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Audit of Maternal and Child Health Programs

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Executive summary

The focus of the audit was on the Community Action Program for Children (CAPC, \$54.9 million), the Canada Prenatal Nutrition Program (CPNP, \$26.8 million) and the Canadian Perinatal Surveillance System (CPSS, \$2.7 million). These programs are a part of the Government of Canada's larger commitment to invest in the well-being of vulnerable children.

The objective of the audit was to assess the effectiveness of the management control framework as it relates to governance, risk management and internal controls for the programs and to assess compliance with the Treasury Board *Policy on Transfer Payments*. The audit was conducted in accordance with the Internal Auditing Standards for the Government of Canada and the International Standards for the Professional Practice of Internal Audit. Sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion.

The children's programs that were examined are governed through Provincial/Territorial Joint Management Committees, based on protocol agreements established twenty years ago. The audit found varying degrees of committee activity and noted that management is in the process of reviewing the external governance model. The audit also examined the roles and responsibilities for program staff at headquarters, regional staff and finance staff. These were well documented and are being operationalized.

Over the past two years, the Public Health Agency of Canada (the Agency) has strengthened its internal controls for its grants and contributions program. In 2013-14, the Agency centralized the financial management of grants and contributions and implemented a new system (the Grants and Contributions Information Management System or GCIMS). Since the administration of the contributions programs is now centralized and automated, there are more standardized operating procedures. As well, systematic monitoring and recipient audits are now being conducted. Staff continue to receive training to support the centralized model.

While the administration of the grants and contributions function has been strengthened, the audit makes two recommendations to support ongoing maturity. The first recommendation relates to developing a strategy to enhance the financial reporting requirements and the second relates to updating the recipient risk assessments, to increase the effectiveness of the monitoring strategy.

The audit found that the surveillance system has been designed to collect relevant and timely perinatal public health data. Surveillance outputs include reports, fact sheets, peer-reviewed papers, abstracts and national surveillance data used for reporting.

The Agency has a current website, along with standards and guidelines, so that stakeholders are aware of program objectives. The website also lists information about the surveillance system.

During 2014-15, the Centre for Health Promotion implemented an updated performance measurement strategy and data collection tool for CAPC and CPNP. The performance information collected to date was not available for review during the audit; however, the programs are planning to utilize the data collected to support funding decisions during the 2017 renewal process.

The audit makes four recommendations to strengthen the programs' external governance, risk management and internal controls related to the administration of grants and contributions.

A - Introduction

1. Background

The Community Action Program for Children (CAPC), the Canada Prenatal Nutrition Program (CPNP) and the Canadian Perinatal Surveillance System (CPSS) are part of the Government of Canada's larger commitment to invest in the well-being of vulnerable children. For more than twenty years, CAPC and CPNP have provided funding to community groups or coalitions, either to deliver programs that address the health and development of children aged 0 to 6 who are living in conditions of risk (CAPC) or to enhance or develop programs for vulnerable pregnant women (CPNP). Together, the two programs have over 600 funded projects in communities across the country. The mission of the surveillance system (CPSS) is to contribute to the improved health of pregnant women, mothers and infants in Canada.

Community Action Program for Children

CAPC is a federal initiative that provides transfer payments to community-based groups and coalitions, to develop and deliver comprehensive, culturally appropriate prevention and early intervention initiatives to promote the health and social development of young children (0-6 years) and their families facing conditions of risk. For the 2014-15 fiscal year, the program comprised 409 projects, with annual contributions of \$54.9 million (See [Appendix C](#)).

The origins of the program can be traced back to 1990 when Canada, along with 71 other nations, made a commitment at the United Nations World Summit for Children to invest in the well-being of vulnerable children. In response to this commitment, in 1992, the Government of Canada initiated Brighter Futures: Canada's Action Plan for Children, which included a five-year, \$500 million Child Development Initiative (CDI). The Initiative was based on evidence that poverty, low education and unemployment have a negative impact on healthy child development. At the time of the announcement, it was estimated that 1.25 million children (one out of every five children) in Canada were likely to experience a higher than normal incidence of poor health and social development.

Examples of community programs

- Violence and child maltreatment prevention;
- Social and emotional resiliency;
- Drop-in childcare;
- School readiness programs for pre-schoolers;
- Outreach and home visiting, nutritional support and collective kitchens;
- Child development activities: cultural programs and celebrations; healthy physical activities;
- Literacy development and community capacity building.

The Initiative outlined four approaches to addressing the conditions of risk for children, including: prevention, promotion, protection and partnerships. CAPC was identified as a significant part of the partnership approach and is based on the principle that communities are well-positioned to recognize the needs of their children and have the capacity to draw together the resources to address those needs. CAPC, the largest of the programs, was announced in 1992, created in 1993 and first implemented in 1994 by Health Canada. The

program results are seen at the child, family and community levels. The Government of Canada, in creating CAPC in 1993, provided a significant and sustained contribution towards the development and delivery of programs, as well as an impetus for partnerships in the planning, development and funding of community-based programs. CAPC projects often act as an entry point, where families that are geographically and socially isolated are linked to the health system and to additional supports in the broader community.

Canada Prenatal Nutrition Program

CPNP is a transfer payment program that delivers services through non-governmental and community-based organizations. CPNP has helped communities promote public health and provide support to improve the health and well-being of pregnant women, new mothers and babies facing challenging life circumstances.

The program was announced in 1994. It provides long-term funding to community groups and coalitions to develop or enhance existing prenatal services, to address the needs of at-risk pregnant women, their families and children, to promote healthy pregnancies and to improve infant outcomes. CPNP supports comprehensive, community-based services and is specifically designed to build upon existing prenatal health programs or to establish programs where none exists.

Examples of Prenatal Programs

- Nutrition and lifestyle counselling;
- Food supplements;
- Prenatal and breastfeeding;
- Infant attachment and child development education;
- Social support and skill development;
- Referral to health and social service.

CPNP is not a universal program; rather, it is targeted specifically at women facing challenging life circumstances such as poverty, teenage pregnancy, alcohol or substance use, family violence, social and geographical isolation and recent arrival in Canada. CPNP projects also increase the availability of culturally sensitive prenatal support for Aboriginal women living off-reserve. It provides contributions to local non-profit and community organizations supporting the provision of preventative and early intervention services. For 2014-15, annual contributions totalled \$26.8 million for the 214 CPNP projects operating across the country.

Canadian Perinatal Surveillance System

CPSS is part of the Public Health Agency of Canada's (the Agency) national health surveillance program. The work of CPSS is focussed on a framework of perinatal health indicators that consist of measures of maternal, fetal and infant health determinants and outcomes. Congenital anomalies surveillance is an important component of the program. The surveillance itself is a continuous and systematic process of data collection, analysis and interpretation of information that is carried out in collaboration with Statistics Canada, the Canadian Institute for Health Information (CIHI), provincial and territorial governments, health professional organizations and university-based researchers.

In 1999, the government announced an expansion of CPNP and CPSS. The enhancements to CPNP were provided to further improve community access to services and enhance

intersectoral collaboration. The CPSS component complements the community-based programs by providing the evidence base for the development of health policies and programs for maternal and infant health. While the surveillance system provides policy and program support to both CAPC and CPNP, it also supports other programs within the Agency (such as the Fetal Alcohol Spectrum Disorder Initiative), as well as initiatives outside of the Agency.

2. Audit objective

The objective of the audit was to assess the effectiveness of the management control framework as it relates to governance, risk and internal controls for the Community Action Program for Children, Canada Prenatal Nutrition Program and the Canadian Perinatal Surveillance System. The audit also assessed for compliance with the Treasury Board *Policy on Transfer Payments*.

3. Audit scope

The Maternal and Child Health activity includes CAPC, CPNP, Aboriginal Head Start and Fetal Alcohol Spectrum Disorder. The scope of the audit included CAPC and CPNP, as well as the CPSS surveillance system. The audit selected CAPC and CPNP based on materiality (\$81.6 million) and a joint governance and management structure. CPSS was also included in the scope since it provides support to the maternal child health programs. Both financial and non-financial aspects of the programs were included. The Agency's management control framework for CAPC and CPNP contribution agreements were also examined. Transaction testing included the 2013-14 and 2014-15 fiscal years.

4. Audit approach

The audit approach included an analysis of documentation, policies, standards, guidelines and frameworks; interviews; testing and analysis. The testing comprised a sample of twenty recipient files that were selected based on materiality, location across Canada and risk. In addition, regional field visits were conducted in Ontario, Manitoba and the North (headquartered in Ottawa). As an evaluation of CAPC and CPNP was also being completed, the audit approach included regular meetings and document sharing with the Office of Evaluation (as of July 2015, the Office of Audit and Evaluation).

5. Statement of conformance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion. The audit findings and conclusion are based on a comparison of the conditions that existed as of the date of the audit, against established criteria that were agreed upon with management. Further, the evidence was gathered in accordance with the Internal Auditing Standards for the Government of Canada and the International Standards for the Professional Practice of Internal Auditing. The audit conforms to the Internal Auditing Standards for the Government of Canada, as supported by the results of the quality assurance and improvement program.

B - Findings, recommendations and management responses

1. Governance

1.1 Governance structure

Audit criterion: *The Community Action Program for Children and the Canada Prenatal Nutrition Program have an effective governance structure to support program objectives and comply with the funding agreement.*

External governance

The Community Action Program for Children (CAPC) and the Canada Prenatal Nutrition Program (CPNP) are jointly managed by the federal and provincial and territorial governments through a Joint Management Committee (JMC) model. This model provides the two levels of government with an opportunity to work collaboratively in an increasingly complex environment. The original funding agreement outlined specific responsibilities, including identifying the gaps where the projects would best reach “at risk target populations”; providing new directions (that is, any underserved or isolated areas); assessing and reviewing projects; and providing guidance and content expertise to applicants.

Each committee typically consists of representation from the relevant provincial or territorial ministries. Membership may also include members from community health organizations. Administrative protocols signed in 1993 set out the terms and conditions and identified funding priorities and funding percentages. The provincial and territorial allocation of program funds was based on the number of children between the ages of 0 and 6. While there is no requirement in the administrative protocols to update the funding allocations based on population changes in the number of children aged 0 to 6, a review of the Statistics Canada Census data revealed that the distribution of children in this age bracket has changed by province and territory since the inception of the programs.

In March 2015, Regional Operations completed a detailed assessment to obtain an update on the roles and activities of each provincial and territorial JMC. The results of the assessment noted that some committees are more active than others (one committee was inactive) and that the active committees play varying roles. For example, the JMC in Quebec has an operational committee to support its activities, while the Ontario committee has made funding reallocation decisions based on changes in the target population’s provincial distribution.

Based on a review of the records of decisions for the various JMCs for fiscal year 2013-14 and 2014-15, it was noted that meetings focused primarily on the renewal process of existing CAPC and CPNP projects. During the renewal process, the Agency recommends the projects to be renewed and asks for concurrence from the JMC members. Project amendments leading to changes in work plans and increased funding are dealt with internally by the Agency and not taken to the JMC for discussion. The audit performed testing in three regions (Ontario,

Manitoba and the North [headquartered in Ottawa]) and found that the JMCs have not reviewed any new projects in the last 10 years.

A review and analysis of the JMCs' terms of reference (TOR) and records of decisions revealed that the majority are not meeting as often as required by the terms of reference. For example, according to the British Columbia TOR, the committee should meet twice a year; however in 2013-14, there was only one meeting to discuss renewals and in 2014-15, the committee did not meet at all. The Alberta Committee is committed to meeting three times a year, but in fiscal years 2013-14 and 2014-15, it only met twice in each year. The TORs for the New Brunswick and Newfoundland and Labrador committees state that they are to meet as required, but in the past two fiscal years, they have met only once, for the purpose of renewing their existing projects.

The audit also found that the schedule for updating the TORs is not standard across the country. Some have not been updated in more than ten years and all are outdated, based on the requirements specified in the individual TORs. For example, the Manitoba CAPC TOR is dated 2006 and is to be updated annually, while its CPNP TOR is dated 2010 and should be updated every two years. The BC TOR is from February 2008 and is supposed to be reviewed annually. Finally, Ontario's TOR does not include a specific requirement regarding updates; however, the last official update occurred in July 2001. CAPC and CPNP would benefit from a review of their committee structure and expectations.

Since the establishment of the committees, there has been a significant evolution in their work. At the outset, the focus was on program start-up, design and development, with an attention to operational requirements. Over time, attention shifted to program maintenance and renewal. As a result of these changes, each committee's terms of reference should be updated to reflect the current model (see [Recommendation 1](#)).

Internal governance

The **Program Governance Committee** (PGC) was created in July 2014 to provide strategic policy direction for the programs, as well as guidance to the Program Management Committee (PMC) and for decision-making. The meetings are held on a quarterly basis, as required by its terms of reference. Membership includes the Director General, Centre for Health Promotion (CHP - Lead), the Director General, Regional Operations (RO) and the Chief Financial Officer. Members of the PMC may also be invited to participate in PGC meetings, as required. Among others, the main objectives of PGC are to provide ongoing direction for the children's programs and address systemic issues with regards to the administration and delivery of the programs. PGC is responsible for the Agency's internal oversight of the programs and is separate from the governance requirements of the JMCs.

Also created in July 2014 was the **Program Management Committee**. Its role is to oversee program delivery and provide operational advice and direction. Committee meetings are held on a monthly basis, as required by the terms of reference. Membership includes the Executive Director, Division of Children, Seniors and Healthy Development (Lead), the Director, Centre for Grants and Contributions (CGC) and Lead Regional Directors for CHP; members

of the operations team may be invited to participate on an as-needed basis. Some of the objectives of this committee are forward planning, priority setting and identifying triggers for notifying the Program Governance Committee of financial, administrative or other project-related concerns.

In conclusion, the programs have an established external and internal governance structure. However, the Joint Management Committees are not operating as intended in the original funding agreement.

Recommendation 1

It is recommended that the Assistant Deputy Minister, Health Promotion and Chronic Disease Prevention Branch, update the terms of reference for the Joint Management Committees, to better align with their current role.

Management response

Management agrees with the recommendation.

Management will review the current terms of reference, engage the Joint Management Committees and update the document as appropriate.

1.2 Roles and responsibilities

Audit criterion: Roles and responsibilities related to the delivery of CAPC and CPNP are documented and communicated.

In order to deliver CAPC and CPNP efficiently and effectively, it is critical to have clearly defined roles and responsibilities. Delivery of the programs is the responsibility of Centre for Health Promotion, but also requires the collaboration of Regional Operations and the Centre for Grants and Contributions within the Office of the Chief Financial Officer (OCFO).

Centre for Health Promotion

As part of the Health Promotion and Chronic Disease Prevention Branch (see [Appendix D](#)), the Centre for Health Promotion (CHP) has a mandate to provide leadership in the form of policy development, strategic and innovative initiatives, programs and investments. CHP is responsible for CAPC and CPNP, and is expected to enable Canada to promote health, reduce health inequalities and prevent chronic disease. CHP supports efforts within and across public and non-public health sectors to promote the health of Canadians and communities. The Centre is expected to empower Canadians through initiatives focused on child development, families, aging and lifestyles. It also administers the contribution programs.

Regional Operations

The regions support CHP in the delivery, management and performance measurement activities of the programs. They also work in conjunction with the Centre for Grants and Contributions (CGC) on the oversight of the programs as it relates to the administration of payments.

Centre for Grants and Contributions

The Centre for Grants and Contributions (CGC) is part of the OCFO. It supports the management of the Agency's grants and contributions programs. CGC is responsible for maintaining the applicant's project information and funding history, payments and project closure. It is also responsible for administrative and financial policy; business processes; administration oversight; quality assurance; and monitoring of expenditures and recipient audits. Finally, CGC provides oversight for the Agency's standard terms and conditions that relate to CAPC and CPNP.

The Agency has standard operating procedures that detail the roles and responsibilities. These are supported with a Business Management Model (BMM). The BMM distinguishes lines of accountability and responsibility under the centralized model for all aspects of grants and contributions management and to clarify requirements for contributing to the completion of tasks.

During the interviews, it was noted that staff frequently referenced the standard operating procedures when questioned about roles and responsibilities. While staff were aware of the BMM, detailed knowledge regarding the content was less evident. For example, the audit conducted testing in three regions and noted that only one of the regions had completed a rolled-up annual report, as expected in the BMM. The audit noted with management that a rolled-up annual report for each region would allow headquarters to identify thematic program issues and best practices. Management indicated that training is ongoing and should address all the responsibilities outlined in the BMM.

Document reviews and interviews with staff at headquarters and in the regional offices support that roles and responsibilities are documented and communicated.

2. Risk management

2.1 Risk management

***Audit criterion:** Risks related to the management and delivery of CAPC and CPNP are identified, assessed and have mitigating strategies that are monitored.*

Identifying, assessing, mitigating and monitoring risks associated with the delivery of contribution programs is an important aspect of ensuring that programs meet their objectives. Identifying potential risk issues through an assessment process assists management in ensuring that the Agency's resources are allocated based on these priorities.

In its 2014 Performance Measurement Strategy, CHP established a process to identify new issues within individual projects and identified challenges associated with data collection and reporting. However, risks that may impact the children's programs as a whole have yet to be considered. Examples of risks could include financial risks related to program delivery, upcoming renewal risks and changes in the distribution of the children's programs' target population.

While the audit found that risks were reported in some documents, it would be beneficial for CHP to develop and monitor a program-specific risk register that includes mitigation strategies and performance measures to assess the effectiveness of these strategies. The information would also enhance the risk intelligence that exists within the Agency and be beneficial in identifying trends and driving program priorities.

Recommendation 2

It is recommended that the Assistant Deputy Minister, Health Promotion and Chronic Disease Prevention Branch, develop a program risk register that includes mitigation strategies and performance measures to track the effectiveness of the mitigating actions.

Management response

Management agrees with the recommendation.

Management will develop a program risk monitor consistent with Agency-wide initiatives, to monitor, mitigate and manage risks associated with grants and contributions programs.

3. Internal controls

3.1 Operational planning

***Audit criterion:** The maternal and child health programs (CAPC, CPNP and CPSS) have operational plans that demonstrate the use of the resources to support program delivery.*

Operational planning is the process by which an organization translates its priorities and program objectives into tangible, effective operational program delivery, program support and management activities. It specifies plans and priorities for the upcoming fiscal year, along with the resources required to deliver these plans. This provides stewardship over public resources and accountability for delivery of its priorities.

The Health Promotion and Chronic Disease Prevention Branch has a two-year branch operational plan (2014-15 to 2016-17) that lists several deliverables related to CAPC, CPNP and CPSS, as well as the planned resources required to carry out the deliverables. The deliverables are listed under the general program activity of addressing maternal, child and family health as an integral part of advancing health equity. Some of the specific deliverables

include developing a renewed approach to performance measurement for CAPC and CPNP; participating in a horizontal assessment of uptake and usage of the CAPC and CPNP knowledge development and exchange products and activities; and completing the CPNP client outcome study. Within the branch, CHP also developed a 2014-2017 Centre for Health Promotion and Regional Operations Agreement, which outlines operational plans to be carried out by the regions and the program staff in headquarters.

Although the branch operational plan identifies the financial resources required to deliver the programs, neither CAPC nor CPNP has received any new funding since 1999. However, the audit did find that in some of the files tested, the contribution agreements had been amended and new funds were added to the projects. To enable such amendments, funds from other grants and contributions programs were transferred to CAPC and CPNP. These one-time funding opportunities were used for new Agency initiatives such as the Fetal Alcohol Spectrum Disorder Initiative or the Stop Family Violence Initiative. One-time additional funding occurrences are a potential short-term solution to increasing funding pressures. However, CAPC and CPNP would benefit from monitoring the financial risk as a part of the overall program risks (see [Recommendation 2](#)).

In conclusion, the programs have an operational plan that includes the required human and financial resources to deliver the plan, which is guided by the Program Management Committee.

3.2 Standards and guidelines

Audit criterion: *Program standards, guidelines and web pages are current and comprehensive.*

It is important that the programs maintain a current and comprehensive web presence that includes standards and guidelines, to ensure that internal and external stakeholders are aware of program objectives and how to access available services.

Standards and Guidelines

Comprehensive program standards and guidelines, introduced in the original funding agreement, are found in both the CAPC and CPNP Guide for Applicants. These guides explain who is eligible for funding, the application process and guiding principles. For example, the CPNP guidelines include mothers and babies, strengthening and supporting families, community based projects and flexibility. These guides were used during the early stages of the programs, when recipients were initially funded. However, since there are no additional program funds, these guides are now not readily available.

Website

The Agency's website includes a section on health promotion and has specific information related to programming on childhood and adolescence. Further, a section contains information on the CAPC and CPNP program objectives and contact information for the public.

On the CAPC and CPNP web pages, there is a list of recipient sites by province. This allows the public to be aware of the services that are available in their community. The audit tested these web pages and found that all program recipients were listed. A list of publications related to maternal and child health (for example, *The Sensible Guide to Healthy Pregnancy*) is also included on the CAPC and CPNP web pages; the publications list was updated in September 2014. Additionally, links are provided to provincial and territorial resources identifying services that compliment CAPC and CPNP.

In conclusion, program standards, guidelines and web pages are current and comprehensive.

3.3 Canadian Perinatal Surveillance System

Audit criterion: *The Canadian Perinatal Surveillance System is designed to collect relevant, timely and accurate perinatal public health data to support decision-making.*

Surveillance is a core public health function for the Agency. The overarching purpose of surveillance is to generate information and knowledge for public health action in both the short and long term. The responsibility for public health surveillance is shared among federal, provincial and territorial and local levels of government, in collaboration with the private sector, non-governmental organizations, health institutions and health professionals and their associations. Data is accessed through existing corporate agreements, special agreements to obtain customized files and memorandums of agreements.

The Canadian Perinatal Surveillance System (CPSS) is a federal surveillance program targeting maternal, fetal and infant health in Canada. The framework includes indicators that describe determinants and outcomes related to the health of mothers, fetuses and babies. Maternal smoking, maternal age, breastfeeding (determinants) and maternal severe morbidity and mortality, infant mortality and prematurity (outcomes) are some examples. Further, the Health Portfolio programs utilize CPSS to guide activities. For example, the monitoring and reporting on national trends for Sudden Infant Death Syndrome (SIDS) by the CPSS helped inform the Agency's ongoing work in promoting safe infant sleep and provided national data on key determinants of health that are used to inform health promotion activities.

As of 2013, CPSS has an external advisory committee that provides expert advice and makes recommendations to the Agency on matters related to perinatal health surveillance. The annual report demonstrates how the committee is responding to its roles and responsibilities. There is also a Provincial/Territorial Collaborators Meeting for the Canadian Congenital Anomalies Surveillance System. The purpose is to formulate collective strategies for improving data, implementing solutions to challenges and identifying surveillance activities pertaining to environmental contaminants and congenital anomalies.

Based on national data availability, CPSS is presently gathering information using the perinatal health indicators framework. Currently, CPSS reports biennially on 16 indicators; additional indicators are reported on through separate research studies. There has not been a data quality assessment to date on the CPSS. However, since CPSS makes up part of a larger surveillance network that has completed a data quality assessment, the program is currently in the process of determining if one is required. It presently relies on corporate practices for its

publications and provides feedback to clients on ways to improve data collection. In terms of privacy, the information gathered to determine the status of and need for privacy assessments indicates that CPSS is low-risk and no privacy assessment is required.

CPSS has clearly identified the constraints it faces concerning data gathering, which include both problems with accessing information from the provinces and territories and limitations unique to specific data questions being reported on. The program continues to work with its data partners to resolve these issues and undertake actions to deal with these limitations, in order to improve data quality and its usefulness in providing guidance for the development of health policy.

CPSS surveillance outputs include reports, fact sheets, peer-reviewed papers, abstracts, presentations and national surveillance data that are used for reporting and to address information needs and requests. Reports are available on the Agency website and the Government of Canada publications website. Since 1997, there have been over 95 CPSS papers published in peer-reviewed journals. CPSS is also responsible for Canada's national Maternity Experiences Survey, which was conducted in 2006-07. There have been recent stakeholder satisfaction surveys undertaken for four of the publications, to measure satisfaction with content, timeliness of information and intended use. The surveys reported positive results on CPSS user satisfaction.

In conclusion, the Canadian Perinatal Surveillance System is designed to collect relevant and timely perinatal public health data to support decision-making.

3.4 Compliance

Audit criterion: *Contribution agreements comply with the Policy on Transfer Payments and the Directive on Transfer Payments.*

Transfer payments are one of the key instruments that the government uses to further policy objectives and priorities. The objective of the Treasury Board *Policy on Transfer Payments* and the related Treasury Board Secretariat's *Directive on Transfer Payments* is to outline the policy requirements and expected results, to achieve effective, risk-based approaches to the design and delivery of transfer payment programs, in order to ensure accountability and value for money for transfer payments.

The audit sampled 20 recipients over two fiscal years and found that all contribution agreements were compliant with the *Policy on Transfer Payments*. However, the interpretation and administration of reporting requirements, including the use of holdbacks, could be improved (see [Recommendation 3](#)). As per section 4.6 of the contribution agreement, the Agency has the right to hold back an amount from the final year of payment. This holdback is released upon submission by the recipient of various items, such as the final cash flow. During fiscal year 2013-14, the final year of the last funding cycle for the programs, a holdback was applied to all CAPC and CPNP recipients. Due in part to the transition to the centralized administrative model, a decision was taken at that time to return the holdbacks to all recipients prior to year-end and without having received the final cash flow report from the recipients. The OCFO is presently revising a number of administrative

procedures, including the holdback process, in order to make it more efficient and effective going forward.

In conclusion, the contribution agreements comply with the *Policy on Transfer Payments*, and it is expected that the administrative changes to be implemented by the OCFO will address the identified inefficiencies.

Compliance with recipient eligibility and continued entitlement

Audit criterion: CAPC and CPNP have a process to establish recipient eligibility and continued entitlement.

Applicant eligibility was established upon approval of the funding agreements in 1993 (CAPC) and 1994 (CPNP). Eligible recipients for CAPC and CPNP include voluntary, non-government and non-profit groups or organizations, associations and educational institutions. Eligible recipients were determined during this initial period and the list of recipients has remained relatively unchanged for the past twenty years. Recipient entitlement is maintained through the submission of cash flow forecasts, work plans reflecting program objectives, annual budgets of eligible expenses and annual reporting of performance against the work plan. These documents are to be prepared and authorized by the pre-authorized recipient signatories.

In order to be entitled to receive an advance payment, recipients must submit a Cash Flow Record of Expenditures. The process involves the preparation of a forecast of eligible program expenses at the start of the year, followed by a summary of expenses versus forecast, submitted at mid-year and year-end. These documents are prepared by the recipient's staff and as such do not provide a full accounting of the financial operations of the recipient or an independent assessment of the recipient's financial status. Obtaining a timely accounting from recipients to ensure that advance payments are spent for authorized purposes is a requirement of the TBS *Directive on Transfer Payments*. The Agency is responsible for ensuring that the total amount of contribution funding paid to a recipient under a contribution agreement does not exceed the eligible expenditures incurred by the recipient in completing the recipient's initiative or project.

The audit tested a sample of 20 recipient files and found that in over 25% of the cases, Cash Flow Forecast and Record of Expenditures forms were received more than four weeks later than the dates specified in the Reporting Plan of the Contribution Agreement (for example, dates for forecast, mid-year, and year-end). In three cases, Cash Flow Statements were signed by recipient staff who were not on the Financial Signing Authority forms found on file.

The cash flows contain generic categories of expenses, and testing found that in 50% of the cases, the year-end expenses balanced exactly with the budgeted amounts. This information is not sufficient to verify actual expenditures related to the work plan. To obtain increased assurance on reported expenditures, the Centre for Grants and Contributions (CGC) has recently started to request general ledgers from select recipients. While general ledgers may provide more detailed information concerning a project's expenditures, they are also prepared by the recipients. This lack of independence may not provide the support and accountability

required for the Agency to ensure that funds are utilized for program objectives and to justify the privilege of the advance payment strategy for all recipients. Furthermore, section 9.2 of the Contribution Agreement states that a “recipient shall provide Canada with a copy of its Annual Financial Statements (identifying Canada’s funding and related project expenses separately from any other income or expenses) within 30 calendar days of the completion of such statements.” However, annual financial statements were not found in 70% of the recipient files sampled.

Other controls to ensure a recipient’s continued entitlement include the regional program consultant’s review of the work plan and detailed budget information, prior to finalizing the contribution agreement. The regional staff’s review is to provide assurance to CGC that the work plan reflects the program objectives and that the budget information is reasonable for the activities identified. Annually, the regional staff reviews the recipient’s annual reporting tool and provides concurrence to CGC that the project’s milestones have been achieved and that the work plan deliverables have been met.

Table 1: Ranges of annual CAPC and CPNP contribution amounts, 2014-15

Ranges of annual CAPC and CPNP contribution amounts	Distribution by percentage
\$0 - \$50,000	24.4%
\$50,001 - \$100,000	25.0%
\$100,001 - \$150,000	14.3%
\$150,001 - \$200,000	10.7%
\$200,001 - \$350,000	13.0%
\$350,001 - \$500,000	6.9%
\$500,001 - \$1,500,000	5.7%
Total	100%

The audit found that administration of the recipient files is the same, regardless of the annual transfer amounts. Administration is based on the risk assessment, without consideration of the funds transferred. As Table 1 shows, contribution amounts in 2014-15 for both CAPC and CPNP ranged from \$8,330 to \$1,490,000, with 49.4% of the recipients receiving less than \$100,000 per year and 50.6% of recipients receiving more than that amount. The average contribution amount in 2014-15 was \$166,000. Given this range, it would be important for the Agency to increase its financial reporting expectations, so that they are commensurate with the funds being transferred.

While CAPC and CPNP have a process to establish recipient eligibility and continued entitlement, with only recipient-prepared cash flow statements and selected general ledgers, Agency staff are unable to ensure that advance payments are being spent for authorized purposes and that unexpended balances (in the hands of recipients) are reasonable in regards to the recipient’s cash flow requirements and in line with the requirements of the agreement and transfer payment. Interviews with staff indicated that advance payments were required to

ensure timely program delivery. For files without annual audited financial statements, there is a lack of definitive evidence to indicate the actual financial situation of the recipients.

Recommendation 3

It is recommended that the Chief Financial Officer:

- a) Revise the financial oversight requirements in order to support eligible expenditures and to be in compliance with the contribution agreement; and*
- b) Ensure that advance payments to recipients are utilized only when essential to the achievement of a project's objectives.*

Management response

Management agrees with the recommendation.

To strengthen grants and contributions administration and compliance, the OCFO, in consultation with the Centre for Health Promotion, will revise the Contribution Agreement's financial reporting requirements to better align with the Risk-based Monitoring Strategy approved by the Executive Committee in March 2015. A comprehensive review will be conducted by the OCFO to determine the full scope of reporting requirements and to ensure that the Agency's agreements align with current management practices.

As well, in March 2015, the Executive Committee approved a revised advance payment approach based on risk level, recipient need and materiality. Starting in March 2016, in order for recipients to receive advance payments, a justification form and the latest audited financial statements will need to be submitted to the Agency for review and approval. This new practice, which aligns with the *TB Policy on Transfer Payments*, will ensure that advance payments are restricted to those recipients for whom an advance is essential for the achievement of the project's objectives and where a reimbursement approach would result in a serious cash flow problem. In all cases, whether delayed or not, Section 33 of the *Financial Administration Act* requires supporting documentation (cash flow forecast) prior to issuing an advance payment.

3.5 Recipient monitoring

Audit criterion: *Risk-based recipient monitoring activities are conducted, including the review of recipient reporting, before the release of future payments.*

The *Policy on Transfer Payments* sets out broad roles and responsibilities for the Treasury Board Secretariat, Ministers and Deputy Heads in the design, delivery and management of transfer payment programs. A key element of the management of these programs is having monitoring practices that facilitate the proper use of public funds, compliance with the terms of the agreements through the early identification of potential risk factors and timely intervention with recipients. Monitoring assists in allowing for the adjustment and reallocation of funds and increasing the likelihood of success for initiatives.

As an element of the grants and contributions transformation, the CGC, in collaboration with program management, established a risk-based approach for monitoring agreements. This approach touches upon the entire process, from payments to recipients to monitoring project activities and expenditures.

The application of the risk-based monitoring strategy is determined by the recipient's risk assessment (that is, low, medium or high). Risk is used to determine administrative requirements for recipients. For example, a high-risk recipient may require active monitoring to ensure adherence to the terms and conditions, while a low-risk recipient might require less active monitoring. The risk-based monitoring strategy includes the frequency of payments, holdback amounts, reporting requirements (activity and financial), site visits, frequency of risk assessment updates and recipient audit requirements (see [Appendix E](#)).

Annually, the regional program consultants give information to CGC regarding the status of work plan activities, milestones and annual reporting. They also provide assurance that the project has no outstanding issues requiring follow-up. The program consultants are expected to provide this assurance using information they have obtained from formal contact (such as telephone calls and site visits) with the recipient, as stipulated in the risk-based monitoring strategy. In cases where the program consultant cannot provide assurance, corrective action may be taken by the CGC (for example, deferral of the next advance payment).

The program consultants use a project monitoring checklist, which contains questions to guide them when monitoring the activities of a project. The questions are designed to generate discussion and assist the regions in determining if the recipient is adhering to the work plan activities and identifying any potential issues for follow-up. The work plan follow-up monitoring form tracks required and subsequent communication with the recipient. The CGC may also use this form to keep track of financial issues and to follow up with the recipient.

If necessary, the regions and CGC work together to recommend stopping payments to recipients. The regions also advise the Centre for Health Promotion of any monitoring issues. Although rare, the audit noted two instances where additional steps were taken to manage recipient issues. A recipient in the Northern region who was medium-risk in 2013-14 became high-risk in 2014-15 when issues related to budget and project delivery were discovered. Future payments to the recipient were stopped until the general ledger was obtained. The Ontario Region also provided the auditors with documentation of a similar situation in 2013-14, where CGC was advised by the program consultant that the project should have no additional payments processed, due to concerns related to the sponsoring organization. In 2014-15, the regions identified that the work plan activities had not been running at full capacity and CGC identified that requests for reports and budget revisions were often late or incorrect.

As mentioned, the recipient risk assessment is a key driver for the application of the risk-based monitoring strategy, thus making it imperative to ensure that recipient risk assessments are accurate and current. However, as a result of the additional work required for the implementation of the new Grants and Contributions Information Management System

(GCIMS), a management decision was made to roll-over the recipient risk assessments prepared in 2013-14. The same approach was used at the end of 2014-15 and 2015-16. Therefore, the vast majority of the current low-risk recipients have not had their risk assessments updated for the past three years. As Table 2 indicates, of the 524 CAPC and CPNP recipients, 95% were classified as low-risk in 2014-15.

Table 2: Recipient risk assessments by program, 2014-15

2014-15 fiscal year					
Transfer Payment Program	Total Value	Low %	Medium %	High %	Total %
CAPC	\$54,874,998	94.3%	5.7%	-	100%
CPNP	26,757,290	96.6%	2.5%	0.8%	100%
TOTAL	\$81,632,288	95.5%	4.1%	0.4%	100.0%

The current Risk-based Monitoring Strategy states that low-risk recipients will not be subject to an annual risk assessment update unless there is new information to suggest a change in the risk level. Although CGC has implemented a process to identify potential issues, there is a risk that given the reduction in the number of site visits by the regions, the cumulative impact of smaller issues that may affect a project in a negative manner will not be identified. There is also the possibility that the lack of annual risk assessments of low-risk projects may not identify trends in CAPC and CPNP that could have an impact on the delivery of these programs in the future. Finally, the current recipient risk assessment tool is not specifically tailored to CAPC and CPNP. Through interviews and testing, it was noted that the risk assessment tool is not always able to represent the “true” risk level of the recipients.

Given the importance of the recipient risk assessment to internal controls, there is a concern that the risk assessments for low-risk projects do not reflect the actual risk level because the assessments are not updated on a regular basis.

Recommendation 4

It is recommended that the Chief Financial Officer update the recipient risk assessments and conduct monitoring.

Management response

Management agrees with the recommendation.

Starting in February 2016, the OCFO will conduct an annual risk assessment of all contribution agreements within the Portfolio. This approach expands on the existing Risk-Based Monitoring Strategy requirement to annually assess risk for medium and high-risk projects. As a result, the OCFO will ensure that CAPC and CPNP recipient risk assessments are updated regularly.

Recipient audits

Audit criterion: *There is a risk-based recipient audit plan and recipient audits are conducted. Results are used to inform CAPC and CPNP program decision-making.*

Another important component of the monitoring approach is the risk-based recipient audit plan and the recipient audits that are conducted by the Centre for Grants and Contribution (CGC).

The recipient risk-based audit plan is developed based on input from CGC, the regions and the programs. Specific factors that are considered for a recipient to be added to the audit plan include results of the last site visit or communication, an abrupt change in the recipient's Board of Directors or Executive Director, findings from ongoing project monitoring activities, irregularities identified in previous audits and recipient activities not compliant with the terms of the contribution agreement.

The 2014-15 fiscal year was the first time that CAPC and CPNP recipient audits were shared with the Programs area. During this period, the recipient audit function scheduled six recipient audits related to CAPC or CPNP projects. Of these six audits, five were completed. All of the completed audits identified the need to recover funds that the recipient had received from the Agency, ranging from \$7,000 to \$107,000. These overpayments related mainly to financial management issues and no cases of misappropriation of funds were identified in any of the CAPC or CPNP recipient audits. The completed audit reports were forwarded to the programs for the development of an action plan to resolve any systemic issues identified.

The Agency has a risk-based recipient audit plan that is updated annually. The recipient audit reports are provided to the programs. Given that 2014-15 was the first year during which the programs began receiving recipient audit reports, they have not yet identified potential operational trends that could influence decision-making at the program level.

3.6 Results and performance

Audit criterion: *CAPC and CPNP have a performance measurement strategy that supports the decision-making process.*

Results and performance information are part of a program's internal controls. This information can provide management with performance information to facilitate decision-making processes and the identification of potential issues that may require mitigation measures prior to the emergence of more complex problems. The Agency's management and external stakeholders require performance information to determine the extent to which expected results have been achieved and to explain why certain established targets have been exceeded or have not been met. It is essential that the appropriate performance measures be monitored regularly in terms of planned results, and that this information then be used to support the management decision-making process.

In May 2014, the Centre for Health Promotion developed a new joint Performance Measurement Strategy for CAPC and CPNP. This evergreen document not only contains extensive information on what type of performance information will be collected and used by the programs, but also provides an overview of the programs, the CAPC and CPNP logic model and the programs' performance measurement plan and evaluation strategy.

The CAPC and CPNP Performance Measurement Strategy identified eight program outputs and outcomes that will be assessed against eighteen performance indicators. For the first time, outputs and outcomes specifically related to the knowledge development and exchange function are also included. Reporting on the indicators in the Performance Measurement Strategy requires the collection of information on a continual basis from individual projects and provides an overall assessment of the programs. During a review of the Results and Data Matrix, it was noted that seven of the eighteen performance indicators (39%) include situations where the baseline and the target information have not yet been established. However, five of the seven indicators relate to the measurement of the newly articulated knowledge and development exchange function, and studies to inform the baseline and target for these indicators are scheduled for completion by August 2015.

Up to the end of 2012, the regions used the Integrated National Analysis Tool (INAT) to assess individual projects. The main purpose of the reports generated using the tool were to provide an overview of the information collected from CAPC and CPNP projects and allow projects to situate themselves in relation to projects in the same province or region and to projects across Canada.

INAT collected information on a number of subjects, including the operations of the project; the project's programs, services and activities; funding, in-kind donations, staffing and volunteers; and partnerships and community involvement. In fiscal year 2013-14, INAT was replaced with the Children's Programs Performance Measurement Tool (CPPMT) for data collection on CAPC, CPNP and Aboriginal Head-Start in Urban and Northern Communities projects. Data collection questions in the new tool are fewer and more streamlined.

The results were collected for the first time in mid-2014. Henceforth, this information will be collected every two years. According to the program, results from 2014 and 2016 will be available to provide insights into the program and project performance going forward.

For the 2014 project renewal process, the Agency relied predominately on monitoring information and not on specific performance measurement data to make project renewal decisions. Project renewal decisions were based on the compliance monitoring of the 623 individual contribution agreements by the CGC and the regions, rather than on specific performance results for the individual projects. Management noted that as a result of the new performance information, from hereon in, they will be able to identify projects that they consider to be high achievers, as well as those that may require additional oversight to improve performance.

In conclusion, in May 2014, CHP introduced the CPPMT, a new performance measurement strategy and tool. CPPMT is a continuation of and an improvement on INAT, which had been

used in the past. During the previous renewal process, the programs utilized only project monitoring information; however, the programs are planning to incorporate their new performance measurement information into ongoing funding decision-making.

C - Conclusion

The Community Action Program for Children (CAPC), the Canada Prenatal Nutrition Program (CPNP) and the Canadian Perinatal Surveillance System (CPSS) have been in existence since the mid-1990s. They are designed to support families and individuals at risk from poverty, physical and mental abuse and addiction, among others. During the last two fiscal years, the Agency's children's programs have gone through a significant transformation, by centralizing the administration of the grants and contributions under a new system (the Grants and Contributions Information Management System or GCIMS). As a result, the internal controls have been strengthened because of the centralization and automation. The administration of the programs is also well controlled through an operational plan and an agreement between headquarters and the regions that includes details on the human and financial resources required to deliver CAPC and CPNP activities.

The children's programs have an internal and external governance structure in place. However, the Provincial/Territorial Joint Management Committees (JMC), which were established in the original funding agreement, are currently not operating as intended. While management is aware of the current program risks, they have not been formally documented or assessed with mitigating strategies and performance measures to determine effectiveness.

The programs are compliant with the Treasury Board *Policy on Transfer Payments* and the related Treasury Board Secretariat *Directive on Transfer Payments*. However, based on the sample of recipient files tested, it was noted that certain key internal controls could be strengthened to support the verification of the actual expenditures incurred by the recipients. As well, the recipient risk assessments have not been updated for three years and the majority are assessed as low-risk, resulting in less oversight.

Ongoing project monitoring is being carried out by the Centre for Health Promotion, the Centre for Grants and Contributions and Regional Operations. This information, along with the results from the recipient audits, will be used to support decision-making at the project level. Another key piece of performance information will be derived from the new performance measurement strategy and data capturing tool. The new data, once analyzed, will also be used to support planning and ongoing funding decisions.

CPSS is part of a larger public health surveillance framework. It is designed to collect relevant and timely perinatal public health data that supports decision-making. A recent CPSS stakeholder satisfaction survey that measured satisfaction with content, timeliness of information and intended use found that CPSS users reported positive results with the information received.

The audit makes four recommendations to strengthen the programs' governance structure, risk management and internal controls.

Appendix A – Lines of enquiry and criteria

Audit of Maternal and Child Health Programs	
Criteria Title	Audit Criteria
Line of Enquiry 1: Governance	
1.1 Governance structure ¹	The Community Action Program for Children and the Canada Prenatal Nutrition Program have an effective governance structure to support program objectives and comply with the funding agreement.
1.2 Roles and responsibilities ^{1,3}	Roles and responsibilities related to the delivery of CAPC and CPNP are documented and communicated.
Line of Enquiry 2: Risk Management	
2.1 Risk management ¹	Risks related to the management and delivery of CAPC and CPNP are identified, assessed and have mitigating strategies that are monitored.
Line of Enquiry 3: Internal Control	
3.1 Operational planning ¹	The maternal and child health programs (CAPC, CPNP and CPSS) have operational plans that demonstrate the use of their resources to support program delivery.
3.2 Standards and guidelines ²	Program standards, guidelines and web pages are current and comprehensive.
3.3 Canadian Perinatal Surveillance System ²	The Canadian Perinatal Surveillance System is designed to collect relevant, timely and accurate perinatal public health data to support decision-making.
3.4 Compliance ^{2,3}	Contribution agreements comply with the <i>Policy on Transfer Payments</i> and the <i>Directive on Transfer Payments</i> .
	CAPC and CPNP have a process to establish recipient eligibility and continued entitlement.
3.5 Recipient monitoring ^{2,3}	Risk-based recipient monitoring activities are conducted, including the review of recipient reporting, before the release of future payments.
	There is a risk-based recipient audit plan and recipient audits are conducted. Results are used to inform CAPC and CPNP program decision-making.
3.6 Results and performance ¹	CAPC and CPNP have a performance measurement strategy that supports the decision-making process.

¹ Office of the Comptroller General – Audit Criteria related to the Management Accountability Framework: A Tool for Internal Auditors, March 2011

² Business Management Model

³ TB *Policy on Transfer Payments*; TBS *Directive on Transfer Payments*

Appendix B – Scorecard

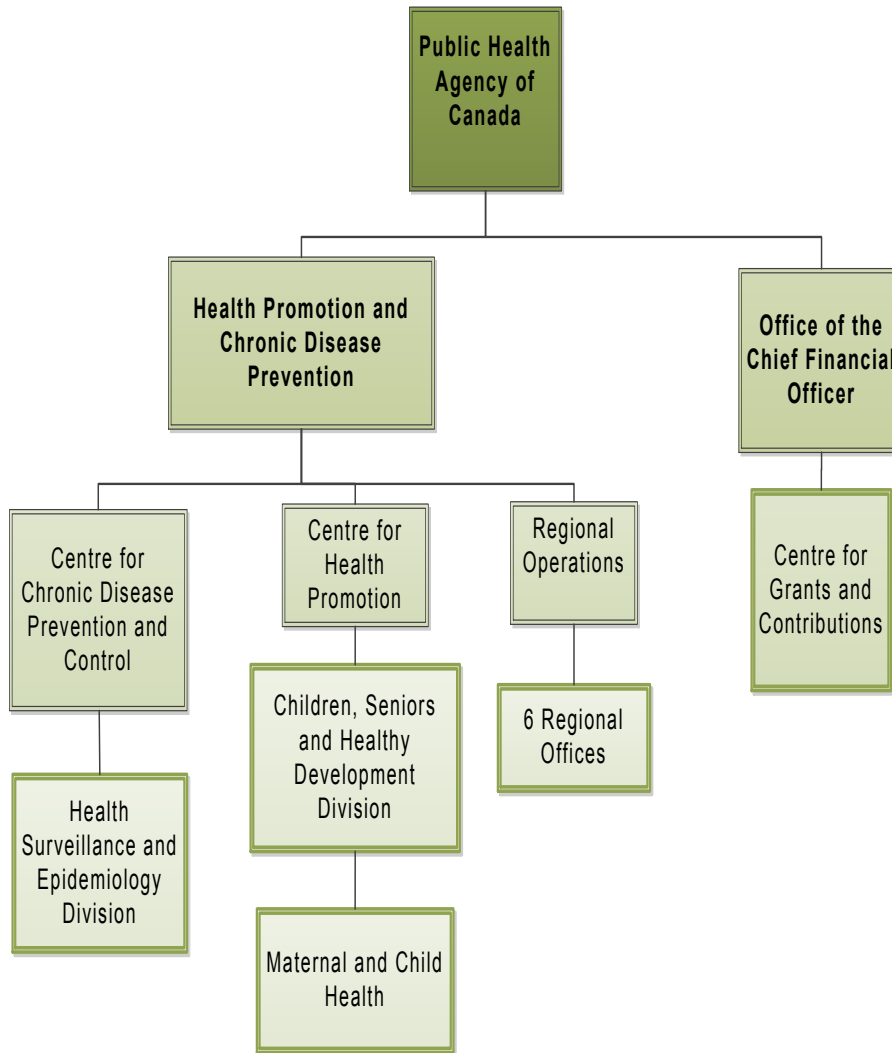
Audit of Maternal and Child Health Programs			
Criterion	Rating	Conclusion	Rec #
Governance			
1.1 Governance structure		The external governance model needs to be reviewed, since the JMCs are not operating as intended in the funding agreement.	1
		The Agency has implemented an internal governance model.	
1.2 Roles and responsibilities		Staff in both the regions and at headquarters have roles and responsibilities that are documented and communicated.	
Risk Management			
2.1 Risk management		Program risks should be formally identified, documented and monitored.	2
Internal Controls			
3.1 Operational planning		The programs have operational plans that detail the human and financial resources required to deliver those plans.	
3.2 Standards and guidelines		The program standards, guidelines and web pages are current and comprehensive.	
3.3 Canadian Perinatal Surveillance System		CPSS is designed to collect relevant and timely perinatal public health data.	
3.4 Compliance		Contribution agreements are in compliance with the <i>TB Policy on Transfer Payments</i> and the <i>TBS Directive on Transfer Payments</i> . The Agency is currently updating administrative actions to make them more efficient.	3
		With only cash flows and selected general ledgers, Agency staff are unable to ensure that expenditures are eligible.	3
3.5 Recipient monitoring		Risk assessments should be updated.	4
		Recipient audits have just recently been shared with the programs. The results of the audits should be used for decision-making.	
3.6 Results and performance		New performance measures and data capture should be used to inform decision-making.	

Satisfactory	Needs Minor Improvement	Needs Moderate Improvement	Needs Improvement	Unsatisfactory	Unknown; Cannot Be Measured

Appendix C – CAPC and CPNP contributions summary

Centre/Region	Fiscal Years			
	2013-14		2014-15	
	Number of contribution agreements	Contributions expenditures	Number of contribution agreements	Contributions expenditures
Centre for Health Promotion	4	\$710,557	409	\$54,874,998
Atlantic	45	7,337,073	-	-
Northern	14	2,364,446	-	-
Ontario	88	17,598,431	-	-
Prairie	37	5,237,567	-	-
Quebec	200	11,455,127	-	-
Western	63	11,661,687	-	-
TOTAL CAPC	451	\$56,364,888	409	\$54,874,998
Centre for Health Promotion	1	\$655,782	214	\$26,757,290
Atlantic	25	2,650,364	-	-
Northern	18	2,288,744	-	-
Ontario	82	8,373,242	-	-
Prairie	15	2,811,574	-	-
Quebec	79	5,433,470	-	-
Western	74	5,632,733	-	-
TOTAL CPNP	294	\$27,845,909	214	\$26,757,290
TOTAL CAPC and CPNP	745	\$84,210,797	623	\$81,632,288

Appendix D – Public Health Agency of Canada organizational chart



Legend:

- Branch, division, centre or unit involved in CAPC, CPNP or CPSS

Appendix E – Risk-based monitoring strategy

	RISK MITIGATION MEASURES	LOW	MEDIUM	HIGH
Risk Tolerance Reflected in Agreement	Payments	Based on eligible expenses and approved payment schedule		
	<ul style="list-style-type: none"> Reimbursement Advance based on annual forecast 	\$100 K or less - 100 % More than \$100 K - 8 months; up to 4 months	8 months; up to 4 months	Every 3 months
	Holdback (applied to final year of agreement)	10% of total value of the agreement		
	Activity reporting			
	<ul style="list-style-type: none"> Progress Reports Annual Reports 		1	2
Monitoring	Financial reporting			
	<ul style="list-style-type: none"> Cash flow/year (excluding forecast) supported by a General Ledger (GL) 	\$100 K or less – 2 (once during the year and at year-end) More than \$100 K – 3 (twice during the year and at year-end)	3 (twice during the year and at year-end)	4 (three times during the year and at year-end)
	Work plan monitoring (Programs)	2/year	4/year	8/year
	<ul style="list-style-type: none"> Formal Contact, e.g., call/meeting (minimum) Activity Report Review 	as per the reporting requirements of the agreement		
	<ul style="list-style-type: none"> Annual Site Visit (% of recipients) 	10%	25%	100% (unless a recipient audit is scheduled)
Monitoring	Financial monitoring using GL (CGC)	as per the reporting requirements of the agreement		
	<ul style="list-style-type: none"> Quality check of cash flow Due Diligence 	20% of agreements; examine 10 % of expenditures	All agreements; examine a minimum of 25% of expenditures	All agreements; examine 50% of expenditures
	<ul style="list-style-type: none"> Year-end Reconciliation 	All agreements		
	Risk Assessment Update	If new information suggests a change in risk level	Annual	Annual
	Follow-up with recipient on results			
Recipient audit	All agreements/recipients are subject to random audits Agreements with provinces/territories are considered for audit on an exception basis		50 % of recipients	