meeting in January 2014.¹ The purpose of the framework is to strengthen WHO's internal control system in response to risks to the Organization's mandate and objectives, and to delineate precisely what the internal control system consists of within the WHO context. It is designed to guide the development of policies, procedures and systems that could be applied to all levels of the Organization. This report provides an update on the progress made to date in implementing the internal control framework across the Organization.

IMPLEMENTATION OF THE INTERNAL CONTROL FRAMEWORK

2. To ensure consistent, comprehensive and effective implementation of the framework across the Organization as encouraged by the Programme, Budget and Administration Committee, a Steering Committee, which is composed of representatives from the regional offices and headquarters, has been established to oversee and coordinate implementation across the Organization, and a detailed implementation plan has been developed. The delegation of authority from the Director-General to the regional directors and assistant directors-general has been revised to include the upholding of the internal control framework in the areas under their responsibility, and to make reference to the letters of representations that require signature by all regional directors and assistant directors-general in the context of the annual closure and audit of WHO's financial statements. An "accountability compact" between the Director-General and the assistant directors-general has been introduced with clear performance objectives, including the effective implementation of internal controls. The initial implementation phase of the framework, which began in September 2014 under the oversight of the Steering Committee, focuses on the following three key activities.

Development of internal control management tools, including a managers' guide and self-assessment checklist

3. The managers' guide and self-assessment checklist build on mechanisms that already exist across the different levels of the Organization. They will help to ensure that managers, within their delegation of authority, are fully aware of the applicable policies and procedures, the controls they are

¹ See documents EBPBAC19/3 and EB134/3.

responsible and accountable for, the related monitoring and reporting requirements, and the purpose and use of the internal control framework.

4. The self-assessment checklist aims to help managers to better understand the strengths and weaknesses in and adequacy of controls in their budget centre. It provides a structured set of questions to: (i) assess and understand their internal operational environment; (ii) identify risks, gaps and weaknesses within existing controls; and (iii) help prioritize actions to strengthen a budget centre control environment.

Assessment of risks, gaps and weaknesses through implementation of the self-assessment checklist

5. A pilot of the self-assessment checklist is currently being run at headquarters and in the regional and country offices. The checklist is designed to be completed by each budget centre manager, who will have access to a dashboard that highlights areas of strength, gaps and actions for improvement. The dashboard is designed to help budget centre managers to identify risks and gaps in internal control for consideration by senior management and business owners. A summary report based on the results from the self-assessment checklist will inform the risk management process and the development of an internal control statement.

Review and update of existing or formulation of new controls, including policies and procedures in key functional areas

6. Based on internal and external audit recommendations and internal assessments, the key areas identified for review and update during the initial implementation phase are the policies and procedures for performance management, procurement, non-staff contracts and direct financial cooperation payments. Progress made in each of these areas is described below.

Performance management

7. In 2014, policies were drafted by the Secretariat to: (i) provide an overarching framework for core principles of performance management; (ii) address underperformance; and (iii) streamline the recognition and rewards process (with emphasis on recognition). The draft policies will be reflected in proposed amendments to the Staff Regulations and Staff Rules to be considered by the Executive Board,¹ and revisions to the WHO eManual, including the shared responsibility of all staff members in support of a successful performance management process.

8. The ePMDS+ performance evaluation tool was reviewed in order to further simplify and harmonize the processes and support the core principles of the performance management framework. The new processes and key features of the framework, including a revised version of ePMDS+, are scheduled to be launched in 2015. It is expected to support the continuous dialogue between staff members and their supervisors, which is crucial for performance management to be successful.

¹ See document EB136/47.

Procurement

9. After staff costs, procurement of goods and services is the Organization's largest expense category. In 2013, US\$ 538 million was spent on procurement, of which 80% was spent on services and 20% on goods.¹ The policies, processes and controls linked to the procurement function vary depending on the type of procurement. For example, the procurement of goods subcategory is mainly handled by procurement specialists across the Organization in a centralized manner, whereas procurement of services is delegated to health technical units. The procurement of services subcategory is made even more complex as different types of procurement actions fall under it, including actions for which specific knowledge is required in the areas of human resources or finance.

10. In the interests of ensuring that procurement is carried out Organization-wide in a strategic manner and through effective and efficient processes, and that it provides the best possible value for money, the internal and external auditors and the United Nations Joint Inspection Unit have highlighted the need for WHO to further refine its procurement-related approaches, policies and procedures.

11. In response, the Secretariat has begun to formulate a procurement strategy, the key objectives of which include:

- (i) the generation of **cost savings** through strategic procurement;
- (ii) fiduciary, financial and reputational **risk management** through improved internal controls; and
- (iii) **operational excellence** through the enhancement of procurement capacity in emergency preparedness and response and improved quality of goods and services to strengthen the technical competence of WHO.

12. A project team has been established and the design and detailed plan of the project have been formulated. An analysis is being conducted to review the current method of procurement and to define strategic objectives. Consultations in the regional offices and at headquarters are under way and are expected to be completed in February 2015. The procurement strategy paper should be drafted by March 2015 and a final strategy will be presented to Member States in May 2015.

13. The main focus of the strategy will be on "pure" procurement, such as procurement of goods, Agreements for Performance of Work, technical services agreements and procurement of general external services. The strategy will also focus on further enhancing WHO's approach and action on the environmental aspects of procurement. Specific finance-related contracts (such as direct financial cooperation, internal services and letters of agreement) and management of non-staff contracts, described in paragraphs 14–16 below, are handled through separate projects, but will feed into the overall procurement strategy.

¹ See document A67/43, Schedule I. Statement of Financial Performance by major funds. Procurement expenses cover Medical supplies and materials, and Contractual services.

Use of non-staff contracts

14. Non-staff contracts include contracts for Consultants and temporary advisers, Agreements for Performance of Work and Special Services Agreements. Over the past few years, the proportion of individuals holding non-staff contracts has increased and in 2013 represented 32% of WHO's global workforce.¹

15. Although there is recognition of the risks and challenges related to the use of non-staff contracts, an organization such as WHO continues to need to have a flexible mechanism in engaging a workforce to provide timely and short-term assistance without it assuming a longer term commitment and liabilities. Further clarity must therefore be brought to the policies and procedures regarding the use of non-staff contracts and that compliance in their implementation must be closely monitored.

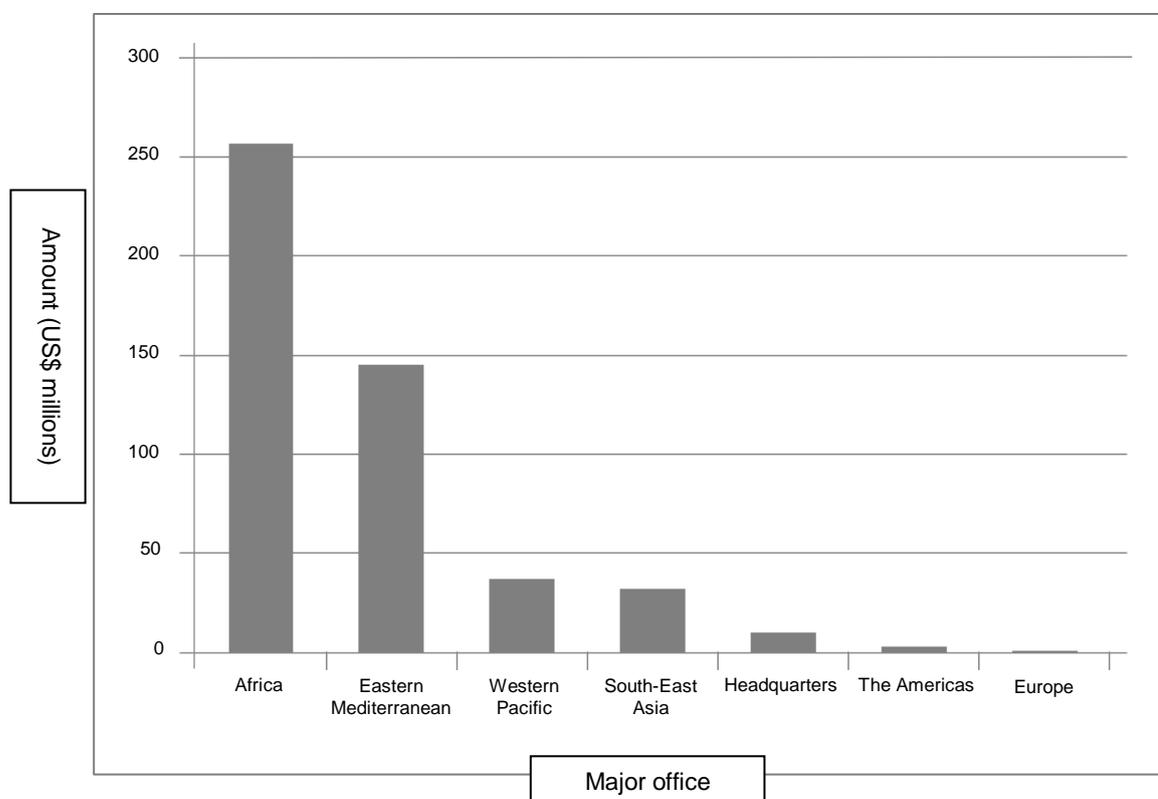
16. According to a recent study by the Joint Inspection Unit, the concern over the use of non-staff contracts is widely shared across many organizations within the United Nations system. Recognizing the risks and benefits of having such a mechanism in place, the Secretariat has begun a comprehensive review of the use of non-staff contracts, including relevant policies, regulations, contractual frameworks and processes at all levels of the Organization. As an initial step, a short study on contracts for consultants and Agreements for Performance of Work granted to individuals has been commissioned, with the aim of improving and streamlining the process and of increasing compliance with current policies and procedures. The study is expected to be completed by the end of 2014 and its findings will be incorporated into the overall review.

Direct financial cooperation

17. Direct financial cooperation is defined as payments made by the Organization to cover the cost of items or activities that would otherwise be borne by governments, in order to strengthen their health development capacity and ability to participate more effectively in, or to meet their commitments to, WHO technical cooperation at country level.

18. Each year, around 9000 individual direct financial cooperation payments are made, with the average payment being US\$ 25 000. For the biennium 2012–2013, the total amount was US\$ 400 million. Direct financial cooperation is used in all WHO regions, with the African Region accounting for just over half of total direct financial cooperation payments for the Organization (see figure below). The ten largest country beneficiaries of direct financial cooperation account for 50% of total payments.

¹ See document A67/47.

Figure: Direct financial cooperation by major office, 2012–2013¹

19. Direct financial cooperation is used across all the programme areas of the Organization, often for supporting, inter alia, training activities and workshops, as part of capacity-building within countries. In recent years, its total value has increased due to its use in immunization campaigns, which accounted for almost half of the total in the period 2012–2013. This has represented a significant amount in Niger, Somalia (operated from Kenya), Sudan and Yemen. The uses of direct financial cooperation as described in the WHO Manual include:

- (i) operational costs of public health activities (including immunization campaigns, health surveys and social mobilization and/or advocacy campaigns);
- (ii) assistance to pay the running costs of national seminars and training courses;
- (iii) travel per diems, subsistence payments, or, exceptionally, salary supplements for government staff carrying out health-related projects;
- (iv) grants towards costs of printing and translating health literature and training aids;
- (v) running and maintenance costs of government-owned vehicles for WHO programme activities.

¹ Additional amounts have been recorded under the “direct financial cooperation” expenditure type, mainly country imprest expenses for directly implemented vaccination activities. Going forward, these expenses will be reported separately.

20. Direct financial cooperation is mostly financed from voluntary contributions, notably those relating to immunization campaigns.

21. Several studies have shown a need for improvement across the Organization with respect to accountability and control of direct financial cooperation. A recently concluded audit report by the Office of Internal Oversight Services proposed improvements in the following areas:

- (i) better planning and alignment of direct financial cooperation with WHO's objectives;
- (ii) timely reporting and better compliance with reporting formats;
- (iii) accountability, including assurance activities: need for enhanced assurance that reported tasks were actually completed.

Improvements during 2014

22. **Greater alignment with Programme budget objectives and increased control over committed funds.** Instances of direct financial cooperation should be strategically planned. Some countries may no longer require this support due to their level of economic development and growth; some applications of direct financial cooperation therefore may no longer be appropriate. In those countries where direct financial cooperation continues to be appropriate, an overall budget for activities for the biennium will be agreed with the respective health ministries in order to avoid piecemeal, ad hoc contracts: this will require strong collaboration with those ministries during budget development.

23. **Better reporting and compliance with reporting deadlines.** Every direct financial cooperation has a final expenditure report, certified by the implementing partner and checked by the regional office. Currently, this report only summarizes the total expenditures incurred. A revised format has been introduced that provides additional details by type of expenditure as specified in the detailed budget agreed between WHO and health ministries, and a summary technical report must be submitted by the implementing partner. The technical report will link to a specific work plan. The existing policy that no further direct financial cooperation be given in the event of outstanding reports is now being strictly enforced in all regions, and, since the end of 2013, the number of overdue reports has reduced from 15% to 10% of the total number of reports.

24. Measures that have improved accountability

(i) Separation of direct implementation from direct financial cooperation. In some countries, WHO has been asked by the government to take responsibility for activities that may have previously been implemented by the health ministry, for example, vaccination campaigns and follow-up surveillance. Differentiation between direct implementation and direct financial cooperation will ensure that the reported amounts of direct financial cooperation expenditure are not overstated and that the appropriate accountability measures are implemented for the activities being financed.

(ii) Introduction of the self-assessment checklist, which includes key points for evaluating compliance with WHO's rules on direct financial cooperation, including alignment with the strategic plan and the relevant work plan, results reporting and donor reporting.

Accountability improvements to be implemented

25. **Training and capacity building.** The audit report by the Office of Internal Oversight Services highlighted the need to make staff in country offices more aware of the correct direct financial cooperation procedures. In order to enhance management effectiveness in country offices, and as part of the wider package of measures being introduced, improved training is becoming available in the preparation and follow-up of direct financial cooperation arrangements, for WHO staff, and as a support to government counterparts.

26. **Establishment of focal points for direct financial cooperation in each regional office.** A focal point is to be established in each regional office. It will take responsibility for monitoring compliance, reviewing proposals for direct financial cooperation, ensuring alignment with priorities and funding, and approving the final expenditure report on the use of direct financial cooperation.

27. Assurance activities:

(i) Post facto assurance activities. Based on a risk analysis, post-activity verification of actual use of funds could be conducted by WHO staff members who are independent of the implementing office. Should these verifications reveal misuse of funds or other compliance issues, further direct financial cooperation payments could be withheld or suspended. In certain cases, these verifications may be outsourced to external firms.

(ii) The audit report by the Office of Internal Oversight Services recommended the development of routine risk-based assurance plans, supported by risk assurance checklists. These assurance activities could include, if needed, up-front assessments of beneficiaries' accounting and control systems and procedures.

(iii) The cost of assurance activities will, to the extent possible, be built into donor agreements. A central budget may also be needed, notably to finance up-front assessments.

28. These measures to improve accountability are consistent with the best practice of "three lines of defence" for internal control: approval of direct financial cooperation by the country office; the compliance check at the regional office; and internal and external audit functions.

Proposed actions for Member States

29. The support of Member States is essential for the measures proposed above. Those Member States receiving direct financial cooperation payments are asked to support efforts to ensure that the relevant government departments provide timely reports on the use of direct financial cooperation, and to facilitate assurance activities, as needed. Those Member States making voluntary contributions are asked to support funding for assurance activities through the respective contributions budgets. Member States are requested to support the adequacy of funding for regional office compliance functions, since each regional office will be responsible for its assurance activities, as well as the compliance checks, which comprise both of the contracts as they are put in place, and the reports once the contracts are completed.

ACTION BY THE PROGRAMME, BUDGET AND ADMINISTRATION COMMITTEE

30. The Committee is invited to note this report.

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