Report Summary for January 2012
Country Management and Support Visit to Botswana

Background

As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State Office of the U.S. Global AIDS Coordinator. CDC uses its technical expertise in public health science and long-standing relationships with Ministries of Health across the globe to work side-by-side with countries to build strong national programs and sustainable public health systems that can respond effectively to the global HIV/AIDS epidemic. All CDC global HIV/AIDS PEPFAR-related activities are implemented by the Division of Global HIV/AIDS (DGHA) in CDC's Center for Global Health.

CDC's Commitment to Accountability

CDC/DGHA launched the Country Management and Support (CMS) initiative in 2011 to identify any challenges resulting from the rapid scale-up of complex PEPFAR/CDC programming as part of CDC's commitment to transparency and accountability. This initiative serves as a basis for ongoing, monitored quality improvement of CDC/DGHA's programs and operations through internal programmatic and financial oversight. CMS is a proactive response on the part of CDC to ensure that CDC/DGHA is supporting the Presidential Initiatives, Department of State, and Office of the U.S. Global AIDS Coordinator. The CMS strategy is designed to assess CDC/DGHA's accountability in the following key areas:

- **Intramural Resources**: Ensuring proper management and stewardship of financial resources, property, and human resources within CDC's overseas offices
- **Extramural Funding**: Ensuring responsible and accurate management of financial and other resources external to CDC's overseas offices
- **Public Health Impact**: Ensuring the delivery of consistently high quality interventions and technical assistance that positively impact the populations the program serves

Botswana Country Management and Support Visit

CDC conducted a CMS visit to the CDC country office in Botswana from January 23-27, 2012. The principal objectives of this CMS visit were to:

- Perform a CDC/DGHA headquarters assessment of internal controls in the field to ensure the highest level of accountability
- Provide clear feedback and support to the country office to improve current internal controls
- Refine, systematize, and modify CMS methodologies, processes, and associated tools for full implementation during future CMS visits across all CDC/DGHA-supported programs in the field

CDC headquarters (CDC/HQ) in Atlanta, Georgia assembled an intra-agency multidisciplinary team of twelve experts to perform the CMS assessment in the following areas: country management and operations, program budget and extramural management, grants management, financial management, and key technical program areas (e.g.,

surveillance, informatics). One staff member from CDC's Center for Global Health (CGH) was also a part of the team and evaluated CDC non-DGHA programs in-country. In addition, the Chief Financial Officer for CDC joined the team for a concurrent visit to the U.S. Embassy to Botswana and the CDC office in Botswana, while also using the visit to evaluate the CMS process itself.

CMS Methodology

The CMS team conducted a five-day visit to the CDC office in Botswana (CDC/Botswana), which included one-on-one meetings with staff, administrative and technical site visits with grantees, data quality spot checks, and reviews of internal financial documents and controls at CDC and grantee offices. It also included meetings with senior staff of the U.S. Embassy to Botswana, the Government of Botswana, and other key stakeholders for CDC's mission in Botswana. Assessment tools and checklists were developed by CMS leadership in consultation with subject matter experts at CDC/HQ. This methodology was designed to provide a "point in time" synopsis of CDC/Botswana's operations.

Scope

CMS visits are designed to provide an overview of CDC country programs and identify best practices and areas for improvement. These visits should not be considered comprehensive and are not intended to replace Inspector General audits.

Program Background

DGHA began supporting Botswana in 2003 building upon CDC's in-country presence for tuberculosis research that began in 1995. With an HIV prevalence rate of 17.6% in the general population, 25% among 15-49 year olds, and 30.4% among pregnant women, many opportunities exist to strengthen Botswana's capacity to respond. PEPFAR is overwhelmingly the largest assistance program of the U.S. Government in Botswana and is committed to supporting Botswana's public and private sectors in bringing treatment services to the community level, strengthening HIV prevention programs, scaling up combination prevention, mitigating the impact of HIV on children, and building the capacity of institutions. Furthermore, increases in coverage of antiretroviral treatment (ART), prevention of mother-to-child transmission (PMTCT), tuberculosis (TB) and testing and counseling programs demonstrate the increased commitment by Botswana to address Botswana's HIV and TB needs.

Summary of Key Findings and Recommendations

Program Administration and Technical Oversight

Country Operations. CMS team members conducted 41 interviews with a mix of technical, non-technical, locally employed, direct hire, and contracted staff in addition to inquiries and document reviews of motor pool and fleet management, personnel, and time and attendance files. A meeting with the Embassy Human Resources Office was also incorporated into the team's assessment of CDC/Botswana's Human Resources procedures. An average job rating of 3.7 (out of 5.0) was cited by those staff interviewed; this finding was mirrored by similar feedback received in an anonymous online survey disseminated among staff. Areas for improvement include the following:

Recommendations:

- CDC/Botswana should improve articulation of motor pool roles, responsibilities, and supervision through completion and dissemination of standard operating procedures for motor pool

- CDC/Botswana should increase quality assurance of time and attendance records and better integrate with Embassy procedures
- CDC/Botswana should incorporate on-going team and trust building exercises to promote unity and togetherness among staff in an effort to enhance morale and confidence
- CDC/Botswana should identify a manager and single point of contact for training. Responsibilities for such a training point of contact would include: maintaining an array or "radar screen" of possible training opportunities relevant to staff training needs; reviewing and helping to prepare training requests for orderly review by CDC/Botswana management as well as individual supervisors; and identifying and addressing systematic obstacles to optimal participation
- CDC/Botswana should conduct strategic planning process to re-visit engagement and interaction across programs, and in particular, engagement with the Francistown satellite office
- CDC/Botswana should elevate IT issues to regional coordinators and track improvements and challenges on a regular basis

CDC/Botswana has had an unusual structure among all CDC Offices, with an Administrative Office composed of CDC/DGHA full time employees, but separated programmatically from the CDC/DGHA Country Team. Under that structure, neither the Country Director nor the Administrative Officer was construed as having authority and accountability for PEPFAR extramural funds. There were also critical gaps in function within the PEPFAR interagency process for CDC, as the CDC Country Director is not routinely included as a Principal within the PEPFAR Country team (instead, the DGHA Program Director is considered the Principal agent functioning on behalf of CDC for PEPFAR strategy and program). Structurally, this can contribute to a disadvantage of CDC within PEPFAR strategy and program development with respect to other PEPFAR agencies at post.

Recommendations:

- CDC/Botswana should change CDC organizational structure to reflect that of CDC Offices in other countries. An essential requirement for the CDC Office is that the Country Director and the Administrative Officer must exercise oversight and have accountability for all resources at the CDC Office, including extramural resources
- The positions of CDC Country Director and DGHA Program Director should be merged, with DGHA Branch Chiefs/Team Leads reporting directly to the CDC/DGHA Country Director

Country Management. Several years ago, PEPFAR Botswana developed a transition plan to scale down or 'graduate' its support for certain core interventions that were seen as needing to move to full Government of Botswana financial support, including ART and PMTCT. The current vision or strategy document for the transition of the nearly $100 million per year PEPFAR program in Botswana to its proposed new 'plateau' of approximately $30 million in 5 years does not include enough attention to the three core USG HIV prevention strategies: increase the number of HIV-positive adults and children receiving antiretroviral therapy; increase the number of HIV-positive pregnant women receiving antiretroviral medications, thereby reducing mother-to-child transmission; and increase the number of males age 15 and over circumcised as part of the minimum package of male circumcision for HIV prevention services.

Recommendation:

- CDC/Botswana should engage the PEPFAR Botswana team in focusing on the virtual elimination of HIV transmission in Botswana through investment in and innovative ways of delivering bona fide, highly-effective

prevention interventions. Other investments should be assessed against the known prevention impact of the three core USG prevention strategies

Science Office. Currently, the Strategic Information team lead at CDC/HQ serves as the acting Associate Director for Science (ADS). There is no clear delegation of Science Office responsibilities in Botswana and no administrative support designated for science activities, despite all staff having completed required scientific ethics training. Standard operating procedures exist for CDC/DGHA protocol and manuscript review but no formal tracking system exists. Additionally, there is no formal document storage for protocol materials and manuscripts.

Recommendations:

- CDC/Botswana should create a Science Office led by a full time ADS or senior scientist with clear ADS responsibilities and with dedicated locally employed staff well-trained in the complex process and document management responsibilities for this function
- CDC/HQ should provide assistance to help CDC/Botswana ADS develop a system for tracking protocols and manuscripts and to develop a document warehouse

Program Management

Procurement and Grants. CDC's Procurement and Grants Office (PGO) visited seven grantees over the course of the CMS visit, three of whom are local grantees. The financial and management performance of grantees visited met basic requirements and all of these grantees had completed an audit within the past year. The majority of grantees, however, did not demonstrate fluency regarding the precise terminology of award terms, key elements of the Code of Federal Regulations, or cost and allocation guiding principles found in the Office of Management and Budget Circulars.

Recommendation:

- CDC/Botswana should consider utilizing the National Procurement Institute contract to bring the Introduction to Cooperative Agreements training course to CDC/Botswana for CDC staff and grantees

Program Budget and Extramural Management. CDC/Botswana's financial reporting procedures and reports require improvement. While the Financial Specialist reviews unliquidated obligations for Post-held funds, unliquidated obligations for CDC/HQ-held funds are not reviewed. CDC/Botswana maintains a fairly complete electronic library of policies, standard operating procedures, report templates, and other documents on its shared drive to support the management of its extramural programs. While CDC/Botswana has established policies and procedures regarding the administrative management of its cooperative agreements, CDC/Botswana's current personnel structure limits this administration to one contractor employee, the cooperative agreement specialist. This poses a potential vulnerability to the organization as only one person actively manages all of CDC/Botswana's PEPFAR cooperative agreements.

Recommendations:

- CDC/Botswana should implement a new budget/business system that: 1) tracks CDC/HQ-held funds; 2) can provide a separate report that shows cooperative agreement and contract obligations, and 3) can provide details of actual obligations when asked by management
- The Financial Specialist should improve the unliquidated obligations review process by creating additional tracking lists for CDC/HQ held funds

- CDC/Botswana should change its personnel structure for supporting the PEPFAR cooperative agreement. Instead of a contractor, it would be ideal to hire a USDH lead cooperative agreement specialist to manage the complex cooperative agreement portfolio. To reduce the reported heavy administrative burden experienced by Technical Staff serving in their roles as Project Officers for these cooperative agreements, additional cooperative agreement specialists may be needed at CDC/Botswana beyond the lead cooperative agreement specialist mentioned above, such as have been employed by CDC in Mozambique and South Africa.

Financial Management

CDC's Financial Management Office (FMO) participated in this CMS visit and completed reviews of financial data in Atlanta and on-site, as well as interviews and daily interaction with CDC and Department of State (DoS) staff during the site visit. DoS personnel stated that the leadership at CDC is responsible for ensuring that all transactions are consistent with HHS/CDC policies, authorities, and regulations; all transactions are reviewed by DoS which helps strengthen internal controls at post. It was found that the CDC/Botswana office has established procedures to review unliquidated obligations and open advances and is encouraged to continue this practice; follow-up with Embassy Financial Management Office staff is also recommended to ensure appropriate action is taken to clear transactions in a timely manner. However, the CDC/Botswana office has not established a well-defined process for managing and providing oversight of all the funds received at Post, regardless of source.

Issues found by the FMO CMS team members include: some potentially questionable expenditures, problematic contracts, and the need to ensure that activities are authorized and in accordance with CDC/HQ policies. At the time of the visit, the CDC/Botswana office did not have a sub-cashier. Although the FMO team carefully reviewed the petty cash records and found no irregularities, the fact that funds are transferring hands so many times and the person actually signing for the funds is not the person who has ultimate role for disbursing them could be problematic.

Recommendations:

- CDC/Botswana should continue to routinely review unliquidated obligations and open advances and follow-up with Embassy Financial Management Office staff to ensure appropriate action to clear transactions in a timely manner
- CDC/Botswana should ensure it has mechanisms and processes that support managing all funds at Post

Next Steps

The CMS team shared their key findings and recommendations with the CDC/Botswana office and CDC/HQ. The team also developed a scorecard for internal management use, which is populated with all of the issues identified during the visit, recommendations, due dates, and primary point of contact for each issue.