GOVERNMENT OF KENYA

COUNTY GOVERNMENT INTERNAL AUDIT MANUAL

October 2021

Distribution of this manual

This manual is strictly for use by all internal auditors at the County Executive and County Assemblies in the Republic of Kenya. No parts of this manual may be copied without the express written permission of its authors.

How to use this manual

This manual has been prepared to conform to the International Professional Practice Framework issued by the Global Institute of Internal Auditors. The International Standards for the Professional Practice of Internal Auditing are highlighted in grey in the manual. Internal Auditors are encouraged to refer to the current version of the standards available at www.global.theiia.org.

Audit templates will be provided separately at the Public Sector Accounting Standards Board website www.psasb.go.ke. The templates are designed to assist internal auditors in implementing best practices in internal auditing and auditors may customize the templates to suit their individual circumstances.

Auditors should refer to the acronyms and definitions of words provided to understand the meaning attributed to names, words and phrases used in this manual.

Contact Information

The County Internal Audit Manual was developed by the Public Sector Accounting Standards Board in collaboration with the Internal Auditor Generals' Department in the National Treasury. Section 194 of the Public Finance Management Act, 2012, mandates PSASB to prescribe internal audit procedures. The Board, through a Gazette notice No. 5440 dated 8th August 2014, prescribed the International Professional Practice Framework for Internal Auditing Standards for use by public sector entities.

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FOREWORD

Internal audit is a mandatory service in all public-sector entities, as stipulated in Public Finance Management Act, 2012 (PFMA) section 155(1) (a) which requires all county government entities to establish internal audit functions. Public Finance Management Regulations (PFMR) r154 require these internal audit functions to conduct internal audit in accordance with the International Professional Practice Framework (IPPF) and with policies and guidelines issued by the Public Sector Accounting Standards Board (PSASB) to ensure uniformity and consistency across County Governments.

The Office of the County Head of Internal Audit Services (CHIAS) at County Executive Treasury and Head of Internal Audit at County Assembly are charged with the responsibility of coordinating internal audit services in the two arms of government at the county as stipulated in PFMA s155(3) and detailed in the County Government Public Financial Management Regulations (PFMR) r157. In discharging this role, the Head of Internal Audit (HIA) shall coordinate with: the Internal Auditor-General Department (IAGD) under the National Treasury, which is charged with the responsibility of enhancing capacity of internal audit services in the public sector as stipulated in the PFMA s155(3) and PFMR r164 (1)(e); The HIA shall further be expected to coordinate with the Public Sector Accounting Standards Board that is charged with issuing policies and guidelines that ensure uniformity and consistency of internal audit in the public sector as stipulated in PFMR r194.

The legal and policy mandate of Head of Internal Audit is to support the County Executive Committee Member County Treasury, the Accounting Officer at the County Treasury and other Accounting Officers in the county government entities in ensuring they have effective internal audit functions that can enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight. The Head of Audit in the County Assembly is also charged with the responsibility of supporting and advising the Clerk of the County Assembly as the Accounting Officer, and managing the Internal Audit activities.

Internal Audit in the county government entities plays a critical role in evaluating and providing reasonable assurance that the county government entities have implemented effective and efficient governance, risk management and control systems that will ensure the entities achieve their mandate and strategic objectives.

The establishment of this Manual is therefore a milestone in the setting of accepted government standards in internal auditing and intends to streamline the operations of Internal Audit in all the county government entities in line with IPPF.

CPA STEPHEN MASHA
INTERIM BOARD CHAIR, PSASB

PREFACE

The County Internal Audit Manual is a handbook for use by County Internal Auditors in the delivery of internal auditing services in all Counties and their entities. It consolidates and brings up to date existing audit guidelines. The Manual supports the development and standardization of Internal Auditing in the County Governments. Implementation of this manual will demonstrate compliance with the Global Institute of Internal Auditors' International Professional Practice Framework (IPPF) and enhance the quality of Internal Audit work towards improvement of governance, transparency, accountability and integrity in public finance management.

This Manual contains a comprehensive framework for internal audit including internal audit techniques, methods and a spectrum of activities that would form part of the audit function for the various departments/ entities in County Government. It articulates the roles and responsibilities of internal auditors, which will go a long way in enhancing the understanding and appreciation of internal auditing services by key stakeholders. It also includes the roles and responsibilities of the management relating to internal audit in the counties.

The manual also contains templates for use as a means of providing guidance to ensure consistency in approach and methodology. Implementation of this manual will extensively assist in enhancing the professional capacity of the county internal auditors and help in eliminating the present challenges around efficiency and effectiveness.

The manual will be updated as guided herein to incorporate new internal audit methodologies and techniques including experiences and lessons learnt in the implementation process. In addition detailed guidelines will be developed to ensure the manual is helpful in sharpening the skills of the county internal audit personnel.

FCPA DR. NICHOLAS LETTING'
<u>CHAIRMAN, INTERNAL AUDIT STANDARDS COMMITTEE</u>

ACKNOWLEDGEMENT

The County Government Internal Audit Manual has been developed to guide internal audit units and internal auditors in County Executive and County assemblies and their entities. This Manual reflects international best practices and standards, is benchmarked against the policies and procedures of a number of countries and organisations and aligned to County Governments Audit Committee Guidelines, Internal Audit Guidelines and the Public Sector Risk Management guidelines among other regulations.

We wish to acknowledge the invaluable support and encouragement received from both the County Executive Committee Members-Finance and Economic Planning, County Treasuries and the Accounting Officers/Chief Officers-Finance and Economic Planning, County Assembly Clerks, County Assembly Forum and Heads of Internal Function of both the Executive and County Assembly from the 47 Counties for their support and input towards the development of the County Government Internal Audit Manual.

We also appreciate the contribution received from the Institute of Internal Auditors, Kenya and the Institute of Certified Public Accountants of Kenya for their great support in ensuring this manual meets international standards. Special thanks goes to the GIZ who funded the development of the initial draft manual, Public Sector Accounting Standards Board in collaboration Internal Auditor General's Department under the National Treasury who prepared the current version of the manual.

FCPA FREDRICK RIAGA
<u>CHIEF EXECUTIVE OFFICER, PSASB</u>

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LIST OF ILLUSTRATIONS

LIST OF ABBREVIATIONS

ACFE	Association of Certified Fraud Examiners
CAATS	Computer Assisted Audit Tools and Techniques
CAF	Current Audit File
CASB	County Assembly Service Board
CHIAS	County Head of Internal Audit Services
CIA	Certified Internal Auditor
COSO	Committee Of Sponsoring Organizations of the Treadway Commission
CoK	Constitution of Kenya
CPSB	County Public Service Board
EACC	Ethics and Anti-Corruption Commission
HIA	Head of Internal Audit
IAGD	Internal Auditor General Department
IAGCGE	Internal Audit Guidelines for County Government Entities
IAU	Internal Audit Unit
ICF	Internal Control Framework
ICT	Information Communication Technology
IIA	Institute of Internal Auditors
IPPF	International Professional Practice Framework
ISO	International Organization for Standardization
ISPPIA	International Standards for the Professional Practice of Internal Auditing
OAG	Office of the Auditor General
PAC	Public Accounts Committee
PAF	Permanent Audit File
PFM	Public Finance Management
PFMA	Public Finance Management Act
PFMR	Public Finance Management Regulations
PIAC	Public Investment and Accounts Committee
PPRA	Public Procurement Regulatory Authority
PSASB	Public Sector Accounting Standards Board
QAIP	Quality Assurance and Improvement Program

PREAMBLE

A. BACKGROUND INFORMATION

The Public Finance Management Act (PFMA), 2012, requires County Government entities to establish Internal Audit functions and Internal Auditing Committees. The PFM Act and Public Financial Management Regulations (PFMR), 2015, gave effect or replaced previous legal instruments establishing internal audit function in Government including:

1. Government Financial Management Act, 2004 which enhanced the legal mandate of the Internal Audit function.
2. Treasury Circular no. 16/2005 that required Government Ministries, Departments and Agencies to establish Audit Committees that had the responsibility of providing oversight over the Internal Audit function.
3. Treasury Circular no. 18/2005 that required management to act on audit reports within two weeks and the Internal Audit Department to submit budget performance reports to Parliament semi-annually. National Budget Speech of 2005 requiring Accounting Officers and Internal Audit Units in the public sector to adopt of risk-based internal audit methodology.
4. Treasury Circular no. 3/2009 of 23rd February 2009 that required entities to develop risk management frameworks.

The County Governments have made numerous strides following the establishment of Internal Audit function in each County Executive and County Assembly. In 2016 the County Governments also started establishing Audit Committees in compliance with the PFMA.

The following Internal Audit Units have been established at the County Government level:

1. Internal Audit Unit in the County Executive also referred to as the Internal Audit Service Directorate of the County Treasury;
2. Internal Audit Unit in the County Assembly;
3. Internal Audit Unit in other public bodies and agencies in the County Government including City Municipality, Urban Area, Water Companies and other agencies owned by County Governments.

The Heads of Internal Audit (HIA) in the county government entities are expected to liaise with each other to ensure the mandate of the Internal Audit Function is achieved and the roles and responsibilities of the Internal Auditors are efficiently and effectively achieved. The HIA in the county government entities shall also coordinate with the Internal Auditor General, IAG, who shall support the IAUs in the county governments in achieving their mandate and undertaking their roles and responsibilities.

B. INTRODUCTION

The Internal Audit function has undergone reforms to enable it cope with the challenges of a dynamic practising environment. The County Government Internal Audit Manual was developed to guide County Government Internal Auditors in the adoption of International Internal Auditing Standards to better deliver internal auditing services. The Manual includes procedures on audit engagements and management of the internal audit unit, outlines the roles and responsibilities of Internal Auditors, and provides templates to help auditors document procedures carried out.

The Manual reflects best practices in Internal Auditing as stipulated in the IPPF promulgated by the Global Institute of Internal Auditors (IIA). This Manual together with the internal audit guidelines provide a clear roadmap on practical implementation of Internal Audit Standards and position Internal Audit to contribute to the improvement of governance, transparency, accountability and integrity in public finance management. Additional guidelines will be issued from time to time on specific areas on internal audit work.

Through Gazette Notice 5440 of 8 July 2014, Public Sector Accounting Standards Board approved the adoption and application of IPPF for Internal Auditing Standards of all Internal Auditors by all public-sector entities.

In order to continue adding value in the delivery of Internal Auditing services, the Manual will be subject to amendments and periodic reviews to cater for new developments in the profession and include experience and lessons learnt in its implementation.

C. OBJECTIVES OF THE MANUAL

2040 – Policies and Procedures
"The Head of Internal Audit shall establish policies and procedures to guide the internal audit unit"

This County Government Internal Audit Manual (Manual) is developed and issued by the Public Sector Accounting Standards Board in accordance with its mandate in PFM Act s194 to provide frameworks and set generally accepted standards for the development and management of accounting and financial systems by all County Government entities. The manual is aligned with the requirements of the Public Finance Management Act, 2012 (PFMA), Public Finance Management Regulations 2015 (PFMR r154) , the IPPF, Internal Audit Charter, Internal Audit Guidelines for County Government Entities 2016 (IAGCGE) published by the Public Sector Accounting Standards Board (PSASB) and the Audit Committee Guidelines for County Governments.

The Internal Audit Manual is intended to:

1. Provide internal auditors of the County Government Internal Audit units with practical professional guidance, tools, and information for managing the Internal Audit unit, and steps for planning, executing and reporting on Internal Audit work. The use of the Manual should help bring a systematic and disciplined approach to the audit of governance, risk management, and control processes, and additionally assist the Internal Auditor to meet the goal of adding value to their respective organisations.
2. Enhance the quality and effectiveness of the Internal Audit Service by paving the way to put into practice procedures and processes that would help it conform to International Professional Practices Framework (IPPF).
3. Be a source of reference on Internal Audit for County Government internal auditors.

The Manual provides perspectives on Governance, Risk Management, Internal Control, and Fraud that underpin almost all internal audit work. The Manual also provides procedures and processes for maintaining a quality Internal Audit service.

Users of the Manual are expected to have at least basic knowledge and understanding of management frameworks including governance, risk management and control processes. In addition to the Manual, Internal Auditors and users of the Manual are expected to: familiarize themselves with the IPPF; have a comprehensive understanding of the Constitution of Kenya, laws, regulations, policies, procedures, strategies, rules, and directives established by the Parliament, National Government, various County government entities that govern the areas they are auditing and funding entities requirements including international and local development agencies and financial institutions in order to design appropriate audit procedures.

The Manual is designed to be flexible and unrestrictive. In particular, it is not intended to restrict any initiative that Internal Auditors can bring to their work based on prior work experience, knowledge, and skills. In many instances, Internal Auditors are encouraged to exercise professional judgement, particularly in determining levels of risk, adequacy of internal control processes, and types of tests to carry out.

Where an Internal Auditor faces difficulties in understanding or complying with the Manual, then appropriate clarifications and/or assistance should be obtained from the Head of Internal Audit. The HIA may seek further guidance from the Public Sector Accounting Standards Board (PSASB) and the Internal Auditor General Department (IAGD).

D. SCOPE AND APPLICATION OF THE MANUAL

This manual applies to the internal audit units under the County Governments and their entities including Departments and Agencies.

E. EFFECTIVE DATE AND REVIEW

This manual shall be effective on the date approved by the Principal Secretary. The manual will take account of the latest international developments in internal audit and shall be reviewed every three years or when circumstances dictate.

F. STRUCTURE OF THE MANUAL

Internal audit units exists to help an entity accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. This manual demonstrates the systematic approach as outlined in the chapters herein as follows;

Chapter 1 Purpose, Independence and Objectivity

Chapter 2 Internal Audit Unit Structure

Chapter 3 Nature of Internal Audit Services

Chapter 4 Managing the Internal Audit Unit

Chapter 5 Internal Auditing Process

Chapter 6 Quality Assurance and Improvement Programme

CHAPTER 1 – PURPOSE, INDEPENDENCE AND OBJECTIVITY

Chapter 1 covers:

(i.) Definition of Internal Auditing

(ii.) Mission of Internal Audit

(iii.) Internal Audit Charter

(iv.) Core Principles

(v.) Standard 1000: Purpose, Authority, Roles and Responsibilities of the Internal Auditing in the County Government

(vi.) Recognition of the Mandatory Guidance

(vii.) Standards 1100: Independence and Objectivity of the Internal Audit function in the County Government

(viii.) The Code of Ethics and Code of Conduct

1.1 INTERNAL AUDIT DEFINITION

Internal audit activity must be consistent with the mandatory elements of the IPPF (The IPPF is a conceptual framework that organizes authoritative guidance to the worldwide internal audit professionals, promulgated by the Global Institute of Internal Auditors) which include the Core Principles for the Professional Practices of Internal Auditing, the Code of Ethics, the Standards and the Definition of Internal Auditing.

"Internal Auditing is an **independent, objective assurance** and **consulting** activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a **systematic, disciplined approach** to evaluate and improve the effectiveness of risk management, control, and governance processes." **(PFMA and IPPF**)

1.1.1 MISSION OF IAU IN THE COUNTY GOVERNMENTS

To enhance and protect organizational value by providing risk-based and objective assurance, advice, and insight.

The IAUs in pursuit of their mission are to help the County Government and entities to satisfy their statutory and fiduciary responsibilities and employ public resources effectively and efficiently. The internal auditors shall ensure an independent and systematic evaluation of risk management, control and governance processes in the County Government.

1.2 INTERNAL AUDIT CHARTER

1000 – Purpose, Authority and Responsibility
The purpose, authority, and responsibility of the internal audit unit must be formally defined in the Internal Audit Charter, consistent with IPPF.

1010 - Recognizing Mandatory Guidance in the Internal Audit Charter
The mandatory nature of the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, the Standards, and the Definition of Internal Auditing must be recognized in the internal audit charter. The Head of Internal Audit should discuss the Mission of Internal Audit and the mandatory elements of the International Professional Practices Framework with senior management and the Audit Committee.

1100 - Independence and Objectivity
The Internal Audit Unit must be independent, and internal auditors must be objective in performing their work

1110 – Organizational Independence
The Head of Internal Audit must report to a level within the organisation that allows the internal audit unit to fulfil its responsibilities. The Head of Internal Audit must confirm to the Audit Committee, at least annually, the organizational independence of the internal audit unit.

1111 – Direct Interaction with the Audit Committee
The Head of Internal Audit must communicate and interact directly with the Audit Committee

1.2.1 MANDATORY RECOGNITIONS IN THE INTERNAL AUDIT CHARTER

The Internal Audit Units in all the county government entities shall establish an Internal Audit Charter that prescribes the Internal Auditor's purpose, authority and responsibility. The Charter must recognize the mandatory nature of the Core Principles for the Professional Practice of Internal Auditing, the Code of Ethics, International Standards for the Professional Practice of Internal Auditing (ISPPIA), and the Definition of Internal Auditing. The Charter shall be approved by the Chair of the Audit Committee, the Accounting Officer, and the HIA. The approval of the Charter shall be documented in the minutes of the governing body. The implementation of this Manual shall ensure the purpose of the Internal Charter is achieved.

The Internal Audit Charter provides for:

(1.) **Purpose of the Internal Audit** in the county governments and their entities which is to provide reasonable assurance on the effectiveness and efficiency of the entity's risk management, control and governance. The internal auditor provides independent, objective assurance and consulting services designed to add value and improving the county's operations. Assurance services include audits on operations, compliance, financial, follow up, investigative, IT and management. Consulting services are advisory in nature such as advisory on control design, training on risk management and internal control and facilitating management's control self-assessment.

(2.) **Internal Audit Authority:**

The Internal Auditors in county government entities shall undertake Internal Audit as per IPPF in line with the requirements of PFMA and PFMR.

The Charter should be consistent with the Mission of Internal Audit and the mandatory elements of the IPPF. The Audit Committee and Accounting Officer shall authorize Internal Audit to:

(a) Have full, free, and unrestricted access to all functions, records, property, and personnel pertinent to carrying out any engagement, subject to accountability for confidentiality and safeguarding of records and information.

(b) Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques required to accomplish engagement objectives, and issue reports.

(c) Obtain assistance from the necessary personnel of the entity as well as other specialized services from within or outside the entity in order to complete the engagement.

(3.) **Internal Audit Independence and Objectivity:**

The Internal Auditors will have no direct operational responsibility or authority over any of the activities audited. Independence is an essential condition for ensuring that the work of the HIA and the IAU are both free from any form of bias or influence and are in fact impartial. The PFMR r.155 and r.163 have various provisions to ensure the organizational, functional, operational and reporting independence of the HIA and the internal auditors at the County Government. The provisions include:

(a) The HIA reports administratively to the Accounting Officer, and functionally to the Audit Committee;

(b) The HIA shall have unrestricted, direct and prompt access to all records, officials or personnel holding any contractual status and to all the premises and properties of the entity for the purpose of performing the internal audit function;

(c) Internal Auditors shall have no direct operational responsibility or authority over any of the activities they review and shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited;

(d) Internal audit activities shall remain free of influence by any element in the organization, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective mental attitude necessary in rendering reports;

(e) The Audit Committee shall approve the annual work plan of the IAU and monitor its execution through communications received from the HIA;

(f) The IAU should be provided with an independent budget allocation to fund the internal Audit unit which shall be approved by the Audit Committee; and

(g) The Internal Auditors have a responsibility not to accept any gift, fees or hospitality from an employee, supplier, business associate or client, the acceptance of which will impair the auditor's objectivity.

(4.) **Internal Audit Reporting line:**

(a) Functional Reporting to the Audit Committee

As provided in PFMR the HIA reports functionally to the Internal Audit Committee which shall:

(i.) Approve the Internal Audit Charter;

(ii.) Approve the risk-based internal audit plan;

(iii.) Approve the Internal audit budget and resource plan;

(iv.) Receive communications from the HIA on the internal audit unit's performance relative to its plan and other matters;

(v.) Participate in the approval decisions by the CPSB or CASB regarding the appointment and removal of the HIA;

(vi.) Make appropriate inquiries of management and the HIA to determine whether there are inappropriate scope or resource limitations; and

(vii.) Assess the performance of the Head of Internal Audit.

(b) Administrative reporting to the Accounting Officer:

As stipulated by PFMR r.155 (2) (a), Accounting Officer shall ensure that the Internal Audit function is appropriately structured to safeguard its independence and objectivity and to ensure the function achieves its roles and responsibilities.

The HIA shall administratively report to the Accounting Officer who shall ensure that the organizational structure of the IAU facilitates:

(a) The entity to accomplish its internal audit responsibilities;

(b) Internal auditor with sufficient authority to promote independence and to ensure broad internal audit coverage and adequate consideration of audit reports;

(c) Appropriate action to be taken on internal audit recommendations; and

(d) The internal auditor to be independent of the programs, operations and activities he or she audits to ensure the impartiality and credibility of the audit work undertaken.

The administrative reporting shall include budgeting and management accounting, human resource administration, including personnel evaluations and compensation, internal communications and information flows, administration of the internal audit unit's policies and procedures.

The ***Internal Audit Charter Template 1*** is provided in the Appendix.

1.2.2 CORE PRINCIPLES FOR THE PROFESSIONAL PRACTICE OF INTERNAL AUDITING

The IIA's Core Principles for the Professional Practice of Internal Auditing are part of the Mandatory Guidance of the IPPF. The core principles taken as a whole demonstrate internal audit effectiveness. For an internal auditor as well as an internal audit unit to be considered effective, all principles should be present and operating effectively. Failure of an internal auditor or the internal audit unit to achieve any of the principle means that the internal audit function may not be effective as it should be in achieving the internal audit's mission.

The internal audit unit should demonstrate the following Core Principles:

(1.) **Integrity** – Internal auditors must follow the rules of conduct related to integrity in the Code of Ethics and perform their work with honesty, diligence and responsibility and contribute to the legitimate and ethical objectives of the county.

(2.) **Competence and Due Professional Care** – Internal auditors must perform only services for which they have the necessary knowledge, skills and experience and they must continually improve their competence and the effectiveness and quality of their services. This can be accomplished through proper structuring of the IAU, developing job descriptions, taking inventory of skills needed to achieve the internal audit plan and developing strategies to recruit or train internal auditors with certain competencies. The internal auditors are expected to apply a systematic and disciplined approach to internal audit work.

(3.) **Objective and Free from Undue Influence** – Objectivity is an unbiased mental attitude that requires internal auditors not to subordinate their judgement on audit matters to others. Independence is the freedom from conditions that threaten the ability of the internal audit unit to execute its responsibilities in an unbiased manner. This can be demonstrated through the direct and consistent functional reporting of the HIA to the Audit Committee.

(4.) **Aligns with the Strategies, Objectives and Risks of the County** – Internal auditors have a responsibility to add value to the county government they serve. This value can be provided when internal audit engagements are connected to the risks that may have greatest impact on the county's ability to achieve its objectives. Internal audit unit's plan of engagements must be based on a documented risk assessment, undertaken at least annually, that incorporates the input of the senior management and the Audit Committee.

(5.) **Appropriately Positioned and Adequately Resourced** – The internal audit unit is able to effectively add value to the county when it is appropriately positioned and adequately resourced. The HIA should functionally report to the Audit Committee to preserve independence by providing the HIA with unrestricted access to address sensitive matters. Administratively the HIA should report to the highest level of management. The Audit Committee should affirm that the internal audit unit's operating budget and other resources are sufficient for the internal audit unit to accomplish its objectives.

(6.) **Demonstrates Quality and Continuous Improvement** – The HIA should establish a comprehensive quality assurance and improvement program (QAIP) by which to evaluate the quality of internal audit unit's work. The QAIP must include ongoing monitoring and structured, internal self-assessments conducted periodically, and external assessments conducted at least once every five years. The HIA may use surveys to solicit feedback from key stakeholders in the internal audit process.

(7.) **Communicates Effectively** – Effective internal auditing requires effective communication. The standards require the HIA to communicate to the senior management and the Audit Committee about the internal audit unit's charter, overall risk assessment, plans, resource requirements, performance relative to its plan and results of the QAIP assessments. The HIA may develop and include a communication plan as part of internal audit policies and procedures.

(8.) **Provides Risk-based Assurance** – The HIA should start with an internal audit plan based on a county wide risk assessment that is aligned with the county's risk universe and takes into account its risk appetite/criteria.

(9.) **Is insightful, proactive and future focused** – Internal auditors should clearly identify and explain the potential impact of identified risks and analyse the information to find the root causes. Besides this, the internal auditors should go beyond the county's immediate strategic plan and consider how emerging risks may affect the county and/ or the process under review.

(10.) **Promotes Overall County Improvement** – Internal auditors will promote county improvement by recognizing where efficiencies and value may be increased and communicating relevant observations and recommendations in a way that addresses risks and root causes. The internal audit unit should also report on the county comprehensively, considering its strategies, objectives, unique business concerns, and operational processes.

1.3 IMPAIRMENT TO INTERNAL AUDIT INDEPENDENCE OR OBJECTIVITY

1120 – Individual Objectivity
Internal auditors must have an impartial, unbiased attitude and avoid any conflict of interest.

1130 – Impairments to Independence and Objectivity
If independence or objectivity is impaired in fact or appearance, the details of the impairment should be disclosed to the appropriate parties (Head of Internal Audit, appropriate Accounting Officer and the Audit Committee). The nature of the disclosure will depend upon the impairment.

1112 – Head of Internal Audit Roles Beyond Internal Auditing
Where the Head of Internal Audit has or is expected to have roles and/or responsibilities that fall outside of internal auditing, safeguards must be in place to limit impairments to independence or objectivity.

PFMR r. 155(5) requires that all internal audit activities remain free of influence by any element in the organization, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective mental attitude necessary in rendering reports.

1.3.1 IMPAIRMENTS TO INDEPENDENCE AND OBJECTIVITY

(1.) There are situations in which certain responsibilities may create (actual or perceived) impairment of the internal audit independence or objectivity. Such responsibilities include:

- (a) Operationalizing the compliance function.
- (b) Supporting management in the development and implementation of policies and procedures.
- (c) Conducting investigations.
- (d) Compliance or risk management implementation activities.

(2.) Internal auditors may at times be in situations that may result to impairment of their independence or objectivity. These include:

- (a) Auditing an area where recently the internal auditor was undertaking a management role.
- (b) Auditing an area which may result to conflict of interest e.g. an area where family member of close friend is working in or an area where the Internal Auditor has self-interest.
- (c) Preconceived ideas towards individuals, or towards the audited bodies or their projects or programmes.
- (d) Auditing an area where the Internal Auditor recently provided consulting services in which the nature of the consulting impaired objectivity and the individual objectivity was not managed when assigning resources to the assignment.
- (e) Financial interest by the Internal Auditor or close association in the audited body, or its activities.
- (f) Assuming without evidence that an area under audit is acceptable based solely on prior positive experience.
- (g) Long-term deployment of Internal Audit staff to one Department or Function can affect their independence and impartiality.

(3.) Impairment to the independence or objectivity of Internal Audit function may also arise due to:

- (a) HIA reporting functionally to an office which the IAU is expected to audit.
- (b) HIA does not have functional reporting to the Audit Committee.
- (c) Limitation of scope.

(d) Limitation of authority.

(e) Lack of control over the budget of the IAU.

(f) Resource limitation including funding, human capital.

(g) Undue influence on the plan, audit procedures and audit reports.

(h) HIA is not readily accessible to those charged with governance, records, other personnel, physical resources and assets necessary for the performance of the audit;

(i) HIA is unable to conduct audits and report findings, opinions, and conclusions objectively without fear of reprisal.

1.3.2 SAFEGUARDS TO LIMIT IMPAIRMENTS TO INDEPENDENCE OR OBJECTIVITY

To manage the risk of impairment of IAU or Internal Auditor independence or objectivity the Audit Committee and Accounting Officer shall work with the HIA to:

(1.) Ensure Internal Auditors do not;

   (a) Perform management or operational duties;

   (b) Initiate or approve accounting transactions external to the IAU; or

   (c) Direct the activities of any employee in the County Government entity not employed by the IAU, except to the extent such employees have been appropriately assigned to auditing teams or to otherwise assist the Internal Auditors.

(2.) Where management activities have been assigned to IAU by the Audit Committee and Accounting Officer, a transition plan to be developed by the Accounting Officer to move these activities out of IAU.

(3.) Ensure Internal Auditors exhibit professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined or audited.

(4.) Ensure Internal Auditors make balanced assessments of all available and relevant facts and circumstances and disclose all material facts known which if not disclosed could distort the reports or conceal unlawful practice.

(5.) Ensure Internal Auditors take necessary precautions to avoid being unduly influenced by their own interests or by others in forming judgments.

(6.) Ensure Internal Auditors do not accept any gifts, inducements, or other benefits from employees of the Unit being audited, or their suppliers and other third parties.

(7.) Obtain external assurance on management activities being undertaken by IAU.

(8.) Regular review the responsibilities assigned to the HIA and the impact they have on independence and objectivity of IAU and Internal Auditors.

(9.) Regular review the reporting lines of the HIA and assess if there are any factors that would impair Internal Audit objectivity and independence.

(10.) Ensure the HIA has developed an effective system for identifying, reporting and resolving impairment factors which shall include:

(a) Ensuring an Internal Auditor is not assigned to audit an area where they have provided consultancy services or undertaken a management role for a period of at least 24 months as stipulated by PFMR r. 161; and

(b) IAU performance management system balances between audit client feedback, results of the audit process and undertaking audit engagements. Where Internal Audit performance is only based on: client feedback it may result to Internal Auditors raising less audit issues so as to get good reviews from the audit client; results of the audit process may result to the Internal Auditors focusing on raising as many audit issues as possible; or undertaking audit engagement may result to the Internal Auditors focusing on taking as little time as possible to complete an engagement.

(c) Undertaking adequate supervision by reviewing of each audit assignment

(11.) Ensure the HIA discloses any interference and related implications in determining the scope of internal auditing, performing work, and/or communicating results to the Audit Committee and Accounting Officer.

(12.) Establish a system for Internal Auditors to report conflict of interest.

(13.) Ensure that planning and assigning Internal Auditors to audit engagements reduces the risk of conflict of interest.

(14.) Ensure the Internal Auditors sign a declaration of independence and objectivity on a regular basis or at least annually.

The ***Declaration of Independence and Objectivity, Template 2*** is provided in the Appendix.

(15.) Ensure the Accounting Office and the Audit Committee receive confirmation from the HIA at least annually on the independence of the Internal Audit Function.

(16.) Ensure there are safeguards in place to limit impairments to independence or objectivity in instances where the HIA has been assigned roles and responsibilities that fall outside of internal auditing role as described in 1.3.1 (1).

Where the HIAU determines that a certain threat will impair the organizational independence and objectivity of the internal audit unit, he or she shall communicate in writing to the Audit Committee. The HIAU shall include the following in the report;

(1.) The identified threat(s)

(2.) Analysis of the threat(s), including root cause analysis

(3.) Projected impact of the threat(s)

(4.) Suggested safeguard interventions

The Chairperson, Audit Committee shall call for a special sitting of the Audit Committee for discussion of the threats to Organizational Independence and objectivity. The Committee shall subsequently pursue the matter with the Management to provide for safeguards against such threats and action plan towards eliminating the threats.

1.4 INTERNAL AUDIT SERVICES STAKEHOLDERS

In the broadest sense, the beneficiaries of the services of Internal Audit are the taxpayers who are considered the indirect customers. The direct stakeholders of Internal Audit services are organs that have oversight, management, and operating responsibilities of county government entities. The direct stakeholders include:

(1.) County Governor
(2.) Speaker, County Assembly
(3.) Audit Committee
(4.) County Executive Committee Members
(5.) Accounting Officers/County Chief Officers
(6.) County Secretary
(7.) County Public Service Board
(8.) County Assembly Service Board
(9.) Board of Directors of county government entities
(10.) Senior Management
(11.) Operating Management
(12.) Internal Auditor-General
(13.) Office of the Auditor-General
(14.) Office of the Controller of Budget
(15.) Ethics and Anti-Corruption Commission
(16.) Public Procurement Regulatory Authority
(17.) State Corporation Advisory Committee

1.5 CODE OF ETHICS AND CODE OF CONDUCT

The Internal Auditors in the county government entities shall comply with the codes of conduct as stipulated in the:

(1.) Public Officers Ethics Act 2016.
(2.) Leadership and Integrity Act 2012.
(3.) Human Resource Policies and Procedures Manual for the Public Service, 2016.
(4.) IIA Code of Ethics.
(5.) Code of Ethics of other Professional Bodies where internal auditors hold membership.
(6.) Respective approved county government code of ethics and code of conduct.

1.5.1 PUBLIC OFFICERS AND ETHICS ACT

Internal Auditors in County Government entities shall:

(1.) Carry out their roles and responsibilities to the best of their ability and ensure Internal Audit Services are provided in an efficient and honest manner.

(2.) Carry out their duties in a way that maintains public confidence in the integrity of the IAU.

(3.) Treat the public and fellow public officers with courtesy and respect.

(4.) Seek to improve the standards of performance and level of professionalism of the IAU and the entity.

(5.) Observe the ethical and professional requirements of the professional body/ies of which s/he is a member.

(6.) Discharge professional responsibilities in a professional manner including; i) provide audit recommendations in an honest and impartial manner without fear or favour; and ii) not knowingly give false or misleading information.

(7.) Carry out their duties in accordance with the law.

(8.) Not use public office to unlawfully or wrongfully enrich themselves or any other person.

(9.) Use his/her best efforts to avoid conflict of interest i.e. where personal interest conflict with official duties.

(10.) Take all reasonable steps to ensure property entrusted to their care is adequately protected and not misused or misappropriated.

(11.) Not practice nepotism, favouritism, sexual harassment, bullying and be political neutral in connection with performing their duties.

(12.) Submit to the responsible authority, a declaration of the income, assets and liabilities of self, spouses or dependent children under the age of 18 years as stipulated by Part IV of the Public Officers Ethics Act.

1.5.2 LEADERSHIP AND INTEGRITY ACT

In addition to the requirements of the Public Officers and Ethics Act, the Internal Auditors in County Government entities shall:

(1.) Respect the values, principles and requirements of the Constitution.

(2.) Exercise their authority and responsibility in the best interest of the people of Kenya.

(3.) Take personal responsibility for the reasonably foreseeable consequences of any actions or omissions arising from the discharge of their duties.

(4.) Carry out their duties in a transparent and accountable manner.

(5.) Maintain accurate records and documents in relation to their duties.

(6.) Not directly or indirectly use or allow person under their authority to use any information obtained while performing their duties, which is not available in the public domain, for furthering any private interest whether financial or otherwise.

(7.) Not participate in any gainful employment where they are employed on a full-time basis.

(8.) Not allow themselves to be influenced in performance of their duties by plans or expectations for offers of future employment benefits.

1.5.3 HUMAN RESOURCE POLICIES AND PROCEDURES MANUAL FOR THE PUBLIC SERVICE

In addition to the requirements of the Public Officers and Ethics Act and the Leadership and Integrity Act, the Internal Auditors in County Government Entities shall adhere to the Code of Conduct as stipulated in the Public Service Commission, Human Resources Policies and Procedures Manual for the Public Service which requires the Internal Auditor:

(1.) Not violate the rights and freedoms of any person enshrined under Chapter Four of the Constitution.

(2.) Not maintain a bank account outside Kenya except in accordance with an Act of Parliament.

(3.) Not to seek or accept a personal loan or benefit that compromises his/her integrity.

(4.) Not to engage in any activity that will amount to abuse of office.

(5.) Not to accept, request or give gifts whether in the form of money, goods, free passages or other personal benefits that may impair or be presumed to impair their professional judgement. In case of accepting any gift, the internal auditor should ensure it is non-monetary and does not exceed the value prescribed by law; or the gift is from or to a relative or friend given on a special occasion recognized by custom. A gift or a donation to the Internal Auditor shall be regarded as a gift/donation to the County Government and shall be delivered to the respective department unless exempted by law.

(6.) Not to engage in any activity that will result to pecuniary embarrassment. Pecuniary embarrassment from whatever cause, will be regarded as impairing the efficiency of an internal auditor and will render him/her liable to disciplinary proceedings.

(7.) Not to act in any manner that may be detrimental to the security interest of Kenya, be an agent for or further interest of a foreign government, organization or individual.

(8.) To uphold official working hours.

(9.) Not to use his/her office to solicit or collect fund raising funds either as a fundraiser or a promoter.

(10.) Conduct private affairs in a manner that maintains public integrity to the office, pay taxes due from him/her with the prescribed period and not neglect their financial or legal obligations.

(11.) Not to cause anything to be done through another person that would constitute a contravention of the Code of Conduct.

(12.) To report to the authorized officer any contravention of the Code of Conduct.

1.5.4 IIA CODE OF ETHICS

The Public Officers and Ethics Act; the Leadership and Integrity Act; and the Code of Conduct, Public Service Commission, Human Resources Policies and Procedures Manual for the Public Service provide that the County Internal Auditors shall maintain high standards of professional ethics and shall observe the ethical and professional requirements of their professional bodies.

Internal Auditors in the County Government entities shall be expected to conform to the IIA Code of Ethics that provide for:

(1.) **Integrity**: Internal Auditors shall hold the highest level of the integrity as this establishes trust among the internal audit's stakeholders and thus provides the basis of the stakeholders to rely on the Internal Auditors' judgement. To achieve the highest level of integrity the Internal Auditors in the County Government Entities shall:

- (a) Perform their work with honesty, diligence and responsibility;
- (b) Observe the law and make disclosures expected by the law and the profession; and
- (c) Not knowingly be party to any illegal activity or engage in acts that are discrediting to the profession of internal auditing or to the County Government entity.

(2.) **Objectivity**: Internal Auditors shall exhibit the highest level of professional objectivity in gathering, evaluating and communication information about the activity or process they have examined/audited. Internal Auditors shall make a balanced assessment of all the relevant circumstances and shall not be unduly influenced by their own interests or by others in forming judgements. To ensure professional objectivity, Internal Auditors in the County Government entities shall:

- (a) Not participate in any activity or relationship that may impair or be presumed to impair their unbiased assessment. This participation includes those activities or relationships that may conflict with the interest of the County Government entity;
- (b) Not accept anything e.g. gift of favour that may impair or be presumed to impair their professional judgement;
- (c) Disclose all material facts known to them that, if not disclosed, may distort the reporting of activities under review; and
- (d) Declare any conflicts of interest arising from audit work assigned to them by the HIA.

(3.) **Confidentiality**: Internal Auditors shall respect the value and ownership of information that they receive and shall not disclose information without appropriate authority unless there is a legal or professional obligation to do so. The Internal Auditors shall be expected to:

- (a) Be prudent in the use and protection of information acquired in the course of their duties;

(b) Not to use information for any personal gain or in any manner that would be contrary to the law or detrimental to the legitimate and ethical objectives of the county entity; and

(c) Have clear guidelines on control of documents in hard and soft copies and restrictions on filing and computer security.

(4.) **Competency**: Internal Auditors shall apply the knowledge, skills and expertise needed in the performance of internal audit services. The Internal Auditors shall be expected to:

(a) Engage only in those internal audit activities/services for which they have the necessary knowledge, skills and expertise;

(b) Perform internal audit services in accordance with the ISPPIA; and

(c) Continually improve their proficiency and the effectiveness and quality of their internal audit services.

1.5.5 CODE OF ETHICS OF OTHER PROFESSIONALS BODIES

Internal Auditors shall also adhere to the code of ethics or by-laws of other professional bodies where they are members. This include: Institute of Certified Public Accountants of Kenya, Institute of Certified Public Secretaries of Kenya, Information Systems Audit and Control Association and Association of Certified Fraud Examiners.

CHAPTER 2 – INTERNAL AUDIT UNIT STRUCTURE

Chapter 2 covers factors that the Head of Internal Audit needs to consider to ensure the Internal Audit Unit is staffed with the required personnel. The chapter provides the linkage between the IAU in the County Government (Executive and County Assembly) and the Office of the Internal Auditor General at the National Treasury. Chapter 2 is aligned to IIA Standard 1200 on Proficiency and Due Professional Care.

1200 – Proficiency and Due Professional Care
Engagements must be performed with proficiency and due professional care.

Performing engagements with proficiency and due professional care is the responsibility of every Internal Auditor. The HIA shall be responsible for ensuring that all Internal Auditors perform engagements with proficiency and due professional care by ensuring they possess the required knowledge, skills and other competencies. The HIA shall achieve this through: attracting and retaining competent staff; ensuring continuous capacity building; and adequate planning, staffing and supervision.

2.1 PROFICIENCY

Proficiency is a collective term that refers to the knowledge, skills, and other competencies required of internal auditors to effectively carry out their professional responsibilities. It encompasses consideration of current activities, trends, and emerging issues, to enable relevant advice and recommendations.

1210 – Proficiency
Internal auditors must possess the knowledge, skills, and other competencies needed to perform their individual responsibilities. The Internal Audit Unit collectively must possess or obtain the knowledge, skills, and other competencies needed to perform its responsibilities

1230 – Continuing Professional Development
Internal auditors must enhance their knowledge, skills, and other competencies through continuing professional development.

2.1.1 PROFESSIONAL KNOWLEDGE, SKILLS AND COMPETENCIES

Internal Auditors shall seek to maintain and develop their professional knowledge, skills, and competencies as provided for in the Scheme of Service. Internal Auditors shall seek the highest levels of proficiency and take personal responsibility for self-improvement and professional development.

The HIA shall ensure the individual Internal Auditors and the IAU collectively have the required mix of knowledge, skills and other competencies to implement: the Internal Audit Charter;

Internal Audit Strategic Plan and Annual Risk-Based Internal Audit Plan; and to add value to the County Government entity.

Internal audits should be performed by, or be under the control of auditors who have the technical skills, experience, and perspective in other areas of audit that will enable them to comply with the IPPF and this Manual. Internal Auditors should be properly trained to fulfil their responsibilities and should maintain and enhance their professional competence through an appropriate ongoing development programme.

2.1.2 STAFFING INTERNAL AUDIT UNIT

The IAU should be appropriately staffed in terms of numbers, grades, qualification levels, and experience, having regard to the Internal Audit Charter, Internal Audit Strategic Plan and Annual Risk-Based Audit Plan. The HIA shall ensure that those with appropriate background, personal qualities, and potential should be recruited as Internal Auditors. Thereafter, steps should be taken to give them the necessary training and experience.

The HIA shall work with the Accounting Officer to ensure the human capital management programme and terms of employment (Scheme of Service) enable the IAU to attract and retain staff with the appropriate academic and professional qualifications, experience, and personal attributes. The HIA shall specify the required competencies, including minimum qualification, experience, and other criteria for appointment/promotion of Internal Auditors to the more senior grades.

As stipulated in PFMR r. 155(2) the Accounting Officer shall ensure the Internal Audit Unit is appropriately placed and the HIA is appropriately positioned to enable: the IAU accomplish its internal audit responsibilities; the internal auditors have sufficient authority to promote independence, ensure broad internal audit coverage and adequate consideration of internal audit reports; appropriate action is taken on internal audit recommendations.

The Audit Committee guidelines through the gazette notice no.2690 provide that the HIA reports functionally to the Audit Committee that in turn reports to the Governor. At the County Assembly, the HIA reports to the Audit Committee that in turn reports to the Assembly through the Clerk.

The County Government Act section 12 and 59 provides for the County Public Service Board (CPSB) and the County Assembly Service Board (CASB) to establish and abolish an office in the county executive and county assembly respectively including its level, grading and remuneration. The HIA in each case may provide advice to the CPSB and CASB on the best appropriate structure in line with professional auditing standards and the needs of each level of County Government.

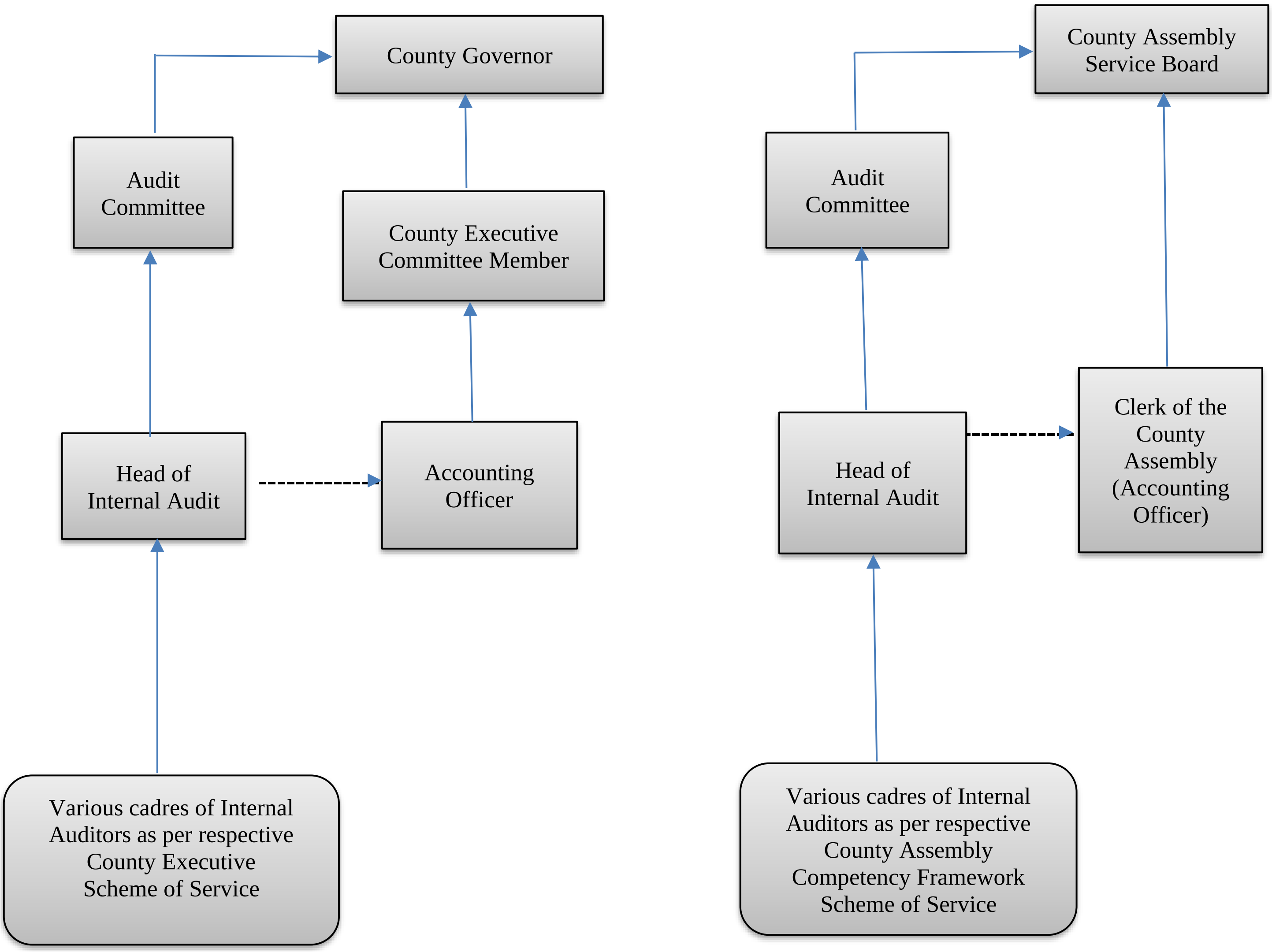
To ensure the County Government entity Internal Audit Unit has the appropriate human capital to meet the required proficiency levels, the IAU shall have a hierarchy that best fits the County Government. Various cadres to be considered include;

(1.) Head of Internal Audit (HIA) or Director, Internal Audit.
(2.) Deputy Head, Internal Audit or Deputy Director, Internal Audit.
(3.) Assistant Director, Internal Audit
(4.) Principal Internal Auditor.
(5.) Chief Internal Auditor.

(6.) Senior Internal Auditor.
(7.) Internal Auditor I.
(8.) Internal Auditor II.

The IAU Structure is provided in Illustration 1.

Illustration 1: County Internal Audit Structure



County Executive Structure **County Assembly Structure**

------------------------- Administrative reporting

NB: ***Standard 1110 Organizational Independence*** - The HIA must report to a level within the organization that allows the internal audit activity to fulfil its responsibilities. Mwongozo Code of Governance requires Audit Committee to ensure that the HIA holds a senior position in the management team, is professionally qualified and is a member in good standing, of the professional body responsible for regulating auditors.

____________________ Functional reporting

Job descriptions and job specifications Template 3 is provided in the Appendix.

2.1.3 INTERNAL AUDITOR GENERAL DEPARTMENT, NATIONAL TREASURY

The Internal Auditor General Department shall assist the HIA in the County Government entity to develop the capacity of internal auditors for efficient, effective and transparent financial management as provided in s. 12(1j) of PFMA on responsibility of the National Treasury. This shall include:

(1.) Secondment of internal auditors to County Government Treasury s.14 of PFMA

(2.) Training of the internal auditors with the relevant skills, competences and techniques that will enable them fulfil their purpose.

(3.) Collaborate with relevant bodies including PSASB to support internal auditors at the County Government.

Additional capacity building strategies that can be considered to promote regular contact and can be adopted by IAG may include:

(1.) Facilitating an annual planning conference.
(2.) Conducting joint audits.
(3.) Reviewing and advising on audit plans.
(4.) Reviewing quality of working papers.
(5.) Supervising pilot audits.
(6.) Maintain a national skills database.
(7.) Assisting in recruiting internal auditors.
(8.) Consolidating county internal audit reports to CS Treasury on fraud.
(9.) Implementing and reporting on Quality Assurance and Improvement Program.

2.1.4 CONTINUOUS PROFESSIONAL DEVELOPMENT

The Internal Auditors shall be required to consider current activities, trends, and emerging issues, to enable them to provide relevant advice and recommendations to management, Accounting Officer and the Audit Committee. This requires the Internal Auditors to continuously enhance their proficiency on a continuous basis. The Internal Auditors shall be responsible for ensuring they continuously obtain the required knowledge, skills and other competencies in order to maintain their proficiency.

Although each individual Internal Auditor is responsible to maintain his/her proficiency, the HIA shall be responsible for ensuring the IAU has the minimum required mix of competencies. The HIA shall report on the adequacy of resources including competencies to the Audit Committee. The HIA shall develop a Training and Development Plan to achieve this which shall contain strategies to:

(1.) Enhance internal audit techniques.

(2.) Provide on-the job training, coaching and mentoring to enable the Internal Auditors to enhance their experience.

(3.) Sensitize and provide training on the operations of the County Government entity to enable the Internal Auditors to have an in-depth understanding of the operations of the entity.

(4.) Acquire specialist training for those Internal Auditors responsible for a particular activity such as ICT audit, forensic auditing, data analytics, system design, procurement audit, compliance audit, technical audits, project management etc.

(5.) Enhance the professional development of the Internal Auditors by developing a competency framework aligned to the schemes of service and ensuring the internal auditors attain relevant certifications and qualifications including the Certified Internal Auditor, Certified Government Audit Professional, Certified Information Systems Auditor, Certified Fraud Examiner among others.

(6.) Manage training for Internal Auditors with responsibility for managing and directing Audit Teams, together with those staff members who show potential for management positions.

(7.) Continuously develop Internal Auditors professionally as per the requirement of their professional bodies.

(8.) Ensure regular assessment of available competencies in the IAU vis-à-vis current and future demand for internal audit services.

(9.) Link the policy and plan to the County Government entity's performance management system.

(10.) Ensure appropriate information is maintained for all capacity building initiatives and their effectiveness (closing skill gaps identified during performance evaluation) are continuously assessed.

(11.) Ensure the capacity building programme are adequately resources.

2.2 DUE PROFESSIONAL CARE

1220 – Due Professional Care

Internal auditors must apply the care and skill expected of a reasonably prudent and competent internal auditor. Due professional care does not imply infallibility.

Due professional care requires the Internal Auditors to understand the IPPF, have the competencies and work with diligence to implement this Manual (that has been aligned to IPPF and Government of Kenya Internal Audit Guidelines for County Governments) and other guidelines issued by the Government. The Internal Auditor shall be expected to apply professional judgement, apply the required expertise and take appropriate steps when planning, executing (gathering and evaluating audit evidence) and reporting on an audit engagement. This will enable the Internal Auditor to gain the respect and co-operation from the audit clients.

In undertaking internal audit activities, the Internal Auditors shall be expected to exercise skills of a reasonably prudent and competent Internal Auditor in the same or similar circumstances. However, the Internal Auditor shall be expected to provide reasonable assurance and not absolute assurance. Reasonable assurance includes the understanding that there is a remote likelihood that material misstatements will not be prevented or detected on a timely basis. Absolute assurance on the other hand means that there is no assurance risk. In exercising due professional care, the Internal Auditors shall be alert to:

(1.) The possibility of intentional wrong-doing.

(2.) Errors and omission.

(3.) Unusual transactions.

(4.) Unauthorized operations.

(5.) Inefficiency, waste, and ineffectiveness.

(6.) Conflicts of interest.

(7.) Fraud and corruption.

(8.) Conditions and activities likely to give rise to non-compliance.

(9.) Inadequate controls including inadequate record keeping.

Due professional care should be appropriate to the objectives, complexity, nature, and materiality of the audit being performed. In exercising due professional care, the Internal Auditor shall: assess the adequacy of the risk management, governance and controls of the area/s being audited; consider and document the work needed to achieve engagement objectives; and use all reasonable care and attention to obtain sufficient, relevant, and reliable evidence on which to base audit conclusions and opinions.

HIAs and Internal Auditors shall bear legal and disciplinary liability for failure to discharge their responsibilities as stipulated by PFMR r. 162.

CHAPTER 3 – NATURE OF INTERNAL AUDIT SERVICES

Chapter 3 covers the nature of internal audit services and the various types of audits that the Internal Audit Unit shall undertake. The chapter is aligned to IIA Standard 2100 on Nature of Work.

2100 – Nature of Work
The Internal Audit Unit must evaluate and contribute to the improvement of the County Government entity's governance, risk management, and control processes using a systematic, disciplined, and risk-based approach. Internal audit credibility and value are enhanced when auditors are proactive and their evaluations offer new insights and consider future impact.

Typically, the governing body is responsible for guiding the governance process while the Accounting Officer and Senior Management are accountable for leading risk management and control processes. Governance, risk management and controls are closely interrelated and linked to each other. Effective governance activities consider risks when establishing organisational goals, objectives and implementation strategies, and the related operational plans. Controls are as a result of risks in the sense that controls represent the actions that are taken to manage risks and increase the likelihood of achieving the established goals and objectives. Effective governance mechanisms rely on the effectiveness of the internal controls. These linkages and their impact on the organisation should be clearly understood and appreciated as they are core elements in the practice of Internal Auditing and encompass all phases of an audit.

The IAU can provide assurance or consulting services in relation to governance, risk management and controls with a view of: providing reasonable assurance that they are operating as intended to ensure entity's objectives are achieved and risks managed; and provide recommendations for improving the entity efficient, effective and economic use of public resources.

When undertaking consultancy role, safeguards should be discussed by HIA and Audit Committee, Accounting Officer and Senior Management and put in place to limit impairments to the independence and objectivity of the Internal Auditor.

3.1 GOVERNANCE

2110 - Governance
The internal audit unit must assess and make appropriate recommendations to improve the organization's governance processes for:

(i.) Making strategic and operational decisions.
(ii.) Overseeing risk management and control.
(iii.) Promoting appropriate ethics and values within the organization.
(iv.) Ensuring effective organizational performance management and accountability.
(v.) Communicating risk and control information to appropriate areas of the organization.
(vi.) Coordinating the activities of, and communicating information among, the Audit Committee, external and internal auditors, other assurance providers, and management.

3.1.1 GOVERNANCE DEFINITION

The IIA has, as part of the Standards, defined **governance** as the combination of processes and structures implemented by the Governing Body to inform, direct, manage, and monitor the activities of the entity towards the achievement of its mandate and objectives and that operations are carried out in an ethical and accountable manner.

Governance also includes activities that ensure a public entity's credibility, establish equitable provision of services, and assure appropriate behaviour of public officials so as to reduce the risk of corruption. County governments in enhancing governance should comply with the national values and principles of governance under Article 10 of the Constitution of Kenya (2010).

The Mwongozo Code of **Governance** defines corporate governance as the structure and system of rules, practices and processes by which an organisation is directed, controlled and held accountable. It encompasses authority, accountability, stewardship, leadership, direction and control exercised in organisations. It also provides the framework for achieving the objectives of the organization and creates benchmarks for the measurement of corporate performance and disclosure.

The Governing Body (including the Audit Committee) and Accounting Officer are responsible for establishing appropriate governance processes and systems. The Governing Body, Accounting Officers, management, OAG and the IAU are considered key components on an effective governance system. Management is responsible for supporting the Accounting Officer implement the governance systems and processes established by the Governing Body.

The OAG and IAU provide reasonable assurance that the governance, risk management and controls processes and systems are appropriately designed and are working as expected. PFMA s. 155 stipulates that the HIA shall review the governance mechanism of the County Government entity and mechanisms for transparency and accountability with regards to the finances and assets of the entity. PFMR r. 153(1) (b) requires the HIA to provide reasonable assurance through the Audit Committee on the state of governance systems and process of the County Government entity.

The HIA should assess the maturity of the governance process and system during the annual audit planning process. A more mature and effective governance process may indicate strong oversight by the Governing Body, Audit Committee, Accounting Officer and management which may result to strong risk management and control systems.

During the annual planning process, the HIA shall assess whether to provide assurance or consultancy services on the entity's governance system and processes. Where the governance processes and systems are immature the HIA may prefer to provide consulting services, given that governance issues may already be known. In providing assurance services, the HIA may decide to assess governance in each area of review e.g. procurement governance when undertaking procurements audit or ICT governance when undertaking ICT audits instead of undertaking a single governance audit.

In assessing the governance system and processes the Internal Auditor may assess:

(1.) **Decision making process**: how Governing Body and management make strategic and operational decisions to establish if: consistent decision-making process has been established; and Governing Body and management directives are effectively communicated, implemented and feedback on the same provided.

(2.) **Risk management and control oversight**: the effectiveness of the annual risk assessment process; if risk management is a key agenda in Governing Body and management meetings; how risk management and controls information is communicated from and to Governing Body and management and the relevance of the information communicated; employees understanding of their responsibilities and ownership of risk management and controls; linkage of risk management to policies, procedures, annual work plan, budgets and performance management; effectiveness of management self-assessment on the effectiveness of implemented risk management strategies.

(3.) **Promotion of appropriate ethics and value within the entity**: how the Governing Body, Accounting Officer and senior management are promoting a culture of ethics and compliance to laws, regulations, policies and standards both internally and among the entity's external stakeholders. This may involve assessing the effectiveness of adherence to the entity's code of conduct and resolving non-compliance incidences. The Internal Auditor can assess how the entity's mission and value statements have been internalized by all employees and how these are supported by human capital management programmes (recruiting, retaining and training). The Internal Auditors can assess the effectiveness of the whistle blowing/hot line system in protecting the whistle-blower and expediting investigations resulting from the system.

(4.) **Strategy**: how well the strategies have been developed, communicated and adopted throughout the entity. This involves assessing whether strategies; are developed through a disciplined process and supported by the best available information; are commonly understood by the personnel; serve as a platform for all major decisions; enhance stakeholder value; align with other strategies, both top-down and across the County entity; clearly reflected in objectives, structures, and operations at all levels; enable alignment of measurement and rewards; eliminate redundancies; are documented; manage/maintain risks within risk tolerance limits;

allow risk expectations to be well understood by stakeholders such as regulators, interest groups, citizens, among others.

(5.) **Compliance**: this relates to compliance with laws and regulations. Audit functions may consider the need for technical assistance from the legal department or an outside third party when evaluating legal and regulatory compliance. It involves assessing whether the methods by which the county entity fosters compliance knowledge and commitment in its employees.

(6.) **Organizational Accountability / Effectiveness of the performance management system**: the entity's target setting, performance evaluation, accountability for results and staff compensation and how these supports the desired behaviour (i.e. prevent or detect unaccepted behaviour or risk-taking) and ensures alignment to the achievement of the strategic plan. When assessing accountability the auditor should consider the county's legal or legislative appointment, legal structures, and applicable laws and regulations; formal and comprehensive "delegated authorities" and "powers reserved"; documented acknowledgement of their accountabilities by key personnel; processes to monitor accountabilities and corrective actions taken when accountabilities are not met.

(7.) **Coordination of Governing Body and management activities**: the effectiveness of establishing the Governing Body calendar of activities and management annual programme and how efficiently this is implemented. The Internal Auditors can assess adherence to the Governing Body terms of reference. The Internal Auditors can assess the effectiveness of Governing Body and management meetings e.g. frequency of meetings, receipt of agenda and necessary materials on time, quorum, contribution by members, establishing resolutions, management of minutes etc.

(8.) **Monitoring**: The purpose of monitoring is to provide Governing Body and management with early indications of progress being made, or not made, in achieving the entity's objectives. It assists in making timely decisions, hold people accountable and continually improve performance. Assessing monitoring considers relevance; reliability; adaptability to address new or changing risks; accuracy; objectivity; completeness; cost-effectiveness; timeliness; usefulness; communication and reporting content.

(9.) **IT Governance**: This consists of leadership, organizational structures, and processes that ensure that the entity's IT supports the entity's strategies and objectives. Effective IT governance should a cohesive and integrated process aligned with the operations, compatible with management decision-making style and culture, and perceived by management to be providing value. Auditors may use widely recognized IT governance frameworks in establishing criteria to assess IT governance such as ISO 38500, Corporate Governance of Information Technology; COBIT 5; GTAGs; IT Infrastructure Library (ITIL).

(10.) **Committees/ Audit Committee**: Committees / Audit Committees should ensure that it is fulfilling its governance responsibilities, the right governance processes are in place within the entity and operating effectively, and transparent communication exists between the organization and its stakeholders. In assessing Audit Committee performance, auditors should focus on a three-pillar framework;

Assessing compliance with charter obligations. Does the Audit Committee discharge its responsibilities as stated in the charter?

Assessing the participation of the Audit Committee members. Is there a formal and effective assessment of each member's performance and contribution to the Audit Committee?

Assessing value-added activities pursued and outcomes achieved. Does the Audit Committee add value to the entity by facilitating well-informed and effective decision-making, promoting and monitoring an ethical culture, implementing an effective system of risk oversight and management, implementing an effective and efficient internal control system, promoting effective communication with internal and external auditors and responding appropriately to matters they raise, promoting high-quality internal and external reporting financial and nonfinancial information?

In providing consultancy services, the IAU may provide advisory services to various oversight and investigatory committees instituted by the County Government. The IAU may also consider outsourcing governance audit and undertaking peer reviews under provisions on coordination in internal auditing.

3.2 RISK MANAGEMENT

2120 – Risk Management
The internal audit unit must evaluate the effectiveness and contribute to the improvement of risk management processes.

3.2.1 RISK MANAGEMENT DEFINITION

The IIA defines risk as the possibility of an event occurring that will have an impact on the achievement of objectives. Risk management is the process whereby management identifies and assesses business and operational risks (internal and external) and puts in place controls and other measures to mitigate the risk so as to have reasonable assurance of achieving the organisational objectives.

According to ISO 31000:2018, **risk** is the "effect of uncertainty on objectives" and an effect is a positive or negative deviation from what is expected. Risk is measured in terms of the likelihood of an adverse event occurring and the impact of that event on the achievement of objectives in case it does occur. COSO Enterprise Risk Management – Integrating with Strategy and Compliance, 2017, defines **risk** as "the possibility that events will occur and affect the achievement of strategy and business objectives."

It's the role of the Accounting Officer of the County Government entity to ensure a risk management framework is established that builds robust business operations and includes fraud prevention mechanisms as stipulated by the PFMR r. 158. The Internal Auditor is expected to provide reasonable assurance through the Audit Committee on the state of the risk management framework established by the Accounting Officer as stipulated by the PFMR r. 153(1) (b) and the public sector risk management guidelines issued by the PSASB.

The Internal Auditor can provide reasonable assurance in reviewing the effectiveness of the risk management framework implemented by the Accounting Officer and senior management by assessing the following:

(1.) **Risk governance:** the oversight role played by the governing body, Accounting Officer and senior management in ensuring the County Government entity has a culture of risk management. This shall involve assessing: if risk management is a key agenda of governing body and management meetings; how expected risk attitudes and behaviour are communicated to all employees and how the governing body and Accounting Officer obtain feedback on the risk culture; how the governance body and Accounting Officer obtain a view of the key risks impacting the entity; how risk management is integrated with decision making; risk management ownership and accountability; risk management function is appropriately positioned; cross-functional risk management; linkage of risk management with performance management; risk management capacity building.

(2.) **Integrating risk management with the business:** This may involve assessing how strategic objectives are aligned to mandate, vision and mission; linkage of strategic and operational objectives; effectiveness of setting risk appetite and risk tolerance and how management ensures the same is adhered with; significant risks are identified and are linked to objectives; risks are correctly prioritized; effective risk management strategies and actions are established; integrating risk management strategies with annual plans, budgets, policies and procedures; if management have selected appropriate risk strategies that are aligned with the approved risk appetite; policies on accepting risks and if management are accepting risks beyond approved risk appetite; the effectiveness of the risk management strategies implemented by management; if management are able to identify new and emerging risks and take appropriate action; and effectiveness of risk monitoring and reporting at a functional level and entity level.

(3.) **Risk management process:** This may involve assessing effectiveness of the process for identifying, assessing, prioritizing, treating, monitoring and reporting risks; whether the risk management process identifies both threats and opportunities; how the governing body and the Accounting Officer obtain assurance on the effectiveness of the risk management process; and whether the risk management process is adequately funded.

Risk management assurance services may be undertaken as part of the normal audit engagement or may be undertaken as a separate engagement.

The Governing Body and the Accounting Officer are expected to undertake risk assessment at least annually. The HIA uses the output of the annual assessment in developing the Annual Risk-Based Internal Audit Plan. The assessment of the effectiveness of the risk management process may enable the HIA to determine on whether to rely the results of the annual risk assessment. Where the HIA concludes that management has accepted a level of risk that may be unacceptable to the organisation, this matter must be discussed with senior management.

Where the IAU is to provide consultancy services on risk management, this should be clearly stated in the Internal Audit Charter and adequate safeguards put in place as outlined in the PSRMC.

3.2.2 EFFECTIVELY MANAGING AUDIT RISKS

Audit risk is the risk that audit procedures will fail to detect an absent, inappropriately designed or ineffectively implemented internal control or management arrangement, which could result in unacceptable level of business risk. Business risk is the risk of organization failing to meet its objectives.

The internal audit unit is not immune to risks. In addition to assessing how the entity manages risks, the HIA shall be expected to effectively manage risks that impact on the IAU which include: false assurance, audit failure and reputational risk. The HIA needs to take necessary steps to ensure that such risks are managed:

(1.) Audit Failure: This is failure to meet audit objectives.

(2.) False Assurance: Giving false confidence or assurance based on perceptions or assumptions rather than fact.

(3.) Reputation risks: Damage to the efficacy of internal audit.

At audit planning stage, the internal auditor should assess and document the potential audit risks in relation with the specific audit assignment including the planned actions to mitigate those risks. Examples of audit risks to any internal audit assignment include:

(1.) The internal auditor may misunderstand the scope of the audit. A too wide scope may not be covered within the available timeframe and resources, whereas a too narrow scope may not fully address the audit objectives. This risk should be addressed by proper audit "scoping" during the planning process.

(2.) Conflict of interest may exist between the internal auditor and his/her work, which may impair objectivity and undermine the audit results. In mitigation, any threat to independence and objectivity must be disclosed at the planning stage or any other time and the affected internal auditor removed from the specific assignment.

(3.) The audit may not meet the expectations of the users. This should be addressed by thorough audit planning, continuous reference to the plan and audit objectives and discussions with management throughout audit testing.

(4.) Less than adequate audit testing or inadequate audit evidence obtained, hence incorrect audit conclusions, due to lack of expertise, experience and proper supervision of the audit team. Close supervision during audit execution can provide timely and invaluable feedback and direction to the audit team.

The HIA should continuously make arrangements for the training of internal auditors to uplift their skills and to keep them current with the trends in the internal audit profession and standards.

(5.) Audit recommendations are not implemented due to the lack of support from the senior management of the audited entity. This requires proper handling of "client" relationships throughout the audit process. The auditor should bear in mind that dealing with senior management of the audited entity is relatively sensitive compared to other personnel, and that it is crucial to make them aware of the audit findings before they are reported to other parties.

(6.) The audit timetable may be missed due to lack of cooperation from the audited entity's personnel. This issue must be addressed during the audit planning meeting to obtain commitment from the personnel.

(7.) The audit timetable may be missed due to poor time management by the audit team. The issue should be mitigated by close supervision of the assignment, improved time plans and management on the part of the auditors – use of weekly time charts and daily action checklists are useful tools.

(8.) Quality of audit reports could be inadequate, contain errors or even be inaccurate. Appropriate review and completing the quality control questionnaire at each stage of the audit will mitigate reporting errors.

3.3 CONTROLS

> **2130 – Controls**
> The Internal Audit Unit must assist the County Government entity in maintaining effective controls by evaluating their effectiveness and efficiency and by promoting continuous improvement.

3.3.1 INTERNAL CONTROL DEFINITION

PFMR r. 158 requires the Accounting Officer to ensure the County Government entity has established a system of internal control that builds robust business operations. Internal control system comprises the whole system of controls, financial and otherwise, established by management in order to carry on operations in an orderly and efficient manner, ensure adherence to management policies and directives, safeguards assets, and secure as far as possible the completeness and accuracy of records.

An internal control is a process, effected by the County Government entity Governing Body, management, and other personnel, that is designed to provide reasonable assurance regarding the achievement of objectives relating to operations, reporting, and compliance. The controls established enables the County Government entity to achieve its objectives in an efficient and economical manner and at the same time manage its risks. Controls are established through policies, procedures, directions, processes and systems and implemented through directing, supervising, monitoring, and reporting on all operations, functions and activities.

The Accounting Officer and management are responsible for establishing, administering and assessing effectiveness of controls whereas the Internal Auditor is expected to provide reasonable assurance to the Governing Body (through the Audit Committee), Accounting Officer and Management that the controls are operating as intended.

Controls are classified into:

(1.) **Preventive controls** – Designed to prevent the occurrence of inefficiencies, errors, or irregularities. While preventive controls cannot guarantee that the controlled factor will not occur, they do reduce the chance of it occurring.

(2.) **Detective controls –** Designed to detect inefficiencies, errors, or irregularities. Detective controls help to ensure that errors are identified and corrected as quickly as possible.

(3.) **Corrective controls –** Designed to help mitigate damage once a risk has materialised.

3.3.2 COSO INTEGRATED CONTROL FRAMEWORK

In conformance with PFMR r. 158, the accounting officers and the internal auditors in the County Government entity may adopt the guidance provided by the COSO Integrated Control Framework (ICF), 2013, as a benchmark to understand and assess whether all aspects of an internal control are considered, all the controls are adequate to manage all the key risks of the county and the county's objectives are effectively and efficiently achieved. Governance, risk management and internal controls requirements are embedded in PFMA, PFMR, guidelines, policies, manuals and procedures.

COSO ICF is a model developed by the Committee of Sponsoring Organizations of the Treadway Commission for the purpose of establishing and evaluating effective internal controls. The COSO ICF identifies the following five components and seventeen principles as necessary for effective internal control:

(1.) **Control Environment** – This is the set of standards, processes and structures that provide the basis for carrying out internal control across the entity. It sets the tone of an entity, influencing the control consciousness of its people. Principles relating to the control environment include:

1) The entity demonstrates a commitment to integrity and ethical values
2) The Audit Committee demonstrates independence from management and exercises oversight of the development and performance of internal control.
3) Management establishes, with Audit Committee oversight, structures, reporting lines and appropriate authorities and responsibilities in pursuit of objectives.
4) The entity demonstrates a commitment to attract, develop and retain competent individuals in alignment with objectives.
5) The entity holds individuals accountable for their internal control responsibilities in the pursuit of objectives.

(2.) **Risk Assessment –** involves a dynamic and iterative process for identification and analysis of relevant risks that threaten the achievement of objectives; it forms the basis for determining how the risks should be managed. Principles relating to the risk assessment include:

6) The entity specifies objectives with sufficient clarity to enable the identification and assessment of risks relating to objectives
7) The entity identifies risks to the achievement of its objectives across the entity and analyzes risks as a basis for determining how the risks should be managed.
8) The entity considers the potential for fraud in assessing risks to the achievement of objectives.
9) The entity identifies and assesses changes that could significantly impact the system of internal control.

(3.) **Control Activities –** These are actions established by policies and procedures to help ensure that management directives to mitigate risks to the achievement of objectives are carried out. Principles relating to the control activities include:

10) The entity selects and develops control activities that contribute to the mitigation of risks to the achievement of objectives to acceptable levels.
11) The entity selects and adopts general control activities over technology to support the achievement of objectives.
12) The entity deploys control activities through policies that establish what is expected and procedures that put policies into action.

(4.) **Information and Communication –** Information is necessary for the entity to carry out internal control responsibilities in support of achievement of its objectives. Communication occurs both internally and externally and provides the entity with the information needed to carry out day-to-day controls. Principles relating to the information and communication include:

13) The entity obtains or generates and uses relevant, quality information to support the functioning of the internal control.

14) The entity internally communicates information, including objectives and responsibilities for internal control, necessary to support the functioning of internal control.

15) The entity communicates with external parties regarding matters affecting the functioning of the internal control.

(5.) **Monitoring –** On-going evaluations, separate evaluations, or some combination of the two are used to ascertain whether each of the five components of internal control, including controls to effect the principles within each component, is present and functioning. Findings are evaluated and deficiencies communicated in a timely manner, with serious matters reported to senior management and to the Audit Committee. Principles relating to monitoring activities include:

16) The entity selects, develops, and performs ongoing and/or separate evaluations to ascertain whether the components of internal control are present and functioning.

17) The entity evaluates and communicates internal control deficiencies in a timely manner to those parties responsible for taking corrective actions, including senior management and the Audit Committee, as appropriate.

3.3.3 INTERNAL CONTROL SERVICES

PFMR r. 153(1)(b) requires the HIA to provide reasonable assurance through the Audit Committee on the state of the County Government entity controls. The PFMA s. 155 (3) requires the HIA to undertake risk-based, value-for-money and systems audits aimed at strengthening internal control mechanisms that could have an impact on the achievement of the entity's strategic objectives.

The Internal Auditor can provide reasonable assurance in relation to controls by assessing the following;

(1.) Controls are clearly linked to: objectives that they are supporting the achievement; and risks they are managing. This will enable the Internal Auditor to establish areas of under-control (i.e. weak or no controls to support achievement of objectives or management of risks) or over-control (i.e. areas where the costs of implementing control/s is more than the benefit derived in relation to achieving objectives and managing risks).

(2.) Management have adopted an appropriate risk management strategy i.e. avoid, accept, transfer/share, mitigate or pursue (for opportunities).

(3.) Management is implementing an appropriate risk treatment activity. This will involve assessing the: design of the treatment activity and if the activity has been implemented as designed.

Where the IAU is to provide consultancy services in improving internal controls, this should be clearly provided in the Internal Audit Charter.

A ***pre-engagement / control questionnaire, Template 4*** is provided in the Appendix.

3.4 CORRUPTION AND FRAUD

1210.A2 - Proficiency
The Internal Auditor must have sufficient knowledge to identify the indicators of fraud but is not expected to have the expertise of a person whose primary responsibility is detecting and investigating fraud.

2120.A2 – Risk Management
The Internal Audit Unit must evaluate the potential for the occurrence of fraud and how the entity manages fraud risk.

2210.A2 – Engagement Objectives
Internal Auditors must consider the probability of significant errors, fraud, noncompliance, and other exposures when developing the engagement objectives.

PFMR r. 160(1)
When indications of fraud, material breaches and wasteful expenditure have been identified in a County Government entity in accordance with section 92 of the Act, the Head of the Internal Audit Unit shall immediately notify the County Executive Committee Member.

The Anti-Corruption and Economic Crimes Act, 2012 defines **corruption** as bribery, fraud, embezzlement, misappropriation/stealing of resources, abuse of office, breach of trust or an offence involving dishonesty in connection with tax or rate imposed levied under Act. Corruption may also take the following forms: skimming (stealing assets before they are recorded in the entity's records); disbursement against falsified and fictitious documents; fraudulent expense claims; ghost workers; procurement fraud (during pre-bidding, bidding, awarding and delivering); conflict of interest among others.

IIA defines **fraud** as any illegal act characterized by deceit, concealment, or violation of trust. These acts are not dependent upon the threat of violence or physical force. Frauds are perpetrated by parties and entity to obtain money, property, or services; to avoid payment or loss of services; or to secure personal or business advantage.

Corruption and fraud have adverse impacts on entity and their true cost is even higher than just the loss of money, given their impact: on time spent to detect, investigate, prosecute and recover lost funds; loss of reputation and trust by ordinary citizens.

Internal auditors should be alert to situations/circumstances that can cause corruption and fraud including:

(1.) **Opportunity**: ability to execute corruption or fraud scheme without being detected. This can be caused by weak governance, risk management and controls.

(2.) **Pressure**: financial or social pressure pushing an individual towards committing corruption or fraud. Pressures can include money problems, gambling debts, alcohol or drug addiction or overwhelming medical bills. There may be pressure from other to prove that an individual is better than others in breaking into systems.

(3.) **Rationalization**: personal justification of dishonest action. The individual manages to justify what he or she is committing the fraud or corruption e.g. they are just going to borrow the stolen goods, or that they need the money more than the "big" place they are stealing from.

(4.) **Capability**: refers to the personal traits and ability of persons that enable them to perpetrate corruption/fraud, beyond the environmental or situational factors of opportunity, rationalization and pressure. This include a person's knowledge of the policies, procedures and controls of the entity and in particular the weaknesses there in; and involvement in and influence over key relationships either internal relationships within the business, or external relationships with third parties.

Good governance, risk management, and internal controls can help establish a combination of prevention, detection, and deterrence measures to minimise opportunities for corruption and fraud. It's the role of the Accounting Officer to ensure risk management and controls are established that prevent fraud as provided by PFMR r. 158.

It's the role of the Accounting Officer and management to establish: corruption prevention system which includes a corruption-prevention policy; integrate corruption risk assessment with entity risk management framework; whistleblowing system that protects the whistle-blower and ensures effective expedition of reported corruption and fraud causes; and communicate the results of investigations to appropriate authorities.

PFMR r. 160(1) requires the HIA to report indicators of fraud, material breaches and wasteful expenditure to the County Executive Committee Member. The County Executive Committee Member may notify the Cabinet Secretary of the findings with a copy to the Auditor-General. Internal Auditors when undertaking their engagements are expected to take due professional care to detect possibility of corruption and fraud. Although Internal Auditors are expected to detect fraud or corruption they are not expected to have the expertise of someone whose role is solely to detect fraud or corruption (i.e. due professional care does not imply infallibility).

Audit procedures alone even when performed with due professional care, cannot guarantee that fraud will be detected. Consequently, the Accounting Officer and management should establish effective systems for preventing, detecting and resolving corruption and fraud. Research by Association of Certified Fraud Examiners (ACFE Report to the Nations on Occupational Fraud and Abuse 2016) indicates that the best means of detecting corruption and fraud in terms of ranking are: tips/whistleblowing system (41% of the cases); Internal Audit (15% of the cases); management reviews (14% of the cases); by accident (6% of the cases); reconciliations (3%); and external auditor (3%). In this respect Internal Audit detects approximately 15% of the fraudulent cases with 85% being systems put in place by management.

Internal Auditor need to be aware that corruption and fraud can be a one-off transaction or can be perpetuated for a long time. Being that corruption and fraud are concealed they may be hard to detect. Internal Auditor should look for the following red flags that may be indication that corruption or fraud **may** be occurring:

(1.) Management override of controls or established controls not applied consistently.
(2.) Weak supervision of activities or unclear lines of responsibility and accountability.
(3.) Unexplained over-performance especially where there is general poor performance in other areas of the entity or sector.
(4.) Non-routine or unusual transactions or journal entries.
(5.) Delays or refusal to provide requested information during audits.
(6.) Unsupported or unapproved transactions.
(7.) Personnel who don't go for leave or when they are on leave no other personnel is able to perform their work.
(8.) Lack of employee rotation in sensitive positions.
(9.) Personnel living beyond their means.
(10.) Personnel always complaining dissatisfaction with their job.
(11.) Unusual close association with suppliers and customers.
(12.) Significant changes in suppliers and customers.
(13.) Personnel with personal financial stress.
(14.) Personnel addicted to drugs, alcohol or gambling.
(15.) Personnel consistently rationalise poor performance.
(16.) Personnel who perceive beating the system to be an intellectual challenge.
(17.) High turnover among supervisory position.
(18.) Personnel refusing transfers.
(19.) Personnel being protected by their seniors.

Where the IAU is to undertake investigations, this should be clearly provided in the Internal Audit Charter. The Internal Auditor may have the primary responsibility for conducting investigation or may act as a resource to support the investigation team (e.g. evidence collection and analysis, review investigation output and recommend controls improvement).

Safeguards should be established where IAU is to undertake investigations to protect: the independence and objectivity of IAU; and perception of the IAU by the audit clients as a trusted a business advisor and not an investigator. HIA should ensure the team (either the Internal Audit team or external consultant) undertaking the investigation has sufficient proficiency to achieve the objectives of the investigation. Code of ethics should be complied with when undertaking fraud investigations.

The HIA should consult with the legal counsel on the investigation process and output to ensure all legal requirements are adhered to being some investigation may result to prosecution or the action taken based on the investigation may be challenged legally. Under investigations resulting to prosecution, only certified fraud examiners registered with ACFE, may present evidence to the court.

All investigations must be approved by the Audit Committee and/or the Accounting Officer with clear terms of reference. The terms of reference may include protocols covered when undertaking fraud investigations:

(1.) Gathering, documenting and preserving evidence.

(2.) Considering legal rules of evidence, and the business uses of the evidence.

(3.) Determining the extent of the fraud.

(4.) Determining the techniques used to perpetrate the fraud and how come the fraud was not detected by management, Internal Auditors, external auditor or other assurance providers.

(5.) Evaluating the cause of the fraud.

(6.) Identifying the suspects.

(7.) Form and periodicity of reporting on the findings of the investigations.

(8.) Recommend on how to strengthen controls to prevent occurrence of fraud in future or ensure they are detected on time.

(9.) How the results of the investigation will be used e.g. to strengthen controls, recover the lost resources, prosecute etc.

Where the IAU is to provide consultancy services on corruption and fraud, advisory on development of a policy on the corruption and fraud that encompasses guidelines and mechanisms for whistle blowing and anti-corruption committees.

Fraud Incident Reporting, Template 5 is provided in the Appendix

3.5 TYPES OF AUDITS

The mandate of the internal auditors as provided for in PFMR r.153 (1), can be achieved through carrying out a number of types of audits. Audits may be categorised under the following types;

(1.) Financial audits

The assertions for which the internal auditor seeks evidence relate to the reliability and integrity of the financial and operating information. It involves the correctness, entirety, legitimacy, provability and regularity of financial transactions, revenue and expenditure, account balances of assets and liabilities, including physical verification of tangible fixed assets, and integrity of accounting books and records.

(2.) Compliance audits

These audits are intended to determine whether an entity has complied with specific policies, procedures, laws, regulations, or contracts that affect the business of the County Government entity such as the Constitution of Kenya, 2010, County Government Act 2012, Public Finance Management Act 2012 and its regulations, Public Procurement and Disposal Act, 2020 and its regulations, Urbans and Cities Act, 2011, the County Assembly Acts and policies among others.

(3.) Operational audits

These audits cover the review and evaluation of the processes the management has established to ensure the achievement of the objectives and goals, economical, effective and efficient use of resources and safeguarding of assets. This is also referred to systems audits where the evaluation involves the design and operation of an organisation's systems and process rather than locations or departments. e.g. Order –to- pay cycle.

(4.) Information Systems audits

This is a process that collects and evaluates evidence to determine whether the information systems and the related resources adequately safeguard assets, maintain data and systems integrity, provide relevant and reliable information, achieve the entity's goals effectively and use of resources efficiently. The process also determines whether internal control exist that provide reasonable assurance that organisational, operational, and control objectives will be met and the undesired events will be prevented or detected and corrected in a timely manner.

(5.) Value For Money Audit (Performance Audit)

Review for processes to determine whether resources have been used efficiently, effectively and economically.

(6.) Procurement Audit

Reviews different contracts and contracting processes to determine the completeness, efficacy as well as the accuracy of the procurement process.

(7.) Project Audit

Examining, researching and verifying a project for consistency and relevance to the basic parameters (quality, performance, cost-effectiveness) that are pre-set at the very beginning of the project.

(8.) Performance management Audit

Reviews to ensure the County conforms to the highest standards of good governance.

CHAPTER 4 – MANAGING THE INTERNAL AUDIT UNIT

Chapter 4 covers factors that the Head of Internal Audit needs to put in place to effectively manage the Internal Audit Unit. Chapter 4 is aligned to IIA Standard 2000 on Managing the Internal Audit Unit.

2000 – Managing the Internal Audit Unit
The Head of the Internal Audit Unit must effectively manage the Internal Audit Unit to ensure it adds value to the County Government entity.

The Internal Audit Unit is considered to be adding value to the County Government entity and its stakeholders when it: considers strategies, objectives and risks impacting the County Government entity; and strives to offer ways to enhance governance, risk management and controls processes and systems of the County Government entity.

4.1 PLANNING

2010 - Planning
The Head of Internal Audit Unit must establish risk-based plans to determine the priorities of the internal audit unit, consistent with the organization's goals.

To ensure the planning process is risk-based, the HIA shall consult with the Accounting Officer, Audit Committee and senior management and obtain an understanding of the county entity's strategies, key business objectives, associated risks, and risk management processes.

4.1.1 STRATEGIC PLANNING

The PFMR r. 163 requires the HIA to prepare a three-year strategic plan which shall be risk based. In preparing this plan the HIA shall consider: the strategies, objectives and risks of the County Government entity; and the Internal Audit Charter. The HIA shall ensure the Internal Audit Strategic Plan is in-line with the County Government Integrated Development Plan. The strategic plan shall contain:

(1.) Vision

This is a possible and desirable future state of the internal audit unit. It describes aspirations for the future – a destination for the IAU.

(2.) Mission

The Mission of Internal Audit articulates what internal audit aspires to accomplish within an entity. It explains why the internal audit unit exists, what its overall goal is, identifying the goal of its operations. The mission of internal audit forms part of the mandatory elements of the IPPF. The framework articulates that the mission of internal audit is 'to enhance and to protect the organization value by providing risk-based and objective assurance, advice and insight'.

(3.) Goals

These are the key focus areas during the strategic period. This should be aligned to the strategic plan of the County Government entity.

(4.) Objectives and Strategies

These are performance targets to be achieved under each focus area. Each objective should have strategies of how it will be achieved and activities to support the strategies. Timelines for implementing each activity, associated costs, resources required and person to implement the activity should also be defined in the Internal Audit Strategic Plan.

(5.) Monitoring and Evaluation

The strategic plan should include a framework to monitor the implementation of the plan. The strategic plan should include a risk matrix indicating events that impede achievement of the plan and strategies instituted to manage these risk events.

(6.) Assumptions

The strategic plan should include information on the assumptions on which the plan is based on.

In addition to the above, the strategic plan shall also contain Critical success factors; SWOT Analysis; Stakeholder Analysis, and Key Strategic Focus Areas, Strategic activities, Budget, implementation plan and monitoring and evaluation framework.

The ***Internal Audit Strategic Plan, Template 6*** is provided in the Appendix.

4.1.2 ANNUAL PLANNING

The PFMR r. 163 requires the HIA to prepare an annual risk-based audit plan based on the three-year risk-based strategic plan. The annual planning process shall involve reviewing and making necessary adjustments to the Internal Audit Strategic Plan to ensure it is responsive to the changes in the county entity's business, risks, operations, programs, systems, and controls. A risk-based plan enables the HIA to determine the priorities of the IAU that are consistent with the entity's objectives.

The annual planning process commences with;

(1.) Establishing the audit universe i.e. all auditable area that may include functions, processes, systems and locations.

(2.) Grouping the audit universe into manageable audit areas.

(3.) Risk assessment and risk mapping of the auditable areas.

(4.) Prioritization of the audit assignment in the annual risk based audit plan.

(5.) Approval of the audit plan.

The ***Internal Audit Universe, Template 7*** is provided in the Appendix.

Risk-based audit is adopted as per PFMR r. 163(1) to ensure that limited resources are directed to areas of greater risk to the achievement of county government objectives. This helps to prioritise limited audit resources. The IAU shall assess and rank each auditable unit based on its significance to the achievement of the county government's objectives, its complexity in terms of ensuring that intended outcomes are achieved, and its sensitivity in terms of the public or the intended beneficiaries.

The HIA shall consider approaches such as the risk factor approach and the risk assessment approach when establishing the areas in the audit universe that are to be audited in a particular financial year.

4.1.2.1 RISK FACTOR APPROACH

Under the risk factor approach the following factors (each factor is weighted based on its importance) can be considered:

(1.) **Risk assessment**: Based on the results of the County Entity's Risk Assessment process, the HIA shall establish the high-risk areas that need to be audited from the audit universe (the all processes or functions that can be audited). Where the entity has not undertaken a risk assessment, the HIA shall facilitate a risk assessment (i.e. work with management to undertake risk assessment or undertake risk assessment and have management validate the results). This enables the HIA to focus the audit on high-risk areas instead of all the areas in the audit universe.

(2.) **Budgetary Allocation**: the HIA shall review the entity's strategic plan, annual budget, annual work plan, performance contract and other relevant literature to establish areas that will be allocated significant funding. Such areas are considered to be of higher risk compared to those that receive less funding.

(3.) **Areas of Management Concern**: the HIA shall engage the Accounting Officer and Senior Management to establish areas that management would like the Internal Audit to focus in the upcoming year. This may include areas that are: experiencing significant changes like process re-engineering, policy changes, automation, new policies and procedures etc; areas of high staff turnover; areas of weak performance; and areas of weak control.

(4.) **Significant Operational Changes**: the HIA shall engage the audit client to determine significant changes in systems, processes and personnel and the impact they have on the achievement of objectives and management of risks.

(5.) **Results of Prior Audits**: the HIA shall review the outcome of previous internal, external, ISO auditors and other audits to identify areas that had significant weak governance, risk management and controls systems and processes and consider them for inclusion in the current annual audit plan. The HIA shall also consider: feedback from management on the implementation of audit recommendations; and the time lapse since an area was last audited.

Illustration 2 provide a guide that the HIA can adopt in establishing the areas to audit in a financial year. The HIA can adjust the planning factors and weights appropriately during the annual planning process.

Illustration 2: Annual Auditing Plan Factors

Planning Factor	Weight (%)	Sub-Factors
Risk Assessment	30%	a. Risks that impact on the function b. Risk maturity level c. Fraud or corruption has been reported
Budgetary Allocation	25%	a. Rating based on budgetary allocation
Management Concern	20%	a. Weak performance of the area b. Consistent weak controls c. Opportunities to increase revenue or reduce costs
Significant Operational Changes	15%	a. New regulatory requirements b. High staff turnover c. New policies, procedures or systems d. Change in organizational structure
Prior Audit Results	10%	a. Internal audit conclusion on governance, risk management and controls b. OAG audit opinion and areas of concern c. Rating by other assurance providers d. The last time the area was audited
Total	**100%**	

Illustration 3 provides sample planning factors and criteria for rating each planning factor. The HIA can adopt a score of; 3 for high rating; 2 for medium rating and 1 for low rating. The HIA can adjust the rating criteria and rating factors appropriately during the annual planning process.

Illustration 3: Annual Auditing Plan Factors Rating

Planning Factor	Sub-Factors	Rating
Risk Assessment	**Risks that impact on the function**	a. **High**: function impacted by strategic risks b. **Medium**: function only impacted by operational risks that are rated high and medium c. **Low**: function impacted by operational risks that are rated low risk
	Risk maturity level	a. **High**: No risk management established. Management have not identified risks and risk management strategies b. **Medium**: Risk management established and management has not identified all the risks and the risk strategies c. **Low**: risk management process is effective. Governing body and Accounting Officer are aware of the strategic risks, are providing oversight over their management and receive regular reports
	Fraud or corruption has been reported	a. **High**: in the last 12 months b. **Medium**: in the last 24 months c. **Low**: in the last 36 months or not reported at all
Budgetary Allocation	**Rating based on budgetary allocation**	a. **High**: i. More than Kes 10m; or ii. More than 10% of total budget b. **Medium**: i. Between Kes 1m and Kes 10m; or ii. Between 5% to 10% of total budget c. **Low**: iii. Less than Kes 1m; or i. Less than 5% of total budget
Management Concern	**Weak performance of the area**	a. **High**: variance of actual performance has been more than 10% in the last financial year b. **Medium**: variance of actual performance has been between 5% and 10% in the last financial year c. **Low**: variance of actual performance has been less than 5% in the last financial year
	Consistent weak controls	a. **High**: controls managing high risk areas have not performed as expected in the last 12 months b. **Medium**:

Planning Factor	Sub-Factors	Rating
		i. Controls managing medium risk areas have not performed as expected in the last 12 months; or ii. Controls managing high risk areas were reported not to have performance as expected more than 12 months ago but less than last 24 months ago c. **Low**: i. Controls managing low risk areas have not performed as expected in the last 12 months; or ii. Controls managing medium risk areas were reported not to have performance as expected more than 12 months ago but less than last 24 months ago iii. Controls managing high risk areas were reported not to have performance as expected more than 24 months ago but less than last 36 months ago
	Opportunities to increase revenue or reduce costs	a. **High**: i. Revenue may be increased by more than 5 % of last financial year audited accounts; or ii. Expenditure will reduce by more than 10% of last financial year audited accounts b. **Medium**: i. Revenue may increase by between 2.5% to 5% of last financial year audited accounts; or ii. Expenditure will reduce by between 5% and 10% of last financial year audited accounts c. **Low**: i. Revenue may be increased by less than 2.5 % of last financial year audited accounts; or ii. Expenditure will reduce by less than 5% of last financial year audited accounts
Significant Operational Changes	**New regulatory requirements**	a. **High**: the new law or regulation has a strategic impact on the entity and impacts on an area b. **Medium**: the new law or regulation has an operational impact on the entity and impacts on an area

Planning Factor	Sub-Factors	Rating
		c. **Low**: the new law or regulation has little or low impact on the entity and impacts on an area
	High staff turnover	a. **High**: i. Turnover at the governance level ii. 10% and above turnover of senior management b. **Medium**: i. Less than 10% but more than 5% turnover of senior management ii. 10% and above turnover of middle management/supervisors c. **Low**: i. Less than 5% turnover of senior management ii. Less than 10% but more than 5% turnover of middle management iii. 10% and above turnover of employees below middle management
	New policies, procedures or systems	a. **High**: i. Changes impact one or more directorates or divisions (this is the highest level of operation). ii. Changes impact departments in more than one directorate (this is the middle level of operation). b. **Medium**: the changes impact one or more departments within a directorate/division c. **Low**: the changes impact one or more processes (this is the middle level of operation) within a department
	Change in organizational structure	a. **High**: the changes impact on the governance level and senior management positions b. **Medium**: the changes impact on the middle management positions c. **Low**: the changes impact on the employees below middle management positions
Prior Audit Results	**Internal audit conclusion on governance,**	a. **High**: rated as weak b. **Medium**: rate as strong with key areas of improvement

Planning Factor	Sub-Factors	Rating
	risk management and controls	c. **Low**: rated as strong
	OAG audit opinion and areas of concern	a. **High**: adverse opinion and areas that led to the opinion b. **Medium**: disclaimer opinion and area that led to the opinion c. **Low**: unqualified opinion
	Rating by other assurance providers	a. **High**: i. Adverse opinion by external assurance providers e.g. Public Procurement Regulatory Authority (PPRA), Ethics and Anti-Corruption Commission (EACC) etc ii. Governance, risk management and controls rated as weak by internal assurance providers b. **Medium**: Governance, risk management and controls rated as strong with key areas of improvement by other assurance providers (i.e. that are not IAU or OAG) c. **Low**: Governance, risk management and controls rated as strong by other assurance providers (i.e. that are not IAU or OAG)
	The last time the area was audited	a. **High**: more than 3 years ago b. **Medium**: more than 2 years ago c. **Low**: last financial year

Annual Risk-Based Internal Audit Work Plan Template 8 is provided in the Appendix.

4.1.2.2 RISK ASSESSMENT APPROACH

Using the risk assessment approach the following steps are followed to assess the risks in each auditable unit;

(1.) Understanding the processes and objectives - Assessment of each auditable unit risk assessment begins with an understanding of the entity and unit, activities or processes.

(2.) Identifying risks - The county government's strategic, financial, operational, regulatory and reputational risks at both a countywide and operational level are identified. Risks whether from external or internal sources are categorised using a suitable risk model. A ***Risk Model, Template 9*** is provided in the Appendix. Information on risks can be gathered:

(a) From interviews of top management;

(b) By consulting external audit;

(c) By reviewing recent audit reports;

(d) From planning documents such as budgets, strategic plan etc;

(e) From the external environment; and,

(f) From other stakeholders.

(3.) Risk analysis

(a) **Inherent risk assessment** - Risks are identified and assessed before considering the controls management has put in place.

(b) **Residual risk assessment** - The controls to mitigate the risks are mapped and their effectiveness considered in determining the residual risk rating based on management's perception and the auditor's professional judgement.

Where management has implemented a risk management framework, internal auditors should make use risk assessment conducted by management in developing internal audit plans. The ***Risk Control matrix, Template 10***, will be used to analyse the risks and arrive at a consensus of the risk rating.

Individual risks are profiled by combining the estimated risk likelihood and impact to give the significance of each risk. Risks shall be assessed as high, medium or low where:

(1.) **High**- A fundamental objective is not met or there is a critical weakness in controls. Resolution would help avoid a potentially critical negative impact involving loss of material assets, reputation, critical financial information, or ability to comply with the most important laws, policies, or procedures.

(2.) **Medium** - An important objective is not met or there is a significant weakness in controls. Resolution would help avoid a potentially significant negative impact on the unit's assets, financial information, or ability to comply with important laws, policies, or procedures.

(3.) **Low** - Objectives are mostly met but further enhancement of the control environment is possible. Resolution would help improve controls and avoid problems in the unit's operations. Individual risk scores are grouped for each auditable area (process) to give the relative significance of each auditable area in the audit universe. Overall risk ratings can be classified as lower, moderate and higher risks and plotted on a ***Heat Map, Template 11***, provided in the Appendix. IA should consider the risk assessments conducted by management when preparing the Annual Audit Plan.

4.1.2.3 ANNUAL RISK-BASED INTERNAL AUDIT PLAN

Upon considering the either of the above approaches and factors therein, the HIA shall develop the Annual Risk-Based Internal Audit Plan that includes:

(1.) A list of audit engagements and specification regarding whether the engagements are: assurance or consulting in nature; governance, risk management or controls engagements; and follow-up audits (as separate engagements or undertaken as part of engagements).

(2.) Objectives, scope and timing of each proposed engagement.

(3.) Rationale for selecting each proposed engagement based on assessment of the factors (i.e. risk assessment, budgetary allocation, management concern etc.)

(4.) Priority level of each engagement based on the risk rating. Area/s of high risk should have a higher frequency of review compared to those of lower risk rating.

Illustration 4 provides a guide on determining the frequency of auditing an area based on its risk as stipulated in the IAGCGE, Guidelines on Preparing a Risk-Based Annual Work Plan. The allocation of audit frequency is a matter of professional judgement.

(5.) A list of initiatives or projects that result from the internal audit strategy but may not be directly related to an audit engagement.

(6.) Time allocated to undertake ad-hoc engagements requested by the Audit Committee or Accounting Officer. Ad-hoc requests by management must be approved by the Accounting Officer. There are times where the ad-hoc requests require more time than what has been allocated in the annual plan. The HIA shall assess the risk profile of the requests and compare with the scheduled engagements to determine if the ad-hoc requests have a higher priority (have a higher risk) than some of the scheduled engagements and adjust the annual plan appropriately.

(7.) The staff resources and other resources available, expected and budgeted.

(8.) The resource gap if any, including proposals on how this gap could be dealt with, and the risks consequences arising if the proposals are not able to be implemented.

(9.) A summary of capacity building that is planned to take place during the period.

Illustration 4: Auditing Frequency

Risk Rating	Frequency of Auditing
High	More Than Once every year
Medium	Every year
Low	Every three years.

4.2 RESOURCE MANAGEMENT

2030 – Resource Management
"The Head of Internal Audit shall ensure that internal audit resources are appropriate, sufficient, and effectively deployed to achieve the approved plan."

4.2.1 STRATEGIC PLAN RESOURCING

The HIA shall establish the resources required in implementing the Internal Audit Risk Based Strategic Plan and timelines of acquiring the same. This shall be integrated with the entity's strategic and business plans to ensure that as the county entity is seeking funding to implement its strategic plan the funding requirements of IAU are also considered. The Internal Audit Risk Based Strategic Plan shall be implemented through the Annual Risk-Based Internal Audit Plan and thus resource mobilization to support the Strategic Plan shall be undertaken through the annual audit plan.

4.2.2 ANNUAL PLAN RESOURCING

The Annual Risk-Based Internal Audit Plan contains internal audit engagements and a list of initiatives or projects that result from the internal audit strategy but may not be directly related to audit engagements. The HIA, in developing the budget to support the annual audit plan, shall consider the two elements. The HIA shall consider the following steps in establishing the budget to support the Annual Risk-Based Internal Audit Plan.

(1.) Establishing Human Capital Resources

Based on the auditable areas identified in the Annual Risk-Based Audit Plan, the HIA shall:

(a) **Assess the Workload**: consider the effort required to audit each area selected for audit. This can be based on factors like: resources required in the past to undertake the audits; changes in the area that may require less/more resources; or challenges faced in the past in undertaking audits in the areas. When developing the schedule for internal audit engagements the HIA shall consider key activities of the entity to ensure availability of the audit client.

(b) **Determine the Resources available:** This is estimated by taking the number of man-days to be provided by each staff in the IAU after making allowance of time for training, annual leave, holidays, estimated sickness time and any other non-productive time. In determining the resources available, the HIA shall ensure there is appropriate mix of knowledge, skills and other competencies needed to achieve the annual plan.

Time management: To enhance time management on audits, a time budget should be prepared for each audit assignment and used as a "benchmark" for the actual hours spent on the assignment. Furthermore, the internal auditors should prepare daily time sheets which show the tasks accomplished on each working day and the number of "person-hours" spent on each task. Those time sheets should be reviewed and approved by the HIA and filed in the administration section of the audit file.

Daily time sheet, Template 12 and ***Work allocation and time budget, Template 13*** are provided in the Appendix.

(c) **Balancing the resources available with the Workload:** this involves getting more resources (either through hiring, out-sourcing or co-sourcing) or reducing the workload to fit with the resources available. In reducing the workload, the HIA should evaluate the risk exposure of not covering an area. Reducing the workload can be achieved through:

1) Omitting certain tasks from the annual plan with the intention of completing them in the following year;
2) Reducing the staff budgets for the individual tasks by reducing the depth of each assignment; and
3) Reducing the frequency of auditing an area.

In balancing the workload, the HIA shall also provide reserves to cater for changes in the annual audit plan that may result due to: ad-hoc requests by the Audit Committee or management; or new high-risk areas detected (by Audit Committee, management or Internal Audit) during the financial year.

A ***Resource calendar or Chronogram, Template 14*** provided in the Appendix, shall be completed for all activities in the annual plan.

Section 5.1.5 contains more information on ensuring the IAU has appropriate and sufficient human capital.

(2.) Establishing Non-Human Capital Resources

The HIA shall establish the resources required to support the Internal Auditors in implementing the Annual Risk-Based Internal Audit Plan. This shall include:

(a) **Travel, accommodation and other ancillary costs:** the HIA shall establish the level of travel and related expenses that are required in undertaking the internal audit engagements based on the expected work load.

(b) **Tools and equipment:** the HIA shall review the existing tools, equipment and technology requirements vis-à-vis what is required to meet the expected workload to determine sufficiency of the same. Where there is a gap the HIA shall consider developing a resourcing strategy to obtain the required tools, equipment and techniques. The HIA shall consider the acquisition and management of data analysis tools – CAATs such as ACC, IDEA to extract and analyse large volumes of data, which would be inefficient to do manually. This will be in conformance with the IPPF standards that require internal auditors to possess sufficient knowledge of key information technology risks and controls and available technology-based audit techniques to perform their assigned work.

(c) **Non-audit strategic initiatives:** the HIA shall review the Internal Audit Strategic Plan to establish the strategic initiatives that are to be implemented in the financial year under consideration and determine the resources required to support their implementation.

(d) **Administrative resources:** the HIA shall establish in-direct costs related to supporting the achievement of the annual audit plan. This includes costs related to capacity building/training and other administrative tasks.

(3.) Compiling IAU Budget

The HIA shall compile the human capital and non-human capital requirements to establish the IAU annual budget.

Annual Risk-Based Internal Audit Work Plan, Template 8 provided in the Appendix contains items to be considered in formulating the IAU Budget.

4.3 PLAN COMMUNICATION AND APPROVAL

2020 – Communication and Approval
The Head of Internal Audit shall communicate the Internal Audit Unit's plans and resource requirements, including significant interim changes, to the Accounting Officer, senior management and the Audit Committee. The Head of Internal Audit shall communicate the impact of resource limitations.

As stipulated in the PFMR r. 163(2) the Annual Risk-based Internal Audit Plan and budget preparation and communicating to Audit Committee, Accounting Officer and Senior Management shall be in-line with the county entity budgeting process and timelines so as to ensure the final approved plan and budget forms part of the county entity's budget. This session enables HIA to obtain the support of the Accounting Officer and Senior Management in implementing the annual plan and obtain the required resources to support the annual plan. The Accounting Officer as stipulated in PFMR r. 155 shall ensure the IAU has vote and adequate budget allocation to fund the activities.

The HIA shall then submit the updated Risk-Based Internal Audit Plan and budget to the Audit Committee for review and final approval. The plan and the budget should be approved by the Audit Committee before 15th February each year.

On a quarterly basis the HIA shall provide progress reports to the Audit Committee, Accounting Officer and Senior Management on the implementation of the plan and budget (reviews, adjustments and re-allocations). Such reports shall provide information on any resource constraints that the IAU is facing and the impact of this on the implementation of the internal audit plan and the risk exposure that the county entity may face.

4.4 COORDINATION AND RELIANCE

2050 – Coordination and Reliance
The Head of Internal Audit shall share information, coordinate activities, and consider relying upon the work of other internal and external assurance and consulting service providers to ensure proper coverage and minimize duplication of efforts.

The HIA may rely on the work of other assurance and consulting service providers so as: to minimize duplication of efforts; maximize efficiency and effectiveness of assurance coverage; assess specializes skills lacking in the Internal Audit team. Internal audit unit may use a combined assurance model approach where, internal audit coordinates assurance efforts with second line role functions such as a support and monitoring function, to reduce the nature, frequency and redundancy of internal audit engagements. Although the HIA may rely on the work of another assurance or consulting service provider, the HIA shall be held accountable and responsible for ensuring that conclusion and opinions made by Internal Audit are adequately supported.

Other assurance and consulting service providers may be classified into:

(1.) **Internal:** these are functions that are often considered as the "second line of defence" according to IIA's Three Lines of Defence Model and may include these functions: Compliance; Quality Control/Assurance; ISO Auditors; Legal; Health and Safety; Environmental Auditors; Risk Management; IT Security. These functions mostly report to management with some reporting to the Audit Committee like Risk Management and Compliance.

(2.) **Internal Auditors of other Government entities:** this is where the Internal Auditors work with others from the National Government Entities, other County Government or other entity in the same county government. The roles and responsibility of each party shall be agreed upon and endorsed by the respective entity Accounting Officer and Audit Committee.

(3.) **External:** these may report to management or external stakeholders. This include: Office of the Auditor General (OAG); Public Procurement Oversight Authority; Ethics and Anti-Corruption Commission; Bank Fraud Investigation Department; and Efficient Monitoring Unit.

To ensure there is a consistent process to determine whether the IAU shall cooperate and collaborate with another assurance or consulting service provider, the HIA shall consider the following factors:

(1.) **Objectivity**: does the service provider have any real or perceived conflict of interest? Has existing conflict of interest been reported?

(2.) **Independence**: what is the service provider reporting relationships and the impact of this arrangement?

(3.) **Competency**: verify whether the provider's professional experience, qualifications, certifications, and affiliations are appropriate and current.

(4.) **Due professional care**: by understanding the service provider's methodology and whether the work undertaken is appropriately planned, supervised, documented, and reviewed. This may also involve understanding the standards by which the other service provider operate on.

(5.) **Reasonableness of work done**: gain an understanding of the scope, objectives, and results of the actual work performed to determine the extent of reliance that may be placed on the provider's work. This involves assessing whether the output of the work done is based on sufficient, reliable and relevant evidence.

(6.) **Confidentiality requirement**: the HIA shall consider the entity's confidentiality requirements especially when dealing with sharing information with external service providers.

Cooperation and collaboration with other assurance and consulting service providers may involve:

(1.) Synchronizing the nature, extent, and timing of planned work.

(2.) Ensuring a common understanding of assurance techniques, methods, and terminology.

(3.) Providing access to one another's work programs, working papers, reports and tools.

(4.) Relying on one another's work to minimize duplication of effort.

(5.) Meeting intermittently to determine whether it is necessary to adjust the timing of planned work, based on the results of work that has been completed.

Cooperation and collaboration with other assurance and consulting service providers may be achieved through **Combined Map Assurance** where all the high-risk areas are identified and role of each provider is indicated/mapped. This enables the assurance providers to: identify high risk area/s that are not covered by any of them (gap) or area/s that are being over audited/assurance (duplication of resource). Such a mapping can then enable the providers to adjust their scope appropriately and identify areas where they can rely on the work done by each other. The parties to the cooperation and collaboration are expected to respect the value and ownership of information they receive and not disclose any information thereof without appropriate authority unless there is a legal or professional obligation to do so (observe confidentiality). The cooperation and collaboration should be approved by the Audit Committee with memorandum of understanding put in place to provide guidance.

4.4.1 COORDINATION AND COLLABORATION WITH THE OFFICE OF THE AUDITOR GENERAL

The Office of the Auditor General who is the external auditor of the entire public sector is established under Article 229 of the Constitution. The Public Audit Act Section 33 stipulates that: the final internal audit report which has been deliberated on and adopted by an Audit Committee of a County Government entity, may be copied to the Auditor-General; and the Auditor-General shall have unhindered access to all Internal Audit reports of a County Government entity. The Public Audit Act stipulates that the Accounting Officer shall support the OAG in fulfilling its mandate. Internal audit is part an entity's internal controls and the OAG has the mandate to review effectiveness of all internal controls.

In addition to the Constitution and the Public Audit Act, the International Standards of Supreme Audit Institutions (ISSAI) that guide how the Office of the Auditor General undertakes external audits provides on how the office can cooperate with the Internal Auditors:

(1.) ISSAI 1/3/par.3 provides for guidance on how the OAG can assign tasks and cooperate with Internal Auditors where the OAG in their own judgement have assessed the IAU to be effective.

(2.) ISA 315, 23 provides guidance on how the OAG can determine whether the IAU is likely to be relevant to the audit being undertaken.

(3.) ISA 610 and ISSAI 1610 provides guidance on how OAG can use the work of the internal auditor.

PFMR r. 165 (1) stipulates that the Accounting Officer shall be responsible for the implementation of audit recommendations of the audit reports, both external and internal audit reports and further develop response and action plan which they shall submit to the Chairperson of the Audit Committee within fourteen days. PFMR r. 165 (2) and Gazette Notice 2690 dated 15 April 2016 stipulates that the Audit Committee shall provide oversight over the implementation of audit recommendations by OAG.

The HIA shall be expected to support the Accounting Officer and the Audit Committee in facilitating the Office of the Auditor-General fulfill its mandate. To support this, the internal audit can maintain and submit a quarterly issue tracking report on OAG audit findings to Audit Committee and Accounting Officer.

4.5 REPORTING TO THE ACCOUNTING OFFICER AND AUDIT COMMITTEE

2060 – Reporting to Senior Management and Audit Committee
The Head of Internal Audit shall report periodically to Accounting Officer and the Audit Committee on the Internal Audit Unit's purpose, authority, responsibility, and performance relative to its plan and on its conformance with the Standards. Reporting must also include significant risk and control issues, including fraud risks, governance issues, and other matters that require the attention of the Accounting Officer and the Audit Committee.

PFMR r. 166 stipulates the HIA shall prepare quarterly reports and submit the same to the Accounting Officer of the concerned entity, County Treasury and the Audit Committee within 14 days after the end of the quarter. At the end of each financial year the HIA shall prepare a comprehensive annual report that consolidates the quarterly reports. At the end of each financial year, the Head of Internal Audit shall prepare for the county government clear and comprehensible annual report that consolidates the quarterly audit assurance reports prepared by all internal audit units' activities in county government entities, in accordance with formats prescribed by the Public Sector Accounting Standards Board. The HIA should allocate time in the annual audit plan for preparing the quarterly and annual reports.

4.5.1 QUARTERLY REPORTS

The quarterly reports will include information on:

(1.) **Implementation of the Annual Risk-Based Audit Plan:** number of actual audits undertaken vs scheduled; or number of audit reports issued vs engagements undertaken.

(2.) **Audit findings**:

(a) Number of high risk audit findings including corruption and fraud risks, irregular and illegal acts, significant errors, inefficiency, waste, ineffectiveness, conflicts of interest, and financial viability.

(b) % of recommendations implemented. This should consider the updated status since the audit follow-up was undertaken.

(c) Status of follow-up on recommendations of the OAG and other assurance providers.

(d) Number of repeat findings.

(e) Number of open audit findings past planned corrective action date.

(f) Audit findings where management has accepted the risk level and HIA is of the opinion that the risk exposure is beyond the approved risk appetite.

(g) Management acceptance of risk that in the HIA's judgment may be unacceptable.

(3.) **Funding**: actual funds allocated vs approved budget and impact of lack of adequate resources on the achievement of the annual audit plan and the resultant risk exposure

(4.) **Staff utilization** man-hour analysis; completed audits per auditor; and staff time utilization (direct time vs indirect time).

(5.) **Challenges:** that the IAU has faced in the quarter being reported and strategies to overcome the same that need Audit Committee and Accounting Officer intervention. Some of these challenges include: lack of adequate funding; impairment of objectivity and independence; and lack of adequate personnel.

Internal Audit Quarterly Report, Template 15 is provided in the Appendix.

4.5.2 ANNUAL REPORTS

The annual reports must include information on:

(1.) **Overall status of governance, risk management and controls**: this summarizes the quarterly reports.

(2.) **Other assurance providers' findings**: key findings by OAG, EACC, PPRA, ISO Auditors and other assurance providers and status of management implementing their recommendations.

(3.) **Adherence to Internal Audit Charter:** assurance that the IAU adhered to the Internal Audit Charter, IPPF, Internal Audit Procedures Manual and relevant laws and regulations. The HIA can report on factors that may have or cause the independence or objectivity of IAU to be impaired and required corrective action.

(4.) **Value addition:** audit client satisfaction rating; number of improvements in processes and systems arising from internal audit work; number of committees and task forces audit is involved in (advisory services); amount of identified cost savings or revenue increase due to internal audit work; and number of innovations arising from internal audit work.

(5.) **Human Capital**: staff competency index; staff engagement index; staff turnover; staff satisfaction rating; and training hours.

(6.) **Quality Assurance and Improvement Program**: results of on-going, annual or external quality assessments.

(7.) Independence of the internal audit unit

(8.) Conformance with the Code of Ethics and the Standards, and action plans to address any significant conformance issues.

(9.) Management's response to risk that, in the HIA's judgment, may be unacceptable to the organization.

Internal Audit Annual Report Template 16 is provided in the Appendix.

4.5.3 RESPONSIBILITIES OF AUDIT COMMITTEE SECRETARY

Audit Committee guidelines through gazette notice no.2690, requires that the HIA shall be the secretary to the committee. The HIA should support the Chairperson of the committee in identifying matters to be discussed. The Chairperson of the committee and the secretary should agree procedures for commissioning briefing to accompany business items on the committee's agenda and timetables for the issue of meeting notices, agendas, and minutes. The Chairperson of the committee should always review and approve minutes of meetings before they are circulated. The specific responsibilities of the Audit Committee Secretary should include;

(1.) Ensuring that new members receive appropriate induction training, and that all members are supported in identifying and participating in ongoing training.

(2.) Draft the Audit Committee Charter for the Chairman and members' review.

(3.) Meeting with the Chair of the Committee to prepare agendas for meetings.

(4.) Draft the work plan for the Audit Committee for the Chairman and members' review.

(5.) Commissioning papers as necessary to support agenda items.

(6.) Circulating meeting documents in good time before each meeting.

(7.) Arranging for executives to be available as necessary to discuss specific agenda items with the committee during meetings.

(8.) Keeping a record of meetings and providing draft minutes for the Chair's approval.

(9.) Ensuring action points are being taken forward between meetings.

(10.) Support the Chair in the preparation of Audit Committee reports to the Governor, CASB.

(11.) Arranging the Chair's private meetings with the management, OAG.

(12.) Keeping the Chair and members in touch with developments and relevant background information of the County.

(13.) Maintaining a record of when members' terms of appointment are due for renewal or termination.

(14.) Ensuring the appropriate appointment processes are initiated when required.

(15.) Managing budgets allocated to the Audit Committee.

(16.) Assist the committee in reporting to the Accounting Officer/Board/Assembly.

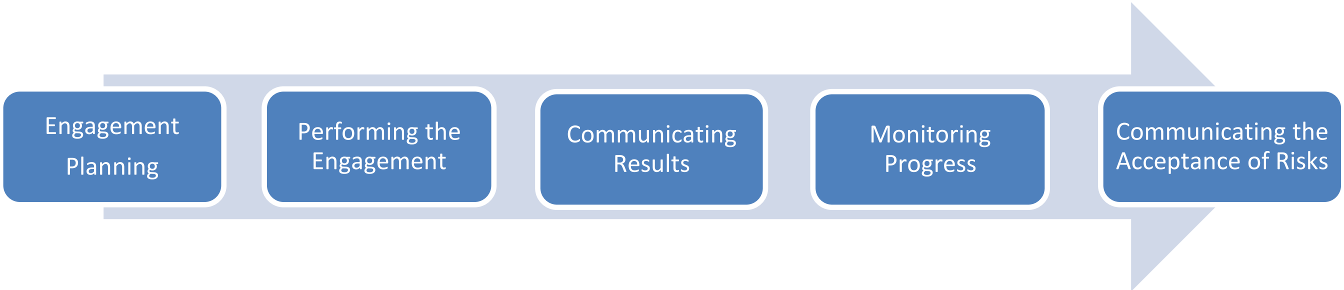
The following templates have been provided for in the Appendix to guide the HIA in offering the aforementioned support to the Audit Committee as a secretary.

#	**Template Name**
Template 17	*List of suggested Audit Committee induction materials*
Template 18	*Audit Committee Charter*
Template 19	*Quarterly Audit Committee report to the governing body*
Template 20	*Audit Committee annual report*
Template 21	*Audit Committee monitoring*
Template 22	*Internal audit assessment by the Audit Committee*
Template 23	*Audit Committee self-assessment*
Template 24	*Individual Audit Committee member performance assessment*

CHAPTER 5 –INTERNAL AUDITING PROCESS

Chapter 5 provides information on the framework for undertaking all internal audit engagements from planning to reporting and monitoring progress on the implementation of audit results. The chapter is aligned to the following IIA Standards:

1. Standard 2200: Engagement Planning.
2. Standard 2300: Performing the Engagement.
3. Standard 2400: Communicating Results.
4. Standard 2500: Monitoring Progress.
5. Standard 2600: Communicating the Acceptance of Risks.



5.1 5.2 5.3 5.4 5.5

In undertaking the different assurance assignments, the Internal Auditor shall adhere to the key tasks outlined in this chapter.

5.1 ENGAGEMENT PLANNING

2200 – Engagement Planning
Internal auditors must develop and document a plan for each engagement, including the engagement's objectives, scope, timing, and resource allocations. The plan must consider the organization's strategies, objectives, and risks relevant to the engagement

The HIA shall ensure an engagement plan is established for all engagements that will enable the goals and the objectives of the Annual Risk-Based Internal Audit Plan to be achieved. An engagement plan describes the overall audit strategy for an audit engagement, approved by the HIA. Although the Internal Auditor who is in charge of a specific engagement is responsible for the planning, execution and reporting of an audit engagement, the HIA retains overall responsibility to ensure all engagements are effectively and efficiently planned, executed and reported on.

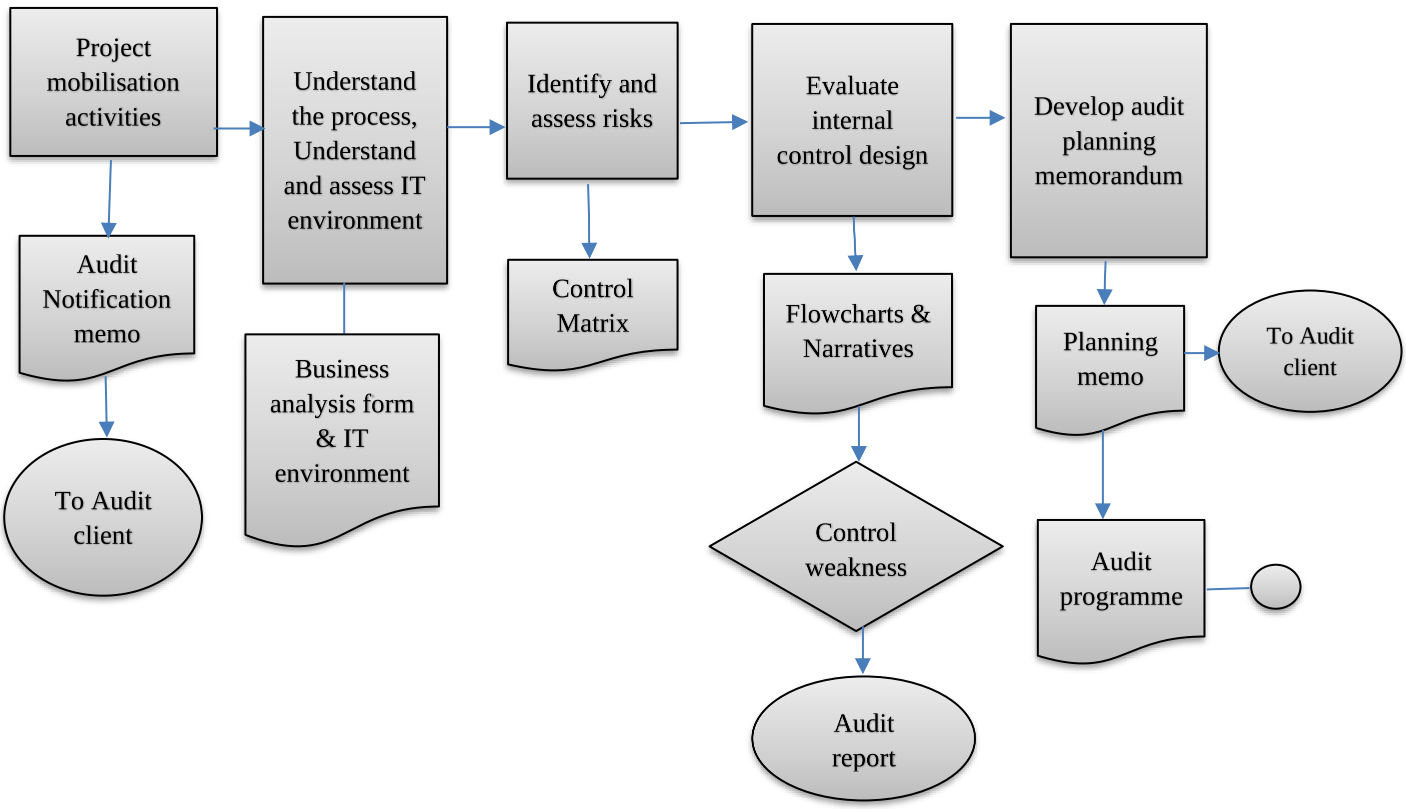
An engagement plan should:

1. Define the objective of the engagement and management expectations.
2. Establish the scope of the engagement.
3. Define the resources required to undertake the engagement.
4. Define audit steps to achieve the engagement objectives and adequately cover the scope i.e. engagement work program or audit programme.
5. Contain a communication plan detailing how the results of the engagement execution shall be communicated.
6. Be approved together with the supporting audit programme/s before commencement of the engagement by the HIA.
7. Communication with all who need to know about the audit and the audit results.

Engagement Plan, Template 25 is provided in the Appendix.

The illustration 5 below gives an overview of the engagement planning activities. The activities may be performed concurrently.

Illustration 5: Overview of Engagement Planning Activities



To adequately plan an audit engagement, the HIA should ensure that the internal auditors have an understanding of the legal framework and other documents maintained in the permanent audit file. A thorough understanding of the process to be audited is undertaken during the planning process (preliminary survey). The HIA should also have an understanding of the IT environment and the complexity of the area to be audited such as the audit of projects to determine the skills required. The extent of the preliminary survey will depend on whether: an area has been audited before or not; the internal audit team assigned to the assignment has audited the area before or not; type of audit. A number of techniques can be used to analyse and present the information required at the planning stage. The techniques include:

(1.) Interviews/meetings with the process owners.

(2.) Process walkthroughs or observation.

(3.) Review of relevant literature review including:

   (a) Functional operational plans aligned to the strategic plan, annual work plan, department budget, function performance contract.

   (b) Policies, procedures, flowcharts, system documentation, technical literature.

   (c) Management reports and management accounts.

   (d) Risks register and risk-control matrix.

   (e) Minutes of function and management meetings and key correspondence.

   (f) Function organogram/structures, key staff job description and key staff turnover.

(4.) Undertaking analytical procedures.

(5.) Internal control survey.

(6.) Narrative notes.

(7.) Flow Charting.

(8.) Data analysis.

(9.) Questionnaires.

The HIA should ensure that documents reviewed by the Internal Auditors during the engagement planning process are appropriately retained as part of work papers including the review notes.

The engagement planning process can also establish if it's feasible to undertake an engagement or not. Where conducting an engagement is not feasible, the HIA should revise the annual audit plan and appropriately communicate the same to the Accounting Officer and the Audit Committee. Some of the factors that may result in an engagement not being undertaken include:

(1) Management having strategic commitments resulting in key personnel not being available.

(2) Delays in completing prior audit engagements resulting in the Internal Auditors not being available to commence an engagement.

(3) Required resources (non-human capital) not being made available by the Accounting Officer.

5.1.1 PLANNING CONSIDERATION

2201 – Planning Consideration

In planning the engagement, internal auditors must consider:

- The strategies and objectives of the activity being reviewed and the means by which the activity controls its performance.
- The significant risks to the activity's objectives, resources, and operations and the means by which the potential impact of risk is kept to an acceptable level.
- The adequacy and effectiveness of the activity's governance, risk management, and control processes compared to a relevant framework or model.
- The opportunities for making significant improvements to the activity's governance, risk management, and control processes.

In developing the audit engagement plan the HIA should ensure the following factors about the area to be audited have been taken into consideration:

(1) Objectives of the function and how this is linked to the achievement of the entity's strategic plan.

(2) Risk assessment of the function by management and management's opinion on the effectiveness of the entity's risk management framework. The Internal Auditor should consider management's opinion on how well risks are being managed.

(3) Management expectations.

(4) Reviewing the risk management strategies established by management to manage risk identified.

(5) Governance process and management's opinion on its effectiveness.

(6) Reviewing the effectiveness of the design of the: risk management strategies and activities/control; and governance system/s and documenting the same in work papers.

(7) Key changes in processes, systems, people, risk management and governance since the annual audit planning was done.

(8) Outcome of prior internal audits engagements.

(9) Outcome of work done by other assurance providers both internal assurance providers (e.g. ISO Auditors, Safety, Health Auditors etc.) and external assurance providers e.g. (OAG, PPRA, EACC etc.).

(10) Outcome of management controls self-assurance.

(11) If the current engagement will involve follow-up on the implementation of management action plan on recommendations of previous audits of IAU, OAG or other assurance providers.

(12) Internal audit skills and other resources needed to undertake the engagement.

(13) How will IAU add value in strengthening governance, risk management and internal controls.

The HIA may use the ***pre-engagement / control questionnaire, Template 4*** to obtain necessary engagement planning information from the audit client.

In addition, the following templates provided in the Appendix may be used in the planning stages of an engagement.

#	***Template Title***
Template 26	*Audit Notification*
Template 27	*Request for Audit Information*
Template 28	*Information Request Monitoring Checklist*
Template 29	*Business Process Analysis form*
Template 30	*Understanding the IT environment*
Template 31	*Assessing IT general controls and application controls*
Template 32	*Standard Flow Charts Symbols & Narratives*
Template 33	*Fraud Risk Assessment*

5.1.2 ENGAGEMENT OBJECTIVES

2210 – Engagement Objectives
Objectives must be established for each engagement.

The engagement objective should be linked to the goals and objectives of the Annual Risk-Based Internal Audit Plan. The engagement objective should answer the following questions:

(1.)Why are we undertaking the audit?

(2.)What value will IAU add to the area being audited?

(3.)Are we focusing on the risky areas? This will ensure resources are focused on area/s of high risk?

The engagement objective should be linked to the risk/s of the area being audited and should ensure the results of the audit meet management expectations of the Internal Audit services are put into consideration. In developing the engagement's objective/s, the HIA should consider the objective of prior audit engagements of the area and assess if they were achieved and any lessons learnt (i.e. did we set the correct objective, was the objective clear to the Internal Auditors and audit client, did we achieve the engagement objectives).

5.1.3 ENGAGEMENT SCOPE

2220 – Engagement Scope
The established scope must be sufficient to achieve the objectives of the engagement.

Audit scope defines the boundaries of the audit engagement i.e. what is in-scope and what is out-of-scope. This identifies the extent of the processes, systems, personnel and physical properties, policies, procedures and time-frame to be reviewed to ensure the engagement objectives is achieved. In defining the audit scope, the HIA should ensure that the Internal Auditors are aware that the IAU does not have limitless resources to audit everything, but they should focus on high-risk areas.

The HIA should ensure factors that may lead to scope limitation are identified during the engagement planning process and strategies to manage the same are established. The HIA should ensure any limitation of scope encountered during engagement implementation is included in the engagement report and appropriately reported to the Accounting Officer and the Audit Committee in the quarterly reporting. The HIA should establish if the Internal Auditors will rely on the work done by other assurance providers (refer to Section 4.4 of the Manual) and provide this in the scope statement.

5.1.4 ENGAGEMENT WORK PROGRAM/AUDIT PROGRAMME

2240 – Engagement Work Program
Internal Auditors must develop and document work programs that achieve the engagement objectives.

2240.A1
Work programs must include the procedures for identifying, analysing, evaluating, and documenting information during the engagement. The work program must be approved prior to its implementation, and any adjustments approved promptly.

The HIA shall ensure for each audit engagement an engagement work program/audit programme is established defining the audit steps/procedures to be carried out to achieve the engagement objective/audit objective and ensure adequate coverage of the audit scope. In establishing the audit programme, the HIA should ensure:

(1.) The engagement objectives and scope are defined.

(2.) The nature, extent and timing of the audit steps are clearly defined. This provides a means: of clearly communicating the necessary instructions to the Internal Audit team; for planning, managing and controlling the engagement; and a basis for reviewing the working papers.

(3.) The audit steps are focusing on the key risk management strategies/controls to be evaluated.

(4.) Procedures for identifying, collecting, analysing, evaluating/interpreting and recording audit evidence are provided.

(5.) Population, sampling criteria and technique and sample size are defined.

(6.) Special audit procedures (e.g. computer-assisted audit techniques) are identified and documented.

(7.) Preliminary assessment of governance, risk management and controls undertaken during the engagement planning phase is considered.

(8.) The audit steps are specific to avoid scope creep (going beyond the defined scope).

(9.) The engagement work program has provision for work paper references.

(10.) Identifies the persons responsible for undertaking the audit steps and reviewing the work done.

(11.) The engagement work program is approved before commencement of field work (engagement execution). The engagement program should be flexible enough to enable the Internal Auditors make appropriate adjustments during field work. Any adjustments should be approved promptly by the HIA or other responsible officer.

5.1.5 ENGAGEMENT RESOURCING

2230 – Engagement Resourcing
Internal Auditors must determine appropriate and sufficient resources to achieve engagement objectives based on an evaluation of the nature and complexity of each engagement, time constraints, and available resources.

The HIA shall ensure all engagements are appropriately and sufficiently resourced to achieve the engagement objective and adequately cover the engagement scope. To achieve this the HIA should ensure engagements are:

(1.) **Appropriately resourced**: human capital (mix of knowledge, skills and other competencies) and non-human resource to ensure the engagement is performed competently and thoroughly.

(2.) **Sufficiently resourced**: the quantity of resources (human and non-human) is adequate to undertake the engagement objective with due professional care.

In determining that each engagement is appropriately and sufficiently resourced the HIA should consider:

(1.) Resourcing planning strategies established during the annual auditing process.

(2.) The audit effort based on the engagement work program or audit programme.

(3.) Consider if there are adequate resources within IAU, staff from other functions within the entity who can be seconded to IAU (safeguards should be put in place to safeguard the objectivity and independence of the employees seconded) or external sources (IAU from other Government entities or consultants).

(4.) Logistics.

(5.) Key management activities being undertaken by management in the area to be audited and the impact it has on the availability of key personnel of the area to be audited.

(6.) Timelines of undertaking the audit and if the outcome of the audit will form a key input in management decision making process.

(7.) Language barriers that may arise e.g. where the audit engagement entails review of community projects.

(8.) Level of supervision required based on the nature and complexity of the audit engagement compared to resources assigned to the engagement.

(9.) Impact of relying on the work of other assurance providers.

(10.) Opportunities of using the engagement as a training ground for Internal Auditors.

(11.) How the application of the resources will be assessed and reported.

Further information on ensuring engagements are adequately resourced is covered under Section 4.2 Resource Management and 2.1 Proficiency.

5.1.6 COMMUNICATING THE ENGAGEMENT PLAN

The outcome of the engagement planning process is the Internal Audit Planning Memo, which should contain the following subject headings:

(1.) Engagement objectives.

(2.) Engagement scope.

(3.) Justification of objectives and scope based on risk analysis.

(4.) Management concerns or expectations.

(5.) Key information required for the engagement.

(6.) Engagement Resources:

(a) Staffing.

(b) Time budget/engagement activity-timelines i.e. kick-off meeting, field work, exit meeting, draft report and final report.

(c) Non-human capital resources e.g. logistic costs, hire of special equipment etc.

(7.) Responsibilities and roles of the internal audit team and audit client.

(8.) Summary results of the pre-field work analysis (where appropriate).

(9.) Key audit client contacts.

(10.) Approval by the HIA or a designated officer.

The approved Internal Audit Planning Memo and audit notification should be issued to the audit client 14 days before the commencement of field work/audit engagement and confirmation of the kick-off meeting date. This however does not prevent an internal auditor to undertake surprise audit in cases of suspected fraud. The Internal Auditor leading the engagement should ensure the Audit Planning Memo is filed under the current audit working papers.

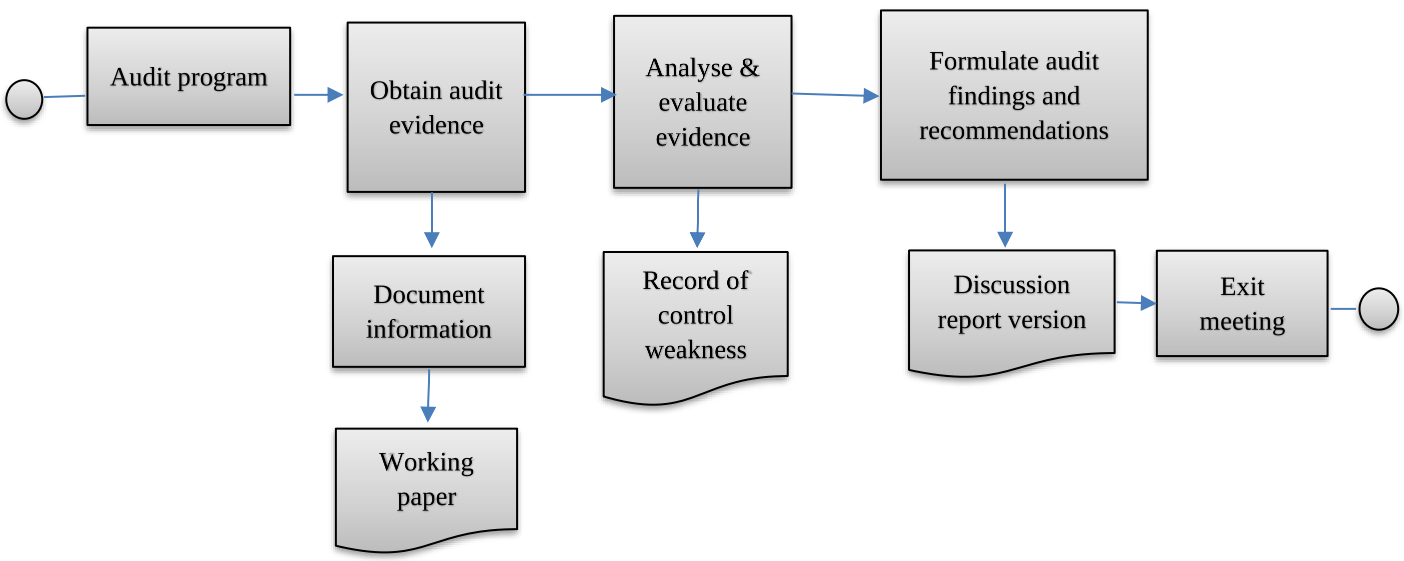
Engagement Work Program, Template 34 and ***Internal Audit Planning Memo, Template 35*** are provided in the Appendix.

5.2 PERFORMING THE ENGAGEMENT

2300 – Performing the Engagement
Internal auditors must identify, analyse, evaluate, and document sufficient information to achieve the engagement's objectives.

The illustration 6 below gives an overview of the performing phase of an audit engagement.

Illustration 6 : Overview of Engagement Performing Phase



The HIA shall ensure the audit steps defined in the engagement work program/audit programme are fully implemented so as to ensure sufficient, reliable, relevant and useful information is obtained to: support the observations/findings, recommendations, conclusion and opinion; and ensure the engagement (assurance or consulting) objectives are achieved and management expectations are met.

To ensure the Internal Audit process is systematic and disciplined, the HIA shall ensure each audit engagement has appropriate audit procedures for identifying, analysing, evaluating and documentation information required to achieve the engagement objectives.

5.2.1 AUDIT ENTRANCE MEETING

Performing the engagement commences with the audit entrance meeting where the Internal Audit Planning Memo is discussed. The HIA or the lead Internal Auditor should liaise with the process owner to ensure key staff and the process owners are available to attend the Audit Entrance Meeting.

The agenda of the Audit Entrance Meeting will include:

(1.) Introduction of audit client's key staff and the Internal Audit team. This shall include clarifying on the roles of the audit client and the Internal Audit team.

(2.) Engagement objectives.

(3.) Engagement scope.

(4.) Concerns or management requests.

(5.) Business conditions and operations of the activity being audited, including recent changes in systems, processes and personnel.

(6.) Timelines of key milestones e.g. end of field work, exit meeting, issue of draft report, obtaining management feedback on draft report, and issue of final report.

(7.) Overview of the Internal Audit process.

(8.) The process of communicating throughout the audit, including the methods, time frames, and individuals who will be responsible.

(9.) Availability of key information that had been requested in the Internal Audit Planning Memo.

(10.) Matters of particular interest or concern to the Internal Auditor.

(11.) Description of the IAU's reporting procedures and follow up processes.

Minutes of the Audit Entry Meetings should be maintained and circulated appropriately. The minutes should be maintained as working papers.

Entry Meeting Agenda and Minutes, Template 36 is provided in the Appendix.

5.2.2 IDENTIFYING INFORMATION

2310 – Identifying Information
Internal auditors must identify sufficient, reliable, relevant, and useful information to achieve the engagement's objectives.

HIA shall ensure that the engagement work program/audit programme has audit steps that will enable the Internal Auditors to identify and obtain audit evidence that is:

(1.) **Sufficient**: factual, adequate, convincing, current and collaborated to support the achievement of the engagement objectives. The information identified should enable a prudent person (with the required proficiency) undertaking the audit steps carried out by the Internal Auditors to arrive at the same conclusion. In determining sufficiency of audit evidence, the Internal Auditors must establish if they will test the entire population or test a sample (refer to Section 5.2.2 A. on sampling criteria).

(2.) **Reliable**: obtained through the best attainable information through the use of appropriate audit techniques.

(3.) **Relevant**: supports engagement's observations/findings, recommendations, conclusions and opinion. The information identified should be in-line with the engagement objectives.

(4.) **Useful**: enables the Internal Auditor make recommendations that add value i.e. enable the entity to enhance its governance, risk management and controls processes and systems and thus achieve its mandate, goals and objectives.

(5.) **Other factors**:

(a) **Legally obtained**: adhere to legal and regulatory requirements on assessing information.

(b) **Efficient and economically obtained**: being the IAU does not have unlimited resources, the audit steps should enable the Internal Auditor/s to prioritize the most relevant and useful information. This would require the Internal Auditors to review all the information sources as a whole to enable them determine the best sources and techniques of acquiring the information.

Some of the audit procedures that Internal Auditors can use to obtain sufficient, reliable, relevant, useful, legal and prioritized audit evidence include:

(1.) **Document review**: reviewing relevant literature which may include plans, budgets, policies, procedures, standards, performance reports and minutes of meetings.

(2.) **Enquiry**: holding interviews or meetings with the process owner and other key officers inside and outside the entity to obtain the required audit evidence. They should be well planned for to ensure key participants are available and follow an agreed outline (interview form/checklist or meeting agenda) which should be flexible to accommodate changes. The degree of reliability that the Internal Auditor attaches to evidence obtained in this manner is dependent on the Internal Auditor's opinion of the competence, experience, independence, and integrity of the respondent.

(3.) **Observation**: looking at an operation or procedure being performed by the process owner with a view to determining the manner of its performance. Observation provides reliable evidence as to the manner of the performance at the time of observation, but not at any other time. Enable the Internal Auditor to have a better understanding of the process and collaborate audit evidence that was gathered through other procedures like documents review.

(4.) **Walkthrough**: understanding a system and its related controls by following one transaction through the entire system, from start to finish. This determines the reliability of a system, and whether there are any issues that should be brought to the attention of management.

The HIA shall ensure the audit teams adopts an open and collaborative communication style with the audit client to enable them to obtain the required information.

Audit evidence can also be classified into:

(1.) **Primary vs secondary evidence**: primary evidence gathered directly by the Internal Audit Team whereas secondary evidence is information gathered by the audit client or third party provided to the Internal Auditor. Primary evidence is considered more reliable than secondary evidence.

(2.) **Conclusive vs circumstantial evidence**: conclusive evidence cannot be contradicted by any other evidence. Conclusive evidence is so powerful that it needs no additional corroboration. Circumstantial evidence is indirect evidence because it proves intermediate facts for which a primary fact that is material to the matter being reviewed may be deduced. Circumstantial evidence relies on an inference to connect it to a conclusion of fact and may require additional evidence to prove the fact.

(3.) **Direct vs hearsay evidence**: direct evidence is proof without presumption or inference e.g. source documents or testimony by the performer of an act or key witness. Hearsay/indirect evidence is a statement made by an individual other than the person declaring the statement.

(4.) **Corroborative evidence**: this is evidence that supports other evidence.

(5.) **Testimonial evidence** is obtained from others through oral or written statements in response to an auditor’s inquiries. Techniques that could be used to gather testimonial evidence include: interviews, focus groups, surveys, expert opinions, and external confirmation.

(6.) **Documentary evidence** is obtained from information and data found in documents or databases. Techniques that could be used to gather documentary evidence include: entity’s documents, file reviews, databases and spreadsheets, internal audits and evaluations, reports from consultants, studies from other jurisdictions, recalculation, and re-performance.

The Internal Auditor shall consider the following when assessing the quality of audit evidence:

(1.) Evidence generated by the auditor is more reliable than evidence provided by the management or staff of audit client;

(2.) Evidence obtained from external sources is more reliable than that provided internally; and,

(3.) Documentary evidence is more reliable than oral evidence.

5.2.2.1 SAMPLING CRITERIA

Audit sampling is the application of audit tests/procedures to less than 100% of items within a class of transactions (population). Audit sampling is used to provide factual evidence and a reasonable basis to draw conclusions about a population from which a sample is selected.

Determining the number of transactions to test is key in determining if the Internal Auditor has obtained sufficient audit evidence to support achievement of the engagement objective. In determining the amount of data/information needed the Internal Auditors has also to consider the efficiency and economy of obtaining the required evidence. This may lead to the Internal Auditor preferring to review a sample instead of the entire population.

The Internal Auditors will consider the following factors when deciding on the sample size:

(1.) **Engagement/audit objectives**: which may include assessing control's design adequacy, if the control has been operating effectively, quantify the impact of control weakness and compliance level.

(2.) **Population quality**: the variability, volatility and completeness of the population to be tested. The Internal Auditor must establish that population from which the sample is being obtained is appropriate to attain the engagement objectives e.g. when testing payments, the Internal Auditor may prefer to sample transactions from bank transactions compared to a list of payment vouchers.

(3.) **Population size**: this depends on the frequency of implementing the control/task/activity with those implemented more than once daily having more transactions compared to those implemented at a less frequency e.g. weekly, monthly or yearly. This will enable the Internal Auditor to establish if the transaction/s to be tested have occurred during the period under review.

(4.) **Risk and materiality:** rating of risks impacting the area being audited and the significant of achieving/not achieving the objective/s of the area under review.

(5.) **Available resource**: available tools and techniques where adoption of CAATs will enable the Internal Auditors review a bigger sample of digital data compared to using a manual process. The proficiency of the Internal Auditors in applying the tools and techniques where more skilled Internal Auditors will be able to review bigger and complex sample data. The Internal Auditors should consider the time allocated to undertake the engagement to ensure best use of available time. However, the Internal Auditors should refer to the HIA or their supervisors if there is good reason to devote more time to an audit than was originally planned. The Internal Auditors should also assess the cost benefit analysis of analysing a large sample compared to a smaller one.

(6.) **Previous assessments outcome**: based on initial assessment of risks and controls during the planning process; outcomes of previous audits by IAU and other assurance providers; and key changes in processes, systems and personnel of the area being audited.

(7.) **Sampling risk**: the risk that the Internal Auditor's conclusion based on a sample may be different from the conclusion if the entire population were subjected to the same audit procedures. In selecting a sample, the Internal Auditor needs to establish tolerable errors i.e. the maximum numbers of errors that the Internal Auditor is willing to accept and still reach a conclusion that the underlying assertion is correct. In establishing the tolerable errors, the Internal Auditor needs to consult with the HIA and the process owner. This may also be influenced by prior audit results, changes in processes and evidence/conclusions from other sources.

Where Internal Auditors are in doubt about the size of samples to use they should discuss this with the HIA or the Auditor leading the engagement.

In order to select an appropriate sample, it is important to define the population of data. This will be influenced by the period that is covered by the audit. There are a number of methods that can be used to select a sample to try and ensure Internal Auditors cover an appropriate cross section of the population. These include, amongst others, the following:

(1.) **Random sampling**: selection of a transaction to test is not governed by predetermined consideration and thus every unit in the population has an equal probability/chance of being selected for testing.

(2.) **Systematic (interval) sampling**: is a type of probability sampling method in which sample members from a larger population are selected according to a random starting point and a fixed periodic interval. This interval, called the sampling interval, is calculated by dividing the population size by the desired sample size

(3.) **Stratified sampling**: the population is divided into separate groups, called strata. Then, a probability sample (often a simple random sample) is drawn from each group.

(4.) **Attribute sampling:** used to determine the characteristics of a population being evaluated.

(5.) **Variable sampling**: used to determine the monetary impact of characteristics of a population.

(6.) **Discovery sampling**: used where evidence of a single error or instance would call for intensive investigation.

(7.) **Judgmental sampling**: is a type of non-random sample that is selected based on the opinion of the Internal Auditor. Results obtained from a judgment sample are subject to some degree of bias, due to the frame and population not being identical.

Although there are no established rules about the sample size, Illustration 7 provides a guide that can be adopted by the Internal Auditors in deciding a suitable sample size. In applying the sampling guide, the Internal Auditors should apply their professional judgement based on the risk of the area under review and the engagement objectives to determine if they need to increase the sample size.

Illustration 7: Sample Size Criteria

Control Frequency	Minimum Sample Size	
	High Risk	Medium Risk
Annual	1	1
Semi-Annually	2	1
Quarterly	4	2
Monthly	6	4
Weekly	25	15
Daily / multiple times per day	60	40
Automated	1	1

Low risk areas shall be audited once every three years. In auditing low risk areas, the Internal Auditor shall use the sampling criteria for medium risk in determining an appropriate sample size.

The audit workpapers should include sufficient detail to describe clearly the sampling objective and the sampling process used. The workpapers should include the source of the population, size of the population, sample size, the sampling method used, sampling period and items sampled.

5.2.3 ANALYSING AND EVALUATION

2320 – Analysing and Evaluating
Internal auditors must base conclusions and engagement results on appropriate analyses and evaluations.

Collected data should be analysed and evaluated against audit criteria to make conclusions. Analysis refers to the breaking down data/activities/processes into smaller, more manageable parts to determine attributes, relationships, cause, effect etc and make inferences or determine whether further examination is required. Evaluation on the other hand is the systematic determination of the merit, worth, significance of the best subject matter to arrive at a judgement in terms of adequacy, efficiency or effectiveness.

The HIA should ensure that the audit procedures enable the Internal Auditors based on the audit evidence obtained to assess that the controls have been:

(1.) **Adequately designed**: to enable the entity achieve its mandate, goals and objectives and at the same time manage its risks. Assessing if controls are adequately designed may commence during the engagement planning stage as the Internal Auditors establish which controls needs to be tested. Where a control is poorly designed, the Internal Auditor may not need to undertake further audit tests to assess if it's been operating effectively. In testing if the control is adequately designed, the Internal Auditor needs to test one (1) transaction, activity or task.

(2.) **Operating effectively**: operating as designed during the review period (defined in the audit scope). This is also called substantive testing.

In testing if the control is adequately designed, the Internal Auditor will use the sampling criteria (refer to Section 5.2.2 A. of the Manual) to establish an adequate sample size to test.

Once the required information is obtained the Internal Auditors will establish if the control is adequately designed and/or operating effectively by undertaking appropriate analysis and evaluation techniques.

(1.) **Analysis Techniques**: some of the analyses techniques that the Internal Auditors can undertake include (performing these techniques also enables the Internal Auditor to gather audit evidence):

(a) **Inspection**: reviewing or examining records, processes or properties and comparing with what is expected (this can be defined in the policies, procedures, laws, regulations or standards).

(b) **Re-performance**: re-performing the steps/tasks undertaken by the process owner and assessing if the output obtain by the internal auditor is similar to that obtained by the process owner.

(c) **Vouching**: testing the validity of a transaction or recorded information by following it backwards to a tangible source.

(d) **Tracing**: testing the completeness of information by tracking information forward from a tangible source to a subsequent prepared document/report. The difference between vouching and tracing is the direction of the audit procedure i.e. vouching moves backwards from the final document to the source where tracing moves forward from the source to the final document.

(e) **Computation**: checking the arithmetic accuracy of accounting records or performing independent calculations.

(f) **Confirmation**: soliciting and obtaining written verification of the information from an independent third party e.g. circularization to debtors and suppliers to confirm accounts receivable and accounts payable balances respectively.

(g) **Analytical procedures:** to compare actual performance against expectations. Analytical procedures include: ratio, trend, and regression analysis; reasonableness tests; period-to-period comparisons; forecasts; benchmarking information against similar sectors or entity units. Internal Auditors may further analyse significant deviations from the expectations (expected variations which failed to occur or unexpected variations) to determine the cause and/or reasonableness of the variance. The analytical procedures to undertake will depend on the nature, accessibility, and relevance of the data available.

(h) **Data analytics** examining data sets in order to draw conclusions about the information they contain. With the increase in the volume of data being generated by entities (Big Data), data analytics is being adopted by Internal Auditors to enable them to develop recommendations that provide insight and foresight.

(2.) **Evaluation**: based on the results of the analysis undertaken, the Internal Auditors apply their professional judgement (experience, logic and professional scepticism) to make a conclusion on the engagement objectives and make recommendations. Evaluation also involves assessing the root cause of the audit observation/finding to enable the Internal Auditor provide recommendations to close or correct the audit finding and resolve the root cause.

The analysis and evaluation should be recorded in the ***Record of Control Weakness, Template 37*** provided in the Appendix

5.2.4 DOCUMENTING INFORMATION

> **2330 – Documenting Information**
> Internal auditors must document sufficient, reliable, relevant, and useful information to support the engagement results and conclusions.

The HIA shall ensure work papers contain sufficient, reliable, relevant and useful information to: support the observations/findings, recommendations, conclusion and opinion; and ensure the engagement objectives are achieved.

The HIA shall ensure all audit evidence obtained during engagement planning and execution are documented in the work papers. While audit testing and audit findings must be adequately documented and supported in the working papers, Auditors should ensure that clarity and functionality is not lost in the volume of data and supporting documents kept.

The HIA shall ensure work papers are appropriately referenced to ensure there is a clear linkage between the audit procedures in the engagement work program and the results of the audit tests (which includes supporting documents).

Internal Audit follows a systematic and disciplined approach. Maintaining appropriate work papers is key in ensuring the internal audit process follows a systematic and disciplined approach. Appropriate working papers are those that are capable of standing on their own without requiring any supplemental oral explanation from the Internal Auditor(s) who did the work. Consequently, an independent reviewer should be able to understand all of the audit work performed, the findings, how exceptions and other issues were resolved, and the conclusions drawn from the work done.

The working papers are used for a number of important functions. They:

(1.) Demonstrate whether the engagement was done in compliance with the relevant standards.

(2.) Aid in the organisation, control, administration, and review of the audit work.

(3.) Evidence the engagement work program was fully executed and provides evidence of the conclusions drawn from the audit work done.

(4.) Support the internal audit report.

The HIA shall ensure appropriate work papers are maintained which may include the following elements:

(1.) Indexed/referenced and consistently organized.

(2.) Title or heading that identifies the area or process under review.

(3.) Date or period of the engagement.

(4.) Scope of work performed.

(5.) Statement of purpose for obtaining and analysing the data.

(6.) Source(s) of data covered in the workpaper.

(7.) Description of population evaluated, including sample size and method of selection.

(8.) Methodology used to analyse data.

(9.) Details of tests conducted and analyses performed.

(10.) Conclusions including cross-referencing to the workpaper on audit observations.

(11.) Proposed follow-up engagement work to be performed.

(12.) Name of the Internal Auditor(s) who performed the engagement work.

(13.) Review notation and name of the internal auditor(s) who reviewed the work.

(14.) Consistently organisation and documentation, irrespective of the type of audit.

Working Paper, Template 38 is provided in the Appendix.

The HIA shall ensure that as the Internal Auditors come across significant findings they complete a ***Draft Finding Sheet provided as Template 39*** in the Appendix. The information contained in the finding sheet enables the lead Internal Auditor to compile information necessary to inform a discussion report version for the exit meeting and to efficiently document the draft report. The HIA shall ensure the information recorded in the draft finding sheet includes:

(1.) **Condition**: standard/criteria i.e. expected condition/should be

(2.) **Finding**: observation i.e. what the actual condition is and how it's different from the condition

(3.) **Root cause**: Identify with the audit client what is the reason for the existence/occurrence of the finding.

(4.) **Risk and impact**: identify if risk will crystallize and the impact if the condition and root cause are not resolved.

(5.) **Recommendation**: suggested approaches to address the weakness, strengthen the control environment and assist management in achieving desired results. [Note that the recommendation should address the root cause and close the finding/observation. The recommendation should be feasible].

5.2.4.1 ORGANIZATION/STRUCTURE OF WORKING PAPERS

The HIA shall ensure working papers are organized in a manner that enhances efficiency and facilitates accessibility. The HIA shall organize working papers into Permanent Audit File (PAF) and Current Audit File (CAF). Having an index on what should be contained in the PAF and CAF enables: the HIA to assess if all the working papers have been prepared; and enables an Internal Auditor or other user of the audit file to easily navigate through the file. Each major section of PAF or CAF is identified by a unique alpha-numeric reference e.g. PAF and Roman Number for PAF and CAF and Roman Number for CAF. The documents within a section are referenced starting with the section reference and then a number, alphabet or alpha-numeric.

(1.) Permanent Audit Files

The **Permanent Audit File** (PAF) contains information that should be relevant to the current and future audits. A PAF is useful for the following reasons:

(a) Information/documents that are long term in nature (i.e. important for more than one audit) are consolidates in one location.

(b) To avoid the necessity to re-read the full documents during successive audits, key information may be summarised and included in the PAF for easy future reference.

(c) Information carried forward from previous audits can be filed in the PAF.

There is no standard organisational rule for the PAF. However, the following types of documents may be included in the PAF:

(a) Strategic information.

(b) Organisation charts.

(c) Relevant legal and regulatory requirements.

(d) Correspondence of continuing interest to future audits.

(e) Risk assessment/risk registers.

(f) Key ratios and expected operational deviation.

(g) Updated engagement work program/audit programme.

Illustration 8 provides an index that can be adopted for the PAF.

Illustration 8: PAF Index

Index Ref	Type of Information
PAFI	**Organizational/Function Information** which may include: overview of the area being audited and linkage to mandate; objective; organizational structure; key personnel and their job description; contracts and key procurements; committees and their terms of reference; and personnel authorization limits.
PAFII	**Policies and Procedures**: which may include system documentation (system notes, flow charts); internal control questionnaires; internal control evaluations/self-assessment by management; and risk register.
PAF III	**Rules and Regulations**: relevant laws, regulations, government circulars, standards and directives (internal and external).
PAF IV	**Previous Year Audit History**: copies of previous Internal Audits reports and OAG reports; copies of follow-up reports; recommendation implementation status report by audit client; review notes that were not closed in the previous audit and are relevant in the current review; and matters deserving attention and follow-up in subsequent reviews.

PAV V	**Correspondence**: strategic or important communication received or sent by the function.
PAV VI	**Internal Audit Information**: audit universe; and engagement work program/audit programme

(2.) Current Audit Files

The **Current Audit File** (CAF) contains schedules and documents relevant to the current audit. There is also no standard organisational rule for the CAF. However, the CAF should contain, as a minimum, following working papers:

(a) Internal Audit Planning Memorandum.

(b) Results of the audit steps including significant observations/findings/issues, their causes, impact of the observation and recommendation.

(c) Other documents supporting the audit test results e.g. copies of audit client documents, testimonials, data extracts etc.

(d) Feedback from the audit client on the results of the engagement.

(e) Copies of the draft and final audit reports.

(f) Latest Corrective Action Plan.

(g) Follow up of prior audit reports and matters that have not been resolved.

(h) Administration/correspondence memos and documents.

Illustration 9 provides an index that can be adopted for the CAF.

Illustration 9: CAF Index

Index Ref	Type of Information
CAFI	**Audit Report**: final audit report, draft audit report, interim audit report, ad-hoc audit reports and latest feedback from management on draft, interim and ad-hoc reports, follow-up of prior audits, summary of findings,
CAFII	**General Information**: discussion with management (minutes and notes); and extract of minutes (management, Audit Committee)
CAFIII	**Audit Procedures**: engagement plan, internal audit planning memorandum, engagement work program; other planning issues.
CAFIV	**Audit Evidence:** work papers containing audit evidence arranged as per the audit procedures; other documents supporting audit results.
CAFV	**Audit Management**: review and check list (review notes and check lists); audit time summary and budget; and administration/correspondence memos and documents.

5.3 COMMUNICATING RESULTS

2400 – Communicating Results
Internal Auditors must communicate the results of engagements.

PFMR r. 164 (1) stipulates that the HIA shall ensure that results of all engagements are communicated promptly to the audit client. In disseminating engagement results, the HIA shall ensure they meet the expectation of the audit client, senior management, Accounting Officer and the Audit Committee.

PFMR r. 164 (3) stipulated that the HIA shall ensure the written report issued to the audit client is objective, clear, concise, timely, acknowledges satisfactory performance and constructive (recommendations for potential improvement). The report shall clearly present the purpose, scope and results of the engagement.

The HIA shall ensure that each engagement has a communication plan that provides guidelines on what shall be communicated, who shall be receive the engagement results, strategies of communicating (verbal and non-verbal); and timing of disseminating the results. The HIA shall also ensure the entity's policy on communication (internal and external) and legal and regulatory provisions are adhered to when communicating engagement results.

5.3.1 CRITERIA FOR COMMUNICATING

2410 – Criteria for Communicating
Communications must include the engagement's objectives, scope, and results.

2410. A1
Final communication of engagement results must include applicable conclusions, recommendations and/or action plans. Where appropriate, the internal auditors' opinion should be provided, taking into account the expectations of senior management, the Audit Committee, and other stakeholders which must be supported by sufficient, reliable, relevant, and useful information.

The HIA shall ensure that for each engagement contains a communication plan that has been agreed with the audit client. The communication plan can be part of the Internal Audit Planning Memo. The communication plan shall define:

(1.) **Why** we need to communicate to the audit client. The audit client should be informed whether the engagement objective was met and management concerns addressed.

(2.) **What** to be communicated to the audit client. The audit client should be informed of the objective, scope, observations, recommendation, conclusion and opinion. What to communicate is also influenced by whom the information is being sent to e.g. the process owner may be issued with the entire audit report whereas the Accounting Officer, Senior Management may be issued with only the executive summary section of the report. The contents of the report to the Audit Committee is subject to agreement between the HIA and the Audit Committee.

(3.) To **whom** communication will be sent. This can be guided by: who needs to provide an action plan for the recommendations made; who needs to act on the action plan or ensure the plan is implemented; or who needs to be aware of the results of the audit (although they may not be expected to provide any feedback or act). On a minimum the Internal Audit report should be issued to the process owner and copied to the Accounting Officer. The communication plan shall consider if there are audit reports that need to be issued to parties outside the entity. In relation to communication to external parties, the HIA should consider the legal requirements, entity's communication policy and impact of such communication to the reputation of the entity. This may require the HIA to consult with Legal Function and Communication Function to ensure required approval are received before the Internal Audit Report is sent to external parties and appropriate communication channels are utilized.

(4.) **How** to communicate to the audit client the audit results. Communication may be verbal (e.g. exit meeting, presentation through Ms Power Point) or in writing (e.g. issuing a draft and final report). The plan should identify the best communication strategy at the different stages of the audit cycle.

(5.) **When** to communicate to the audit client. Communication of results with the audit clients commences during engagement planning (i.e. preliminary study undertaken during engagement planning can identify issues that can be communicated e.g. lack of controls to manage specific risks), is carried on during engagement execution (observations are communicated to the audit client as they are identified) and end when the final audit report is issued. Communication of results also happens when the Internal Auditors are undertaking follow-up audits.

The HIA shall ensure the audit report provides information on the following:

(1.) Engagement objective.

(2.) Engagement scope. Statement of limitation of scope where it was encountered and the impact of achieving the engagement objective or management concerns.

(3.) Management request or concerns.

(4.) Summary of the audit approach/methodology.

(5.) Outcome of engagement tests:

(a) Satisfactory performance – The internal controls are working efficiently and effectively as expected.

(b) Significant audit findings/observations. This shall provide information on what is expected/criteria (based on laws, regulations, policy, procedures, standards or good business practise) and what is the actual condition. Colour coding of findings can be adopted where the high-risk issues are coded red, medium risk issues coded yellow and low risk issues coded green (may not be included in the report being they are not significant).

(c) Causes of the observations.

(6.) Risk exposure and impact/effect of the observations.

(7.) Recommendations that calls for action to rectify the weakness (or improve efficiency) and resolve the cause.

(8.) Clearly report indications of fraud, corruption, wasteful expenditure and material breaches in line with PFMR r. 160 if fraud has been detected.

(9.) Management action plan to implement the recommendations. This should provide information: on the activity that shall be implemented by management to resolve the audit finding and close remedy the cause; when the activity shall be undertaken; the person to implement the activity; and resources required to implement the activity (where appropriate).

(10.) Proposed time when a follow-up audit will be undertaken.

(11.) Conclusion.

(12.) Limitation on the use of report by parties outside the entity.

5.3.2 QUALITY OF COMMUNICATING

2420 – Quality of Communicating
Communications must be accurate, objective, clear, concise, constructive, complete, and timely.

2421 – Errors and Omissions
If a final communication contains a significant error or omission, the HIA must communicate corrected information to all parties who received the original communication.

The HIA shall ensure the information contained in audit reports (draft or final) issued to the audit clients has the following attributes:

(1.) **Accurate**: The Internal Audit Report should be free from errors and distortions. The information in the audit report should be based on facts and appropriated supported by audit evidence contained in the work papers.

(2.) **Complete**: The Internal Audit Report should contain all material facts (lacks nothing that is essential) known to the Internal Auditors that if not disclosed will distort the meaning of what is being reported. The report should contain all the significant and relevant information to support the engagement observations, recommendations and conclusion.

Where the HIA identifies errors and omissions after issuing a final report, s/he must assess if the errors or omissions are significant enough (i.e. magnitude (quantitative or qualitative), relevance and impact) to change the audit observation/finding, recommendation, conclusion or opinion. Where the errors or omissions are significant (i.e. relative important within the context of what is being considered) the HIA shall:

(a) Establish the cause of the errors or omissions and how to prevent such occurring in future engagements.

(b) Establish the most appropriate way to communicate the corrected information to the recipients of the original final engagement communication and communicate.

(c) Ensure the corrected final audit report provides information on: what has been corrected; cause of the error or omission; and strategies HIA to prevent such causes from recurring again in future audits.

(3.) **Objective**: The Internal Audit report should be fair, impartial and unbiased. The report should demonstrate that the audit process was a balanced assessment of all relevant facts and circumstances. The Internal Auditors should adopt balanced reporting where satisfactory performance is also contained in the report. Satisfactory reporting may include: effectives of controls assessed; improvement in governance, risk management and controls since the previous audit; or implementation of audit recommendations raised by the Internal Auditors, OAG and other assurance providers. Balanced reporting is important to ensure the results of the engagement does not alienate the reader being the key objective of the engagement report is to "call for action" i.e. to make the audit client take effective remedial action.

(4.) **Clear and concise:** The Internal Audit report should be easily understood by its recipients. This requires the report to: be logical with high risk issues being reported first; only contain significant and relevant information; be precise and to the point (avoid unnecessary elaboration, redundancy, wordiness); and only include terminologies used by the entity, sector or government entities (avoid jargons).

(5.) **Constructive**: Recommendations provided in the Internal Audit reports should add value i.e. result to the improvement of governance, risk management or controls.

(6.) **Timely**: Internal Audit reports should be issued on a timely basis (as per the communication plan) to ensure management can take timely corrective action and the reports can contribute to management decision making process. A report issued late may be irrelevant to management decision making process resulting to the Internal Audit process not adding value.

5.3.3 OVERALL OPINIONS

2450 – Overall Opinions
When an overall opinion is issued, it must take into account the strategies, objectives, and risks of the entity; and the expectations of the governing body, Accounting Officer, senior management and other stakeholders. The overall opinion must be supported by sufficient, reliable, relevant, and useful information.

The HIA shall be responsible for issuing audit conclusion and audit opinion.

The HIA shall ensure that the engagement final report provides a conclusion of the audit work undertaken. A conclusion answers the question being raised by the engagement objective e.g. if the audit objective was to assess if the controls of a particular process are working, the conclusion provides feedback if the controls are working as expected or not. The HIA may provide the following conclusions:

(i.) **Satisfactory:** where all key risks have been identified and controls have been properly designed and implemented;

(ii.) **Partially satisfactory:** where some important risks have either not been identified and/or the required controls have either not been established or are not functioning effectively; or

(iii.) **Not satisfactory:** where key risks have not been identified and/or related controls have not been implemented or are not functioning in accordance with the plan.

An audit opinion provides the HIA professional judgement on the status of the entity's governance, risk management and controls. The audit opinion is based on the conclusion of a number of engagements. The HIA shall decide on an appropriate frequency to provide an audit opinion to the Audit Committee, Accounting Officer and Senior Management with the minimum frequency being annual.

(i.) In determining the audit conclusion and/or opinion the HIA shall consider:
(ii.) The scope of the engagement/s including the period to which the opinion pertains.
(iii.) Scope limitations.
(iv.) Impact on the reliance of other assurance providers.
(v.) Summary of the information that supports the opinion.
(vi.) Sufficiency, reliability, relevance and usefulness of the audit evidence on which the audit conclusion or opinion is based on.
(vii.) The overall opinion, judgement, or conclusion reached.
(viii.) Effectiveness of the risk management process.

The reasons for an unfavourable overall opinion must be stated.

Example of audit opinions, Template 40 is provided in the Appendix

5.3.4 DISSEMINATING RESULTS

2440 – Disseminating Results
The HIA must communicate results to the appropriate parties.

The HIA shall be responsible for reviewing and approving the draft and final audit reports before they are issued to the audit client, senior management, Accounting Officer, Audit Committee or any other appropriate recipient. Although the HIA delegates the role of disseminating results, s/he shall remain overall responsible.

Engagement results are disseminated based on the communication plan i.e. why we are communicating, to whom to communicate, what to communicate, how to communication and when to communicate.

The HIA shall ensure a distribution list is maintained for the recipients of the Internal Audit reports. The HIA shall establish a system that enables recipients of Internal Audit reports to confirm receipt of the same. Such information is key where: the HIA is to issue a corrected or revised report (refer to Section 5.3.2 on issuance of a revised report in case of significant errors or omissions); or where the audit client or any other officer who was supposed to receive the report claims that the same was not received by them.

In conformance to the Code of Ethics, and PFMR r. 155(4), confidentiality of the Internal Audit reports is critical and HIA shall ensure that all reports are handled and distributed under confidential cover. Where the Internal Audit report is disseminated in soft copy, a signed hard copy of the final report shall be maintained by the HIA.

The HIA disseminates engagement through:

(1.) **Regular updates**: The Internal Auditors communicate significant audit observations to the audit client as they arise during the audit. The Internal Audit team can agree with the audit client to be holding regular meetings where the team can update the client on the progress of the engagement and significant findings. These sessions can also be used to communicate challenges that the team is facing.

(2.) **Interim audit reports**: Inform the audit client on the progress of the engagement and changes in the audit objective or scope that have occurred during engagement execution. It can also be used to communicate information that requires immediate attention during the course of field work.

(3.) **Exit Meeting**: In conformance to PFMR r. 164(3) (a) that requires an oral preliminary report to be given, the HIA shall ensure an exit meeting is held at the end of field work for every engagement to discuss significant observations and proposed recommendations with the audit client. The meeting provides an opportunity for:

(a) **The Internal Auditor**: To obtain feedback from the audit client on the accuracy of the audit results; determine if further work needs to be done based on the feedback provided by the audit client; and sensitize the audit client that recommendations are more of advisory rather than mandatory; the performance of the Internal Audit team;

(b) **Audit client**: To clarify and agree on the audit findings and recommendations before they are put in the audit report; propose alternative recommendations that are more practical; provide more information where the same had not been provided before; provide information on the management action plan to address the audit recommendations; and communicate areas where they accept the existing risks and justification for the same.

(4.) The HIA shall ensure exit meetings are planned for well to ensure the process owner is available to attend and key personnel in the function that are key in implementing recommendations. This also ensures that HIA has gets buy-in for the Internal Audit report as this is key in ensuring the process owner provides feedback on the audit report. Besides the key audit issues, the exit meeting should cover the tentative timetable for the issuance of the draft audit report and what the entity would be expected to do after the receipt of the draft report which is to provide written comments on the report and submit them to the auditor within the prescribed timeframe. The HIA shall ensure minutes of the exit meeting are prepared and distributed appropriately and maintained as part of the work papers. ***Exit Meeting Agenda and Minutes, Template 41*** is provided in the Appendix.

(5.) **Draft report**: it is issued to the audit client **within 7 working days after the exit meeting**. The purpose of the draft report is to: inform the audit of the key audit observations and recommendations made by the Internal Auditor; request the audit client to provide feedback in writing on the accuracy of the report; reasonableness of the recommendations and conclusions; and request the audit client to provide an action plan on implementing the audit recommendations. ***Internal Audit Draft Report, Template 42*** is provided in the Appendix.

(6.) **Final report**: this contains feedback received from the audit client on the draft report and management action plan on implementing the audit recommendations. **The audit client should provide feedback on the draft report within 14 days after receiving the draft report**. If the Internal Auditor and audit client disagree about the audit results, the final audit report may state both positions and the reasons for the disagreement. The audit client written comments may be included as an appendix to the audit report, in the body of the report or in a cover letter. The report should also communicate where management accepts risks (refer to Section 5.3.5 of the Manual). ***Internal Audit Final Report, Template 43*** is provided in the Appendix.

The HIA should ensure the final signed audit report is issued to the audit client and copied to the Accounting Officer (at a minimum) **within 30 working days of date of issuing the draft report**.

The HIA shall ensure the draft and final audit reports contain:

(a) **Cover page**: should include name of the county government department or entity, author of the report (i.e. IAU), type of report (e.g. draft, final etc), unit/process being reviewed, report date (month and year), type of audit (e.g. ICT Audit) and report reference number. The cover page should include the word confidential.

(b) **Report recipients**: designation and use of the report i.e. action required (provide management comment or/and act on recommendation) and for information purpose. The section includes report distribution restrictions to ensure that the report is not used for a purpose that it was not intended for.

(c) **Executive summary**: summarizes the most significant information in the report. Should be organized according to the sequence of the main report. Where necessary the executive summary should stand on its own (communicate independently of the main report). All the information in the executive summary should be supported by the main report. Executive summary should contain summaries on:

i. PFMR requirements on preparing the report
ii. Area being reviewed.
iii. Objective and scope. Limitation of scope if it occurred.
iv. Positive attributes.
v. High risk/key findings.
vi. Overall conclusion.

(d) **Table of content**: generated from the report should have three levels i.e. Heading 1, Heading 2 and Heading 3.

(e) **Introduction**:

i. Background: PFMR requirements on preparing the report, information about the area being reviewed, type of audit, who commissioned the audit and why the audit is being undertaken.
ii. Engagement objective.
iii. Engagement scope including limitation of scope.
iv. Methodology.

(f) **Positive attributes**: status of implementing recommendations of prior audits and area where governance, risk management and controls are effective.

(g) **Detailed findings**: the findings should be prioritized based on their risk level based on a finding rating matrix. The finding matrix should be defined in the report and can be contained in this section or as an appendix. For each finding the following should be provided

i. Criteria: what should be.
ii. Condition: what is i.e. actual status.

iii. Cause: likely cause of condition.

iv. Potential Risk and Impact: this should be linked to the risks register.

v. Recommendation: address the cause and the condition.

vi. Management response: action that the audit client will undertake to address the cause and the condition. Should include timeliness, responsibility and resources requirements.

(h) **Conclusion**: overall opinion of the HIA on the effectiveness of governance, risk management or controls of the area being reviewed. A criterion on how the HIA arrived at the conclusion should be provided in this section or as an appendix.

(i) **Acknowledgement**: appreciate the audit client and officers from other functions that assisted during the engagement.

(j) **Approval**: signing of the report by the HIA or appropriate officer in the IAU. For special assignments like investigation the team members involved should also sign the report to ensure ownership.

(k) **Annex/Appendix**: includes necessary additional information to support audit findings, recommendations and conclusion that would otherwise interrupt the flow of the report if included in the main body of the report.

(7.) **Quarterly and annual reports**: In compliance with PFMR r. 166(2) and in addition to issuing engagement reports, the HIA is expected to issue quarterly and annual audit reports to the Accounting Officer and Audit Committee (refer to Section 2.5 of the Manual). The quarterly report highlighting the significant observations of assurance engagements shall be submitted within 14 days after the end of a quarter. The HIA may maintain a database of significant observations/findings and respective recommendations and management action plan to enable the HIA to: prepare the quarterly and annual reports; and to follow-up implementation of recommendations.

Audit Findings Database, Template 44 is provided in the Appendix.

(8.) **Annual report by the Internal Audit Service Department of the County**: as stipulated by PFMR r. 166 (3), the Head of the Internal Audit Unit in the County Executive/Internal Audit Service Department of the County Treasury shall prepare for the county government an annual report that consolidates the quarterly audit reports (considering only assurance engagements) prepared by all IAUs in the county government entities.

5.3.5 AUDIT CONDUCTED IN CONFORMANCE WITH IPPF

2430 – Use of "Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing"
Indicating that engagements are "conducted in conformance with the International Standards for the Professional Practice of Internal Auditing" is appropriate only if supported by the results of the quality assurance and improvement program.

1321 – Use of "Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing"
Indicating that the internal audit unit conforms to the International Standards for the Professional Practice of Internal Auditing is appropriate only if supported by the results of the quality assurance and improvement program.

2431 – Engagement Disclosure of Non-conformance
When non-conformance with the Code of Ethics or the Standards impacts a specific engagement, communication of the results must disclose the:

1. Principle(s) or rule(s) of conduct of the Code of Ethics or Standard(s) with which full conformance was not achieved.
2. Reason(s) for non-conformance.
3. Impact of non-conformance on the engagement and the communicated engagement results.

1322 – Disclosure of Non-conformance
When non-conformance with the Code of Ethics or the Standards impacts the overall scope or operation of the internal audit unit, the Head of Internal Audit must disclose the non-conformance and the impact to the Accounting Officer and the Audit Committee.

The HIA **may** include a statement in the engagement report that the engagement was conducted in conformance with IPPF. Although this is not a requirement, it's good to build the credibility of the audit process and engagement report. The HIA **can only** include this statement in the Internal Audit Report or use it verbally where the results of both the internal and external quality assessment provide evidence that the IAU generally conforms to IPPF. After an external quality assessment, the HIA can only use this statement if the results of the internal quality assessment continue to support this until the next external quality assessment.

The HIA shall communicate where the audit process was not in conformance to IPPF to the Accounting Officer and the Audit Committee. This can be communicated through meetings (with the audit client, senior management, Accounting Officer or Audit Committee) or can be included as part of the Internal Audit report. Instances of non-conformance should be adequately documented in the work papers and supported with appropriate audit evidence. Communication shall include impact of the non-conformance to: the scope and operations of the IAU; and meeting expectation of management, Accounting Officer and the Audit Committee.

Some of the factors that can result to the audit process not conforming to IPPF include:

(1.) Impairment of internal audit objectivity and independence.

(2.) Limitation of scope.

(3.) Lack of required information/data or management issuing the Internal Auditors unreliable data/information.

(4.) IAU lacking the required proficiency.

(5.) Failure to consider risk when preparing the internal audit plan.

(6.) Lack of adequate resources.

The HIA shall consider the following factors in determining on whether to use the statement "Conducted in Conformance with the International Standards for the Professional Practice of Internal Auditing":

(1.) If the results of either the current internal quality assessment or most recent external assessment do not confirm general conformance with IPPF, the HIA cannot use the conformance statement or where it is using it, the HIA must discontinue indicating that it is operating in conformance.

(2.) If an IAU has been in existence at least five years and has not completed an external assessment, the HIA may not indicate that it is in conformance with IPPF*.*

(3.) If it has been more than five years since the last external assessment was conducted in, the HIA must cease indicating that it is in conformance, until a current external assessment is completed and it supports that conclusion.

(4.) If an IAU has undergone an external quality assessment within the past five years but has not conducted an internal quality assessment annually or after every other year after the external assessment, the HIA shall consider whether it is still operating in conformance and if appropriate to indicate conformance until validated by an internal assessment.

(5.) If an IAU that has been in existence fewer than five years may indicate that it is operating in conformance with IPPF only if a documented internal quality assessment (i.e., the periodic self-assessment) supports that conclusion.

(6.) If an external quality assessment reflects an overall conclusion that the IAU was not operating in conformance with the Standards, the HIA must immediately discontinue using any statements that indicate conformance*.* The HIA may not resume use of a conformance statement until it has remediated the nonconformance and conducted an external assessment to validate an overall assessment of conformance with IPPF.

Refer to Chapter 6 on undertaking internal and external quality assessments.

5.4 MONITORING PROGRESS

2500 – Monitoring Progress
The HIA must establish and maintain a system to monitor the disposition of results communicated to management.

PFMR r. 164(2) and 165 stipulates that the Accounting Officer shall be responsible for the implementation of audit recommendations made in the audit reports and shall develop response and action plan and submit the same to the Chairperson of the Audit Committee within 14 days of receiving the quarterly audit report. ***Template 45*** in the Appendix (***Quarterly Summary of Status of Implementing Audit Recommendations***) provides a template that the Accounting Officer shall use to communicate to the Audit Committee the status of implementing audit recommendations. The Accounting Officer in communicating to the Audit Committee on implementation of audit recommendation shall provide the following information:

(1.) Status of the most recently issued internal audit reports which should include status of previously issued reports.

(2.) Status of implementing audit recommendations from OAG and Public Investments and Accounts Committee (PIAC).

(3.) Status of implementing Audit Committee directives and directives from the Governing Body in relation to audit issues.

(4.) Reason for non-implementation of audit recommendations (e.g. lack of resources, no longer applicable etc) and indicate strategy to overcome implementation challenges and provide a new anticipated implementation date.

The Audit Committee shall follow-up the implementation of the response and action plan. Audit Committee Guidelines for County Government (Gazette Notice 2690 of 15 April 2016) Section 2.2(a)(vi) and Section 3.1(b) provides the mandate and objective of the Audit Committee is to provide oversight over the implementation of accepted audit recommendations of the internal auditor, external auditor and Public Investment and Accounts Committee (PIAC).

The HIA shall discuss with the Audit Committee and the Accounting Officer in establishing an effective and efficient system for monitoring the implementation of management action plan in relation to audit recommendations. Such a system shall include:

(1.) Mechanisms of process owners to report to senior management and Accounting Officer on the status of implementing the management action plan.

(2.) Follow-up activities undertaken by other assurance providers.

(3.) Role of IAU in following-up implementation of management action plan in relation to:

(a) Internal audit engagements (assurance and consultancy).

(b) OAG and PIAC recommendations.

(c) Other assurance providers: what they are monitoring, frequency of monitoring, methodology and tools used for monitoring and reporting on the outcome of the monitoring process.

(d) Frequency of monitoring progress. High risk observations should be followed-up within 12 months of their reporting.

(4.) Role of IAU in coordinating receipt of feedback from process owners on the implementation of audit recommendations and submitting a report to the Accounting Officer and the Audit Committee.

(5.) IAU follow-up strategies which may include:

(a) Obtaining feedback from management on the implementation of management action plan.

(b) Undertaking follow-up as part of an engagement.

(c) Undertaking specific follow-up assignment which covers a specific period or a number of engagements.

In undertaking follow-up engagements, the HIA may consider the following:

(1.) Verify the activity reported as implemented by management (***Implementation Status, Template 45*** provided in the Appendix, may be used by management to report on status of implementing agreed management action).

(a) Adequacy of the control's design.

(b) If the control has been operating effectively.

(c) Timeliness of implementation.

(2.) Verify that the action implemented has resolved the weakness identified during the audit

(3.) Verify if implementing the action plan has led to benefit perceived at the time of the undertaking the engagement. This enables the HIA to assess if the recommendations provided by Internal Audit are adding value.

(4.) Assess the rate of implementing the action plan. Where key activities have not been fully implemented (i.e. partially implemented, not implemented or suspended), the Internal Auditor should discuss with the process owner to establish the cause which may include: lack of resources; complexity of the activity vis-à-vis current capacity; unrealistic timelines initially assigned; the cost of implementing the activity being more than the benefit; or risk exposure declining since the time of the engagement.

The nature, extent and timing of follow up should be guided by the following factors:

(1.) Significance of the reported finding. The following approach could be adopted:

(a) Major finding: – follow up promptly after the agreed date for implementation;

(b) Significant finding – follow up review during the next scheduled audit visit; and,

(c) Minor finding – rely on the feedback provided by management on implementation of recommendation.

(2.)Degree of effort and cost needed to correct the reported condition.

(3.)Complexity of the corrective action.

(4.)Time period involved.

The HIA shall ensure the results of the monitoring progress are reported to the process owner, senior management, Accounting Officer and Audit Committee. Reporting to the process owner may be done as part of the engagement report and reporting to the Audit Committee and Accounting Officer may be done as part of the quarterly reporting. Where the Internal Auditors have undertaken a specific follow-up engagement, a specific report will be issued for the engagement and distributed accordingly. The summary results of the follow-up shall be used to update the database of findings (refer to ***Audit Findings Database, Template 44***).

Reports on monitoring progress can be included in the engagement report of the audit where the follow-up was undertaken or can be in a separate follow-up report. The separate follow-up report may include the following information:

(1.)**Objective of the follow-up**: Confirming implementation of management action plan; assessing the effectiveness of activities implemented; or verifying the impact of audit recommendations.

(2.)**Scope of the follow-up**: Covering certain period; covering a number of previous Internal Audit engagements; or covering a number of assurance providers (e.g. Internal Audit, OAG, PAC/PIC, EACC, PPRA, ISO Auditors etc).

(3.)**Status of implementation**: The Internal Auditors should focus their effort on monitoring the implementation of action plan that relate to high risk findings/observations. The report may contain information on:

(a) Action plan completed on time.

(b) Activities that are over-due.

(c) Percentage of activities completed.

(d) Impact of implementing action plan e.g. improvement in efficiency, cost saving, increase in revenue etc.

(e) Poorly implemented activities.

(f) Areas where management has accepted the risk and thus planned action plan has not been implemented. The Internal Auditor shall obtain audit evidence to justify this.

(4.)**Conclusion**: On the degree of satisfaction with the implementation of management action plan.

The format used to report on engagements shall be used to report monitoring progress ***(refer to Template 42 and 43 in the Appendix).***

5.5 COMMUNICATING THE ACCEPTANCE OF RISKS

2600 – Communicating the Acceptance of Risks
When the HIA concludes that management has accepted a level of risk that may be unacceptable to the entity, the HIA must discuss the matter with senior management. If the HIA determines that the matter has not been resolved, the HIA must communicate the matter to the Audit Committee.

In undertaking assurance or consultancy engagements, the Internal Auditor may establish an area where management is taking risk/s that is above the approved risk appetite. The Internal Auditor can also discover such areas when: undertaking audit follow-ups; reviewing management reports, minutes of meetings or documents; or reviewing the reports of the OAG or other assurance providers. The unacceptable risk levels may be as a result of: weak risk management strategies; failure to identify key risks and act on them; or accepting risks based on inaccurate assumptions.

For the Internal Auditor to establish that management has accepted a level of risk that may be unacceptable, the Internal Auditor should understand the entity's risk management policy framework, approved risk appetite statements and approved risk tolerance levels.

Once the Internal Auditors identify instances where management has accepted a level of risk that may be unacceptable, they shall communicate the same to the HIA. The HIA shall assess the same to determine if the assertion by the Internal Auditors is accurate based on the nature, urgency and potential impact of the risk. The HIA shall ensure there is adequate audit evidence to support the assertion that management has accepted a level of risk that is unacceptable.

Where the HIA establishes that management has accepted a level of risk that may be unacceptable, the HIA shall communicate the same to the process owner recommending corrective action. Where the process owner does not adequately address the issue, the HIA shall escalate the matter to the appropriate member of senior management for appropriate action. Where the matter is not resolved by senior management, the HIA shall escalate the matter to the Accounting Officer and eventually to the Audit Committee where the same is not resolved by the Accounting Officer.

In reporting the matter of management taking unacceptable risk, HIA shall be aware that it's not the role of Internal Audit to manage risk but this is a management role. Thus, the HIA shall use professional judgement when escalating the matter. The HIA shall use the established risk management communication channels (based on the entity's risk management policy framework) when communicating and escalating instances where management has accepted a level of risk that may be unacceptable. The HIA shall also establish the best strategy to communicate to management which may include a combination of both verbal and written communication.

CHAPTER 6 – QUALITY ASSURANCE AND IMPROVEMENT PROGRAMME

Chapter 6 covers Standard 1300: Quality Assurance and Improvement Program

1300 - Quality Assurance and Improvement Program
The Head of Internal Audit must develop and maintain a quality assurance and improvement program that covers all aspects of the internal audit unit.

1310 - Requirements of the Quality Assurance and Improvement Program
The quality assurance and improvement program must include both internal and external assessments.

PFMR 159 (3)
At least once every three years, but not more than five years, internal audit unit shall undergo a professional assessment of its effectiveness undertaken by a professionally recognized body or institution

PFMR r. 159(1) requires that in each year the head of internal audit unit shall assess its own effectiveness through an internal performance appraisal and shall carry out annual review of the performance of the internal audit unit commenting on its effectiveness in the annual report to County Treasury. Further, each year the Audit Committee shall carry out annual review of the independence, performance and competency of the internal audit unit and comment on their effectiveness in the annual report.

The work of Internal Audit should be controlled at each level of operation to ensure that a continuously effective level of performance is being maintained. Consequently, the HIA shall establish a Quality Assurance and Improvement Program (QAIP) that enables continuous: evaluation of IAU conformance with the Standards and Internal Auditors application of the Code of Ethics; assessment of the IAU conforms to good practices of the Internal Auditing profession; assessment of IAU efficiency and effectiveness; assessment of the value added by the IAU; and identifies opportunities for improvement. The QAIP shall enable the HIA to assess if the IAU is complying with PFMR r. 161 that stipulates all Internal Auditors shall comply with IPPF and conduct audits in accordance to policies and guidelines issued by the PSASB.

The HIA shall ensure the QAIP covers all aspects of operation and management of the IAU. The HIA should have mechanism for: assessing the implementation of the action plan resulting from internal and external quality assessment; and continuously enhancing QAIP.

The HIA shall ensure the QAIP established consists of:

(1.) Internal quality assessment.

(2.) External quality assessment.

(3.) Reporting results of the QAIP.

The HIA can only use the statement (in writing or verbally) that internal audits are conducted in conformance to IPPF if the results of the internal and external quality assessments conclude that the IAU generally conforms to IPPF. On the use of the conformance statement please refer to Section 5.3.6 Audit Conducted in Conformance with IPPF.

6.1. INTERNAL QUALITY ASSESSMENT

1311 – Internal Assessment
Internal assessments must include:

- Ongoing monitoring of the performance of the internal audit unit.
- Periodic self-assessments or assessments by other persons within the organization with sufficient knowledge of internal audit practices.

6.1.1 ON-GOING MONITORING

The HIA shall ensure ongoing monitoring is an integral part of the day-to-day supervision, review, and measurement of the IAU audit activity. Monitoring ensures that there is adherence to IPPF and quality is improved on an engagement-by-engagement basis.

The HIA shall ensure there is on-going monitoring from engagement planning to dissemination of engagement results which shall be achieved through: effective engagement supervision; consistent application of this Manual and templates (provided as appendices) which will ensure standard work practice; sign-offs of work papers by the preparer; review of the work papers and engagement results which shall be evidenced by sign-offs by the reviewer.

The HIA shall ensure the on-going monitoring provide feedback on the adequacy of this Manual (and associated appendices). Periodic assessment of achievement of IAU's Key Performance Indicators (KPIs) shall form part of the on-going monitoring.

On-going monitoring shall include:

(1.)Engagement supervision.

(2.)Audit client feedback/survey.

(3.)Engagement completion checklist.

(4.)Post-engagement review.

(1.) Engagement Supervision

2340 – Engagement Supervision
Engagements must be properly supervised to ensure objectives are achieved, quality is assured, and staff is developed.

The HIA has the overall responsibility of providing the conclusion and opinion of each audit engagement. This requires the HIA to ensure all audit engagement are properly supervised from planning to communicating results to ensure: the engagement work program is fully implemented so as to achieve the engagement objectives; management expectations are met; quality is maintained which involves adherence to the procedures in this Manual and conformance to Standards; establish if there are any scope limitations; and engagement results are fully supported. The HIA may delegate the supervision responsibility to the Lead Internal Auditor who should be an experienced Internal Auditor.

The HIA shall determine the extent of supervision required for each engagement based on the nature and complexity of the engagement compared to the proficiency of the Internal Audit team.

Engagement supervision commences during engagement planning and ends when the results of the audit have been communicated to the audit client. During engagement planning supervision involves review and approval of the engagement plan. During engagement execution supervision involves ensuring the engagement work program is fully implemented; any amendments of the engagement work program are approved; results of the audit steps are recorded in the work papers; and work papers are reviewed. During communication of audit results, supervision involves reviewing the accuracy, objectivity, clarity, constructiveness, completeness and concise of information contained in the report and timely issuance of the audit report.

The lead Internal Auditor shall review the work papers on an on-going basis as they are prepared by the Internal Audit team and any discrepancies or information gaps identified rectified. On completion of field work and before the issuing of the draft report, the lead Internal Auditor shall issue the reviewed audit file to the HIA for further view. On receipt of feedback from the audit client, the lead Internal Auditor shall ensure: necessary additional audit steps are undertaken; additional information is acquired; appropriate work papers are maintained; and final audit report is prepared. The lead Internal Auditor shall issue the final report and updated audit file to the HIA for final review and issuance of the final report to the audit client.

Responsibility for first stage work paper review (during field work) and second stage work paper review (before issuance of draft report) will depend on the seniority of the Internal Auditor who performed the detailed audit work. Illustration 10 provides guidance on who can undertake the first and second stage reviews.

Illustration 10: Work Paper Review

Audit Performed By:	First Stage Preview	Second Stage Review
Internal Auditor or below	Senior Internal Auditor	Deputy Head of Internal Audit
Senior Internal Auditor	Deputy Head of Internal Audit Internal Auditor	Head of Internal Audit /Director, Internal Audit

Irrespective of the person performing the first and second stage review, the HIA must review and sign all documents issued to the audit client including Internal Audit Planning Memo, draft Internal Audit report and final Internal Audit report.

The HIA shall ensure there is documentary evidence of engagement supervision. This may include: review notes/sheet and responses to the same (which includes updating the appropriate work papers); and reviewer initials and dating each work paper after it is reviewed. Issues arising from the review, which are not resolved immediately, should be noted on a review sheet by the reviewer. The review should be conducted at a level of responsibility higher than that of the preparer of the working papers. ***Review Notes, Template 46*** is provided in the Appendix that can be adopted by the HIA.

Supervision provides the HIA or the lead Internal Auditor an opportunity to conduct on the job training to the Internal Audit team. Reviewing of the work papers enables the HIA or the lead Internal Auditor to assess the performance of the Internal Audit team and identify skill gaps. The reviewers should use the review sheets to provide feedback to the Internal Auditors and to ensure that lessons are learnt for future audits. To be effective, this feedback should be provided as promptly as possible. In addition to reviewing work papers at the end of field work, the HIA should plan to visit the Internal Audit team while they are undertaking their field work to observe their performance and discuss significant audit observations and challenges that the team may be facing.

(2.) Audit Client Satisfaction Survey

The HIA shall ensure that an audit client satisfaction survey is conducted for each engagement. The Audit Client Satisfaction Survey form shall be submitted to the audit client with the draft internal audit report. The completed survey shall be returned by the audit client with the comments on the draft internal audit report.

A meeting should be scheduled with the audit client to discuss any negative feedback contained in the completed audit client satisfaction survey. The issues raised should also be discussed at the team debriefing, even if the audit client declines to meet in this regard.

Note that the ***Audit client Satisfaction Survey, Template 47*** provided in the Appendix contains the minimum content and the relevant Team Leader can add additional content on which feedback is required if deemed necessary meet the IAU requirements.

(3.) Engagement Completion Checklist

The HIA shall ensure an Engagement Completion Checklist is completed for each engagement. The checklist is important in assisting the Internal Audit team in: ensuring that all required activities have been undertaken and this Manual has been adhered to in planning, executing, reporting and following-up engagements; and the required documentation is in place.

The completion checklist must be signed-off by the relevant lead Internal Auditor throughout the engagement to ensure that the checklist is accurately completed and the working paper file is complete. The HIA must also sign-off the checklist as an indication that he / she is satisfied that the audit working paper file is accurate and complete to substantiate the final audit report.

An Engagement Completion Checklist, Template 48 is provided in the Appendix which the HIA can amend appropriately to meet the IAU requirements.

(4.) Post-Engagement Review

The IAU may select a sample of engagements from a particular timeframe and conduct a review to assess compliance with IPPF and this Manual. These reviews are typically conducted by Internal Auditor who was not involved in the respective engagement.

6.1.2 PERIODIC SELF ASSESSMENT

The PFMR r. 159(1) requires the HIA to undertake an annual self-assessment to assess the effectiveness of the IAU and provide recommendations on improving the same. The periodic self-assessment shall entail assessing:

(1.)The effectiveness of the on-going monitoring.

(2.)The quality of audit work done.

(3.)The quality of supervision and monitoring.

(4.)Status of the independence and objectivity of the IAU.

(5.)Compliance with the Internal Audit Charter and this Manual.

(6.)Compliance with IPPF and other professional guidelines.

(7.)The achievement on stipulated key performance indicators.

The HIA shall agree on the frequency of undertaking the periodic self-assessment which should be on a minimum annually and a maximum of 2 years. The HIA shall ensure the assessor has sufficient knowledge of internal audit practices requirements and an understanding of all elements of IPPF. This can be a senior member of the IAU unit. The self-assessment can also be conducted by a member of another function who was worked in the IAU provided they have the required competencies. The HIA can include the junior Internal Auditors in the team undertaking the self-assessment to provide them with a learning opportunity.

The periodic self-assessment is more holistic compared to the on-going monitoring as it covers all standards whereas on-going monitoring mostly focuses on the performance standards and is engagement based. In addition to assessing conformance, the self-assessment involves surveys or meetings with key audit clients to establish if the IAU is meeting their needs and adding value.

The periodic-self assessment also involves assessing implementation of action plan developed during previous internal and external quality assessments. The periodic self-assessment is very helpful when undertaken before an external quality assessment as it enables the HIA establish gaps and work on closing them before the external quality assessment.

A ***Self-Assessment, Template 49*** is provided in the Appendix that the HIA can amend appropriately to support in undertaking Periodic Self-Assessments.

1.1 EXTERNAL QUALITY ASSESSMENT

1312 – External Assessment
External assessments must be conducted at least once every five years by a qualified, independent assessor or assessment team from outside the organization. The Head of Internal Audit must discuss with the Audit Committee:

- The form and frequency of external assessment.
- The qualifications and independence of the external assessor or assessment team, including any potential conflict of interest.

PFMR r. 166(3)2 – Performance Appraisal
At least once every three years but not more than five years the Internal Audit Unit shall undergo a professional assessment of its effectiveness undertaken by a professionally recognized body of institution.

PFMR r. 159(3) stipulates that the HIA shall ensure an external quality assessment is undertaken at least every three years and not more than five years. The external assessment may be undertaken more frequently where there is: change in the leadership of the IAU; high turnover of

Internal Auditors; change in the organizational structure of the IAU; and significant changes in the Internal Audit Charter and this manual.

External quality assessment shall be undertaken by a qualified assessor or assessment team that demonstrates competence in two areas: the professional practice of internal auditing and the external assessment process. In establishing the competency of the assessor, the HIA shall consider: professional qualification (Certified Internal Auditor, Certified Quality Assessor); experience in managing internal audit unit; experience in undertaking quality assessment in organizations of similar size, complexity, sector or industry. The HIA shall ensure the assessor or assessment team is independent and objective i.e. not having either an actual, potential or a perceived conflict of interest.

In addition to the external assessor concluding on the IAU conforming with IPPF (the Code of Ethics and the Standards), the assessor shall:

(1.)Verify whether Internal Auditors are fulfilling their mandated roles and responsibilities as defined in the Internal Audit Charter.

(2.)Verify whether the IAU is meeting its vision, mission and strategic objectives as stipulated in the Internal Audit Strategic Plan.

(3.)Verify if the IAU is achieving its KPIs as stipulated in the Annual Audit Plan.

(4.)Establish sub-standard practices and make recommendations on improvements.

(5.)Check whether the Internal Auditors are adhering to this Manual.

External assessments may be accomplished through the following means. The HIA shall consult with the Accounting Officer and the Audit Committee to determine the most appropriate approach.

(1.)Full external assessment: or

(2.)Self-assessment with independent external validation.

1.1.1 FULL EXTERNAL ASSESSMENT

The external assessors evaluate: conformance to IPPF; effectiveness and efficiency of IAU; if the IAU is meeting the requirements of IAU's clients and stakeholders; and whether IAU is adding value. In addition to reviewing the work papers maintained by the IAU, the assessment also involves engagement with Audit Committee, Accounting Officer, management, IAU staff and other key IAU stakeholders.

1.1.2 INTERNAL ASSESSMENT WITH EXTERNAL VALIDATION

The involves undertaking a self-assessment following the methodology of undertaking an external assessment and having on-site validation of the results of the self-assessment by an independent, qualified and competent external assessor.

1.2 REPORTING ON THE QUALITY ASSURANCE AND IMPROVEMENT PROGRAM

1320 – Reporting on the Quality Assurance and Improvement Program
The Head of Internal Audit must communicate the results of the quality assurance and improvement program to the Accounting Officer and the Audit Committee. Disclosure should include:

- The scope and frequency of both the internal and external assessments.
- The qualifications and independence of the assessor(s) or assessment team, including potential conflicts of interest.
- Conclusions of assessors.
- Corrective action plans.

1.2.1 QUALITY ASSURANCE IMPROVEMENT PROGRAM EXTERNAL ASSESSMENT RATINGS

Quality assurance and improvement program external assessment reports include the expression of an opinion or conclusion on the results of the external assessment. In addition to concluding on the internal audit unit's overall degree of conformance with the Standards, the report may include an assessment for each standard and/or standard series. An example of a rating scale that may be used to show the degree of conformance is:

(1.) Generally Conforms

For individual standards, that the internal audit activity conforms to the requirements of the standard or elements of the Code of Ethics (both Principles and Rules of Conduct) in all material respects.

For the sections (Attribute and Performance) and major categories the internal audit activity achieves general conformity with a majority of the individual standards and/or elements of the Code of Ethics, and at least partial conformity to others, within the section/category.

For the internal audit activity overall, there may be opportunities for improvement, but these should not represent situations where the internal audit activity has not implemented the standards or the Code of Ethics, has not applied them effectively, or has not achieved their stated objectives.

(2.) Partially Conforms

For individual standards, the internal audit activity is making good faith efforts to conform to the requirements of the standard or elements of the Code of Ethics (both Principles and Rules of Conduct) but falls short of achieving some major objectives.

For the sections (Attribute and Performance) and major categories the internal audit activity partially achieves conformance with the individual standards within the section/category and/or elements of the Code of Ethics.

For the internal audit activity overall, there will be significant opportunities for improvement ineffectively applying the Standards or Code of Ethics and/or achieving their objectives. Some deficiencies may be beyond the control of the internal audit activity and may result in recommendations to senior management or the Governing body of the entity.

An internal audit activity assessed at the level of **"Generally Conforms"** would be able to use the phrase: "Conforms with the International Standards for the Professional Practice of Internal Auditing" **Standard 1321**

(3.) Does Not Conform

For individual standards, the internal audit activity is not aware of, is not making good faith efforts to conform to, or is failing to achieve many/all of the objectives of the standard and/or elements of the Code of Ethics (both Principles and Rules of Conduct).

For the sections (Attribute and Performance) and major categories the internal audit activity does not achieve conformance with a majority of the individual standards within the section/category and/or elements of the Code of Ethics.

For the internal audit activity overall, there will be deficiencies that will usually have a significant negative impact on the internal audit activity's effectiveness and its potential to add value to the organization. These may also represent significant opportunities for improvement, including actions by senior management or the Governing body.

The HIA shall communicate the results of the QAIP as well as the impact from the results to management, Accounting Officer and Audit Committee in the following frequency:

(1.) On-going monitoring: on an annual basis through the Internal Audit Annual Report.

(2.) Periodic self-assessment: on an annual basis through the Internal Audit Annual Report. Where this is done every 2 years, to be reported in the annual report of the financial year that it was undertaken.

(3.) External assessment: on completion by the external assessors.

In reporting the outcome of the assessment, the HIA shall ensure the following information is provided:

(1.) Objective and scope of the assessment (i.e. internal or external).

(2.) Qualification of the assessors.

(3.) Conclusion/opinion of the assessment.

(4.) Status of implementation of action plan for previous assessments.

(5.) Corrective action plan.

PFMR r. 159(2) requires the Audit Committee on an annual basis to assess the independence, performance and competency of the IAU and comment on the effectiveness of the function in the

Audit Committee annual report. In undertaking this assessment, the Audit Committee shall obtain feedback from the Accounting Officer, management, OAG and other key stakeholders on the performance of the IAU. Interaction with the HIA and Internal Auditors during Audit Committee meetings provides continuous feedback to the committee on the proficiency of the audit team and should be used by the committee to obtain necessary information required for undertaking the annual assessment. The Audit Committee shall hold private meeting with the HIA at least once in a year to obtain feedback on the performance of the IAU and challenges that the function is facing which forms a key input in the annual assessment process. The Audit Committee shall consider performance information contained in the Internal Audit Quarterly and Annual reports in assessing the effectiveness of the IAU.

A ***QAIP Maturity Model, Template 50*** is provided in the Appendix that illustrates the various levels of quality of internal audit units in conformance with the IPPF standards.

GLOSSARY OF TERMS

IIA Standards – The purpose of the International Standards for the International Professional Practice Framework(IPPF) of Internal Auditing (IIA Standards) is to: ▪ Delineate the basic principles that represent the practice of Internal Auditing as it should be; ▪ Provide a framework for performing and promoting a broad range of value-added Internal Audit activities; ▪ Establish the basis for the evaluation of Internal Audit performance; and, ▪ Foster improved organisational processes and operations. The Standards consist of Attribute Standards, Performance Standards, and Implementation Standards: **Attribute Standards** address the characteristics of organisations and parties performing Internal Audit activities **Performance Standards** describe the nature of Internal Audit activities and provide quality criteria against which the performance of these services can be evaluated **Implementation Standards** describe how the attribute and performance standards can be applied to specific types of audit engagements. Implementation Standards have been established for **Assurance** and **Consulting** activities. The Standards are part of the **Professional Practices Framework** of the IIA that includes the Definition of Internal Auditing, the Code of Ethics, the Standards, and other guidance.
Accounting Officer – An officer designated in writing by the County Executive Committee member finance to be responsible for managing the finances of the county government entities.
Add Value – Value is provided by improving opportunities to achieve organisational objectives, identifying operational improvement, and/or reducing risk exposure through both assurance and consulting services.
Adequate Control – Present if Management has planned and organised (designed) in a manner that provides assurance that the organisation's risks have been managed effectively, and that the organisation's goals and objectives will be achieved efficiently and economically.
Analytical Review – The study and investigation of significant ratios, trends, and other statistics to form conclusions about the likelihood of weaknesses and errors in financial and operating systems.
Analytical Procedures – Tests of the reasonableness of account balances and transactions, involving comparisons of recorded amounts with expectations developed by the Auditor, and scrutinising for unusual items. Analytical procedures may be used at all stages of the audit and are required by Generally Accepted Auditing Standards to be used in the mobilisation and completion phases.

Assurance Services – An objective examination of evidence for the purpose of providing an independent assessment on risk management, control, or governance processes for the organisation. Examples may include financial, performance, compliance, system security, and due diligence engagements.
Attribute Sampling – Selection of items from a population according to attributes of the item other than its financial value.
Audit Comfort – The assurance derived by the Auditor that sufficient appropriate audit evidence has been obtained for each significant business activity and related audit area with financial reporting significance to reduce audit risk to a level that will enable the Auditor to issue his opinion on the financial statements.
Audit Documentation and Guiding Principles – Audit procedures should be documented in sufficient detail to enable a reviewer to understand what work was done (nature, timing, and extent), what evidence was seen (results) and what conclusions were drawn from the evidence obtained. There are four guiding principles: ▪ Maximise the use of the tailored audit programme, which becomes the record of work done; ▪ Write it once (in detail); ▪ Ensure effective use of additional detailed working papers for areas of higher risk and/or matters of significant judgement; and, ▪ Ensure effective application of Generally Accepted Audit Working Practices.
Audit Plan – The overall service plans to meet and preferably exceed client expectations. The Audit Plan should consider items such as developments affecting the client's business, client and stakeholder needs and expectation, risk assessment, potential critical matters, the audit strategy, engagement management, client communication, client reporting, as well as actions for other assurance services beyond the audit. The Audit Plan is communicated to the client. The format of the documentation of the Audit Plan is flexible and can range from a formal document, which can be a multi-disciplinary plan, to a very concise memo or outline containing only the minimum expected written sections on client needs/expectations and related actions.
Audit Programme – A document comprising a detailed description of the work to be performed. When completed it forms, with supporting documentation where necessary, the record of work done.
Audit Risk – The risk that an inappropriate opinion on financial statements will be issued. Audit risk consists of three components: Inherent Risk, Control Risk (Inherent and Control Risk are together referred to as the risk of material misstatement), and Detection risk.
Audit Sampling – Audit sampling is the application of auditing procedures to a representative group of less than 100% of the items within an account balance or class of transactions (or subject of either) for the purpose of evaluating some characteristic of the entire balance or class (or population tested).

Automated Controls – Controls performed by the computer systems or enforced by system security parameters.
Application Control – Manual or automated control activities that typically operate at a detailed business process or transaction level and are designed to ensure the integrity of the accounting records. Application controls, which can be preventive or detective in nature, directly support the information processing objectives of completeness, accuracy validity, and restricted access.
Business Objectives – Business can be defined at a very high level (e.g., a company mission statement) or at a lower level in the organisation (e.g., operational objectives that accomplish the strategy set by the high-level objectives) but are best clearly stated and specific. Objectives are used to measure performance, and they are essential to any planning process. For purposes of the audit, understanding the client's business objectives is the necessary first step to identifying risks because risks are defined in relation to specific objectives.
Business Process – Any sequence of transactions that takes place in order to get work done and achieve the business' objectives. These may range, in order of complexity, from a simple procedure, such as paying a bill, to a key element of the business operations, such as a wholesaler's stock management and distribution system, to functional, such as maintaining an organisation's financial records, to cross functional, like application of human resources.
Business Risk – The risk of the organisation failing to meet its objectives. Anything that can prevent the achievements of the organisation's objectives, including strategic, operational, financial, and compliance objectives. Business risks can only be identified and defined in relation to a business objective, which means understanding objectives must be a prerequisite for identifying risks. To derive real value for audit purposes risks should be defined in detail.
COBIT (Control Objectives for Information and Related Technologies) - Framework created by ISACA for information technology (IT) management and IT governance.
Compliance – Conformity and adherence to policies, plans, procedures, laws, regulations, contracts, and other requirements.
Computer Environment – A specific set of hardware and system software on which the client's business and accounting systems run (e.g., AS/400. UNIX).
Confidence Level – The level of assurance derived from audit testing based on samples rather than evaluation of the whole population.
Conflict of Interest – Any relationship that is, or appears to be, not in the best interest of the organisation. A conflict of interest would prejudice an individual's ability to perform his or her duties and responsibilities objectively.
Consulting Services – Advisory and related client service activities, the nature and scope of which are agreed with the client and which are intended to add value and improve an organisation's governance, risk management, and control processes without the Internal Auditor taking management responsibility. Examples include counsel, advice, facilitation, and training.

Control – Any action taken by management, the board, and other parties to manage risk and increase the likelihood that established objectives and goals will be achieved. Management plans, organises, and directs the performance of sufficient actions that provide reasonable assurance that objectives and goals will be achieved.
Control Environment – The attitude and actions of the board and management regarding the significance of control within the organisation. The control environment provides the discipline and structure for the achievement of the primary objectives of the system of internal control. The control environment includes the following elements: ▪ Integrity and ethical values ▪ Management's philosophy and operating style ▪ Organisational structure ▪ Assignment of authority and responsibility ▪ Human resource policies and practices ▪ Competence of personnel
Control Framework – Internal control should be evaluated against a framework of five interrelated components that should be applied at any level of the organisation (i.e. at the entity, management unit and/or business process level). These components are: Risk assessment; Control environment; Information and communication; Control activities; and Monitoring of controls. The division of internal control into the five components provides a useful framework to consider how different aspects of an entity's internal control may affect the audit. However, the primary consideration is, to evaluate and validate whether material misstatements in classes of transactions, account balances or disclosures and related assertions rather than its classification into any particular component.
Control Processes – The policies, procedures, and activities that are part of a control framework, designed to ensure that risks are contained within the risk tolerances established by the risk management process.
Control Risk – The level of business risk not being prevented or detected by the internal control environment as a whole. One of the three components of audit risk, control risk is the risk that a material misstatement that could occur in an account or cycle will not be prevented or detected and corrected on a timely basis by the client's internal controls. This risk is a function of the effectiveness of the design and operation of internal control in achieving the client's objectives relevant to the preparation of the client's financial statements. Control risk is considered through the application of the audit comfort cycle, particularly at "taking stock" meetings when relevant parties consider how much comfort has been obtained.
Corporate Governance - structure and system of rules, practices and processes by which an organisation is directed, controlled and held accountable. It encompasses authority, accountability, stewardship, leadership, direction and control exercised in organisations.

Chief Officer - A person appointed by the County Governor to administer the County department responsible for financial affairs;
Detection Risk – Detection risk is the risk that the auditor will not detect a material misstatement that exists in an account balance or class of transaction. This risk is a function of the effectiveness of the auditing procedures and their application by the auditor. Detection risk is considered when determining the nature and extent of audit work.
Development and Implementation controls – Procedures or mechanisms in place to ensure that systems are developed, configured, and implemented to meet financial, operational, and compliance business objectives.
Direct Substantive Testing – Evaluation of an organisation's internal control environment purely through the detailed testing of individual transactions, assets, and liabilities (e.g., used when the internal control environment is too weak to justify tests of controls, or evidence of the existence and operation of controls is not available).
Engagement – A specific Internal Audit assignment, task, or review activity, such as an Internal Audit, Control Self-Assessment review, fraud examination, or consultancy. An engagement may include multiple tasks or activities designed to accomplish a specific set of related objectives.
Engagement Objectives – Broad statements developed by Internal Audit that define intended engagement accomplishments.
Engagement Work Program – A document that lists the procedures to be followed during an engagement, designed to achieve the engagement plan.
Fraud – Illegal acts characterised by deceit, concealment, or violation of trust. Fraud comprises both the use of deception to obtain an unjust or illegal financial advantage, and intentional misrepresentations affecting the financial statements by one or more individuals among management, employees, and third parties. Fraud can be broken down into two main categories: Fraudulent financial reporting, and Misappropriation of assets.
Fraud Risk –The risk of material misstatement of the financial statements due to fraud.
General computer controls – Controls used to manage the IT activities and computer environment, covering the following areas: Maintenance of existing systems, Development and implementation of new systems, information security, and computer operations.
Governance – The combination of processes and structures implemented by the board in order to inform, direct, manage, and monitor the activities of the organisation toward achievement of its objectives.
Governance Arrangements – The means by which an organisation is directed and controlled.
GTAGs (Global Technology Audit Guide) - describes how members of governing bodies, executives, IT professionals, and internal auditors address significant IT-related risk and control issues and presents relevant frameworks for assessing IT risk and controls.

Haphazard Selection Method – A common method of selection in non-statistical sampling. This provides a method for selecting a judgmentally representative sample without relying on a truly random process. "Haphazard" does not mean without thought or effort.
Independence – The freedom from conditions that threaten objectivity or the appearance of objectivity. Such threats to objectivity must be managed at the individual auditor, engagement, functional, and organisational levels.
Information and Communication – Systems that support the identification, capture, and exchange of information in a form and time frame that enables people to carry out their responsibilities.
Information Processing Control – A type of control activity comprising two broad groupings – application and general computer controls.
Information Processing Objectives – Management's goals in relation to controls, which, if effectively met, help support management's implicit financial statement assertions: completeness of records, accuracy of records, validity of records, restricted access to assets and records.
Information Security Controls – Procedures or mechanisms in place to ensure that access (physical or logical) to systems resources and data is authenticated and authorised.
Inherent Risk – The level of business risk associated with the organisation as a whole, or the individual system being examined. Inherent risk is one of the three components of audit risk. The susceptibility of an account balance of cycle to material misstatement, assuming there were no related internal controls. These risks are specific to the client and can relate to macro-economic, industry, or company level conditions, or to characteristics of the client's accounts.
Interval Sampling – Selection of a sample by extracting every n^{th} item from the population.
ISO 38500 - provides guiding principles for members of governing bodies of organizations on the effective, efficient, and acceptable use of information technology (IT) within their organizations.
ITIL (Information Technology Infrastructure Library) - set of detailed practices for IT activities such as IT service management (ITSM) and IT asset management (ITAM) that focus on aligning IT services with the needs of business
Management Information – Any information that management uses to control the business, and on which they make business decisions. This may be the formal output from a business process or any other informal source from which management obtains information.
Management's Risk Assessment Process – The entity's process for identifying and analysing relevant risks to achievement of its objectives, forming a basis for determining how the risk should be managed.

Materiality – The degree of relevance or significance of an absent, inappropriately designed, or ineffective control or management arrangement, in relation to the business risk of the organisation. Materiality is the magnitude of an omission or misstatement of accounting information that may change or influence the judgement of a reasonable person.
Materiality by Nature – The degree of relevance towards business risk of an individual system or set of transactions arising from the characteristics of that system and its sensitivity towards public opinion.
Materiality by Value – The degree of relevance towards business risk of an individual system or set of transactions arising from its monetary value.
Monetary Unit Sampling – The selection of items from a population in such a way that the probability of an item being selected is proportional to its financial value.
Monitoring of Controls - A process that assesses the quality of internal control performance over time. This is accomplished through on-going monitoring activities, separate evaluations, or a combination of the two.
Non-sampling Risk – The risk that the auditor draws an incorrect conclusion from an item or items that (s)he has examined.
Objectivity – An unbiased mental attitude that allows Internal Auditors to perform engagements in such a manner that they have an honest belief in their work product, and that no significant quality compromises are made. Objectivity requires Internal Auditors not to subordinate their judgement on audit matters to others.
Population - The source of items to be selected by audit sampling. Can be an entire account balance or class of transactions. However, the population should be restricted to the group of transactions, for the time period and under the same system of controls that are relevant to the objectives of the test to be performed.
Precision - A term used in connection with the assurance, which substantive procedures provide. In relation to analytical procedures, the degree of precision refers to the closeness of the expectation to the "correct" amount. In relation to audit sampling, it represents the excess of tolerable misstatement over estimated misstatement and is a measure of how precise the conclusions from sampling applications need to be.
Professional Scepticism - An attitude, which means that the auditor should not accept explanations at face value but should validate or corroborate explanations with additional evidence.
Preliminary Systems Evaluation – An initial evaluation of an audited body's control environment conducted to establish whether proper accounting records are maintained to provide sufficient, relevant, and reliable audit evidence to support a systems-based audit approach.
Process – A procedure designed to pass transactions or other information through a system.

Random Sampling – A common method of selection in non-statistical sampling involving the selection of items from a sample such that all items have an equal chance of being selected, with all bias removed.
Ratio Analysis – This is the comparison, across time or to a benchmark, of relationships between financial statement accounts (e.g., return on equity), and between an account and non-financial data (e.g., cost per order or sales per square foot). Ratio analysis allows one to understand how the entity stands in relation to its industry competitors and also in relation to itself between periods.
Reasonable Assurance - is a high level of assurance regarding material misstatements, but not an absolute one. Reasonable assurance includes the understanding that there is a remote likelihood that material misstatements will not be prevented or detected on a timely basis.
Reasonableness Test – This is the analysis of account balances, or changes in account balances, between accounting periods, that involves the development of a model to form an expectation based on financial data, non-financial data, or both. In many instances, an auditor uses very simple computations. For example, an expectation for hotel revenue may be developed using a model that includes the average occupancy rate and the average room rate by category or class of room. Similarly, to develop an expectation expense, one may use a model including number of employees, pay rates, hire and termination dates, and overtime.
Reportable Condition – Matters that should be communicated because they represent significant deficiencies in the design or operation of internal control that could adversely affect the entity's ability to record, process, summarise, and report financial data consistent with management's assertions in the financial statement. Such deficiencies may involve aspects of the internal control components of: ▪ The control environment; ▪ Entity's risk assessment process; ▪ Control activities; ▪ Information system, including the related business processes, relevant to financial reporting and communication; or, ▪ Monitoring controls.
Sample Selection Method - To obtain a representative sample so that sample results can be projected to the population or stratum. Random, haphazard, or systematic methods may be applied, according to the circumstances.
Sampling Risk – The risk that sampling techniques will lead the auditor to an incorrect conclusion, compared to the conclusion reached if the whole population were tested. The risk that the conclusions drawn from an audit sample testing might be different from those that would have been reached if the auditing procedures were applied to all the items in the account or population.

Sampling Unit – The specific population characteristic that defines the items to be sampled. For example, in testing accounts receivable, the sampling unit might be the customer balance, invoice number, or individual sales transaction.
Substantive Audit Evidence -The evidence obtained from performing substantive tests, which could be either substantive analytical procedures, tests of detail, or a combination of both.
Substantive Tests – An evaluation of an individual transaction, asset, or liability in comparison to its recorded or expected value or state. Substantive tests include substantive analytical procedures and tests of details of transactions and account balances. Their purpose is to provide evidence supporting management's implicit financial statement assertions or, conversely to discover misstatements in the financial statements directed to management information capable of being related to financial statement assertions.
Substantive Error – A physical difference between the transaction or property being examined, and what the auditor expects to find.
Systems – The procedures and operations by means of which an organisation's transactions and events are affected and recorded.
Systems Based Auditing – Evaluation of the design and operation of an organisation's systems of internal control.
Systematic Selection Method – A common method of selection in non-statistical sampling. This method of selecting a sample selects every nth item. A sampling interval is established based on the number of items, without reference to size or monetary value of the item.
Targeted Testing - The preferred method of selecting items to be tested based on some characteristic, rather than selecting them "randomly" using audit sampling.
Test of Controls – The evaluation of the design and operation of an identified internal control.
Tests of Control Error – A failure to operate a control in the manner intended by management, record evidence of the operation of that control, or failure to comply with rules and policies which exercise control.
Value for Money – The economy, efficiency, and effectiveness of an organisation's operations.
Walk Through Test – The process of confirming an Auditor's understanding of a system and its related controls by following one transaction through the entire system, from start to finish.
Walk Through Error – The failure of a document or process to follow the system described to the auditor.

APPENDICES: AUDIT TEMPLATES

No.	Description	Purpose
1	Internal Audit Charter	Purpose, authority and responsibility of the internal audit unit
2	Declaration of Independence and Objectivity	To document conflict of interests and threats to the auditors objectivity
3	Job descriptions and job specifications	Describe the roles and responsibilities of each job position
4	Pre-engagement / control questionnaire	Conduct survey of the entity level controls
5	Fraud incidence reporting	To report identified fraud incidences for further action
6	Internal Audit Strategic Plan	Departments long term plan
7	Internal Audit Universe	List of audit areas within audit
8	Annual Risk Based Internal Audit Work Plan	Lists audit assignments to be undertaken in the year
9	Risk Model	To categorise risks based on their source for analysis
10	Risk control matrix	To map risks and internal controls
11	Heat map	To give a graphical view of risks per auditable area
12	Daily time sheet	To show the tasks accomplished on each working day and the number of "person-hours" spent on each task
13	Work allocation and time budget	To assign work and time to assignments in the audit plan
14	Resource calendar or chronogram	For approval by the Audit Committee at the beginning of the year
15	Internal audit Quarterly report	Summary report to the Audit Committee and senior management
16	Internal audit Annual Report	Summary of all audit activities compared to the audit plan
17	List of suggested Audit Committee induction materials	Materials needed for induction of Audit Committee members

No.	Description	Purpose
18	Audit Committee Charter	Purpose, authority and responsibility of the Audit Committee
19	Quarterly Audit Committee report	Outline of an Audit Committee quarter report on matters stakeholders may need to know in relation to the Audit Committee
20	Audit Committee annual report	Outline of an Audit Committee annual report on matters stakeholders may need to know in relation to the Audit Committee
21	Audit Committee monitoring	To track information discussed in the Audit Committee quarterly meeting
22	Internal audit assessment by the Audit Committee	To document understanding of the process
23	Audit Committee self-assessment	To assess the performance of an Audit Committee
24	Individual Audit Committee member performance assessment	To assess the performance of individual Audit Committee members
25	Engagement Plan	Summarise audit objective, scope, key risks, controls, audit approach , audit client, team etc. for consideration and approval by head of internal audit
26	Audit Notification	To Inform audit client of commencement of an audit
27	Request for Audit Information	A list of documents to be prepared in advance by the audit client for the auditor
28	Information request monitoring checklist	To track when information requested was provided
29	Business process analysis form	To document understanding of the process
30	Understanding the IT environment	To document understanding of the IT environment and assess IT complexity
31	Assessing IT general controls and application controls	To conduct a high level assessment of IT general controls and application controls

No.	Description	Purpose
32	Standard flow chart symbols and narratives	To document flow of activities in a process
33	Fraud risk assessments	To document fraud risk assessment by the team and plan appropriate audit steps
34	Engagement work program	List of audit procedures to be carried out
35	Internal Audit planning memo	To inform the audit client of the scope
36	Entry meeting agenda and minutes	To be record audit client and audit team expectations
37	Record of control weakness	Form for evaluating audit finding
38	Working paper	Document work carried out
39	Draft finding sheet	A record of potential audit comments for discussion with audit client
40	Example of audit opinions	Different audit opinions for different types of audits
41	Exit Meeting Agenda and Minutes	To be record of audit draft findings and recommendations
42	Internal audit draft report	Audit report format for draft client submitted for audit client comments
43	Internal audit final report	Audit report format for final communications
44	Audit findings database	A repository of all previous audit findings
45	Quarterly summary of status of implementing audit recommendations	Database for monitoring disposal of audit findings
46	Review notes	To record supervisors comments and disposal of the comments
47	Audit client Satisfaction Survey	To obtain feedback after the end of the assignment on internal audit service
48	Engagement Completion Checklist	Used in wrapping up audit file to ensure completion of audit tests and working paper file
49	Self-Assessment	To assess the quality of the internal audit unit

No.	Description	Purpose
50	QAIP Model	To demonstrate levels to quality in internal audit conformance with IPPF standards