Country Monitoring and Accountability System Visit to Uganda – May 13-17, 2013
Summary of Key Findings and Recommendations

Introduction

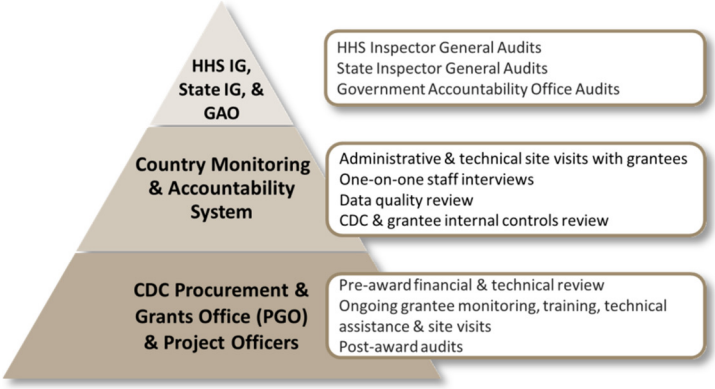
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global AIDS Coordinator (OGAC). CDC uses its technical expertise in public health science and long-standing relationships with Ministries of Health (MOH) 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. CDC global HIV/AIDS PEPFAR-related activities are implemented by the Division of Global HIV/AIDS (DGHA) in CDC's Center for Global Health. PEPFAR activities represent the largest portfolio of global health activities at CDC.

CDC's Country Monitoring and Accountability System

CDC/DGHA launched the Country Monitoring and Accountability System (CMAS) in 2011 to identify challenges resulting from the rapid scale-up of complex CDC/PEPFAR programming as a part of CDC's commitment to transparency and accountability. This initiative serves as a basis for ongoing, monitored quality improvement of DGHA's programs and operations through internal programmatic and financial oversight. CMAS is a proactive response on the part of CDC to: 1) ensure accountability for global programs and proper stewardship of U.S. government resources by promoting explicit performance standards and defining expectations for bringing all components of program accountability up to the highest standards; 2) ensure DGHA is supporting DOS, OGAC, and the Presidential Initiatives; 3) serve as a basis for ongoing, monitored quality improvement; and 4) effectively prepare CDC for future oversight audits, congressional inquiries, and special data calls.

CDC Commitment to Accountability

Ensures optimal public health impact and fiscal responsibility



CDC also maintains a Global Management Council chaired by CDC's Chief of Staff which meets regularly to address cross-cutting issues related to the management and oversight of CDC's global programs.

The CMAS strategy was designed to systematically assess CDC's accountability and proper stewardship of U.S. government resources and provide feedback on key business and program operations 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

The first round of CMAS visits (formally known as Country Management and Support visits - CMS I) took place between February 2011 and March 2012 and assessed 35 country offices. A second round of CMAS visits (CMAS II) evaluated 30 country offices and one pilot. A few CMAS II visits were cancelled due to political unrest. CMAS II assessments occurred between June 2012 and June 2014 and increasingly emphasized supportive technical assistance to ensure continual quality improvement. In addition to the focus on CDC's PEPFAR program activities, CDC's Office of the Chief Financial Officer reviewed financial transactions for CDC's other global health programs.

Scope

CMAS II visits were designed to provide an overview of CDC country programs and identify good practices and areas for improvement. While the scope of these visits was primarily focused on CDC/DGHA's activities implemented through PEPFAR, other CDC global health programs were assessed in countries where they have a significant presence. Financial management activities were assessed for all CDC programs in-country. CMAS II visits were not considered comprehensive, nor were they intended to replace Inspector General audits.

Objectives

DGHA conducted a CMAS II visit to Uganda from May 13-17, 2013. The principal objectives of this visit were to:

- Perform a CDC headquarters assessment of internal controls in the field to ensure the highest level of accountability;
- Review intramural and extramural resource management to ensure financial stewardship of U.S. government funds;
- Generate a multidisciplinary snapshot of how CDC country offices are performing regarding programmatic effectiveness in the areas of AIDS-Free Generation Strategy, site visits, and data driven programs to ensure DGHA is achieving the greatest public health impact; and
- Provide clear feedback and technical assistance to the country office to improve current internal controls.

Methodology

CDC headquarters in Atlanta assembled a multidisciplinary team of twelve CDC subject matter experts in the following areas to perform the CMAS II assessment: financial management, program budget and extramural resources, grants management, country management and operations, and several key technical program areas

(e.g., epidemiology, strategic information, care and treatment).

The CMAS II team conducted a five-day visit to the CDC/DGHA office in Uganda (CDC/Uganda) and provided grants management technical assistance to CDC/Uganda staff and grantees during the week following the CMAS visit. Team members reviewed financial and administrative documents at CDC and grantee offices and conducted administrative and technical grantee site visits, one-on-one meetings with staff, and data quality spot checks. Subject matter experts developed assessment tools and checklists at CDC headquarters in consultation with CDC field staff representatives. A standardized assessment instrument gauged performance using a four-level capability maturation scoring scale. Team members provided additional recommendations for quality improvement and noted good practices observed during the visit that will be shared across DGHA country programs. This methodology provides a "point-in-time" synopsis of CDC/Uganda's operations.

Background on Country Program

CDC/Uganda has been working alongside the Government of Uganda for the past 20 years. During this time CDC/Uganda has built capacity to manage and deliver HIV prevention, care, and treatment by supporting the development of national policies and strategies; provided technical assistance in planning, operating, analyzing, and evaluating HIV programs; developed model interventions that can be replicated; supported infrastructure developments; and provided equipment and commodities. With PEPFAR support, 63% of the eligible population in Uganda is now receiving anti-retroviral therapy and 57% of pregnant women attending antenatal care sites are now receiving prevention of mother-to-child transmission services. In addition, CDC/Uganda has more broadly strengthened the health sector response to not only HIV/AIDS but also tuberculosis, malaria, and dangerous pathogens; supported the development of Uganda's national, regional, and facility laboratory systems; provided critical training to the nation's health care workers; and supported the development of the Uganda Blood Transfusion Service.

CDC/Uganda currently supports programs in the following areas: HIV/AIDS, tuberculosis, malaria, polio, measles, influenza, plague, Ebola, Marburg virus, and yellow fever. Across this portfolio, CDC/Uganda focuses its efforts in the areas of epidemiology, surveillance, informatics, laboratory, monitoring and evaluation, research, and health systems strengthening.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

Major Achievements

The management and leadership assessment of the CDC/Uganda office included individual interviews with 39 locally employed and U.S. direct hire staff members and an analysis of 85 employee viewpoint surveys. A meeting with the post Human Resources Officer was conducted as well as completing several assessments on

inherently governmental functions, such as information technology and communication, motor pool, facilities, safety and security, travel, and time and attendance. In addition, the Country Manager met with the U.S. Embassy Deputy Chief of Mission, the PEPFAR Coordinator, and the United States Agency for International Development (USAID) Health Lead.

Over the past year, CDC/Uganda has undergone a major reorganization including a substantial workforce reduction in March 2013. This reorganization was necessary to scale back the size of the program after the conclusion of a number of large research projects, which significantly reduced the size of CDC/Uganda's research portfolio. Despite significant changes, CDC/Uganda staff and key stakeholders reported universally respecting the reorganization process, acknowledging that there were ongoing efforts to solicit staff input and to ensure transparency. The personnel files for CDC/Uganda staff included a separate section specific to the reorganization that methodically evaluated each employee's time-in-service, qualifications, training, and performance awards. The majority of current staff expressed their appreciation for the new organizational structure, and many reported gratitude for new position descriptions that more appropriately reflected their responsibilities. By and large, the employees expressed hopefulness that CDC/Uganda has turned the corner on a difficult time and hope that the in-country CDC leadership will take advantage of this opportune moment to lead the program into a period of great teamwork and achievement.

Administrative achievements included exceptional relationships with U.S. Embassy counterparts, solid security on the Uganda Virus Research Institute campus (where CDC offices are located), an extensive motor pool vouchering system that could potentially serve as a model for other programs, and a simple but effective motor pool tracking database.

Major Challenges

While optimism is clearly apparent, the staff expressed lingering fear that the reorganization is not over and there will be additional efforts for downsizing. Scores on the employee viewpoint question, "CDC is a good place to work" were fairly positive, as was the overall rating provided in the one-on-one interviews for overall job satisfaction. Though staff appreciated the new organizational structure, many staff in supervisory roles were unsure of their authorities; they expressed concern over which decisions they were allowed to make and that they did not receive feedback after making key decisions. Most staff expressed a strong desire for greater communication, responsiveness, and engagement from leadership, especially given the lack of clarity about the expectations in their new roles. A number of the staff framed these related issues within the broader programmatic question of wanting to know "where are we going?"

During the reorganization period, CDC/Uganda instituted a training moratorium and also placed U.S. direct hires in decision-making roles previously held by locally employed staff. As a result, staff felt that the program has taken a step backward in grooming locally employed staff for leadership roles.

Administrative challenges included personal service agreements that had executed between locally employed staff and the Department of State (rather than CDC); the use of a U.S. Embassy overtime form that did not provide a field to document pre-approval; and failure to process time and attendance for CDC/Uganda direct

hire staff.

Recommendations

- Review supervisory processes including ensuring that all supervisors schedule regular one-on-one meetings with their staff.
- Disseminate and discuss the CDC/Uganda training policy at the next all-hands meeting.
- Continue with plans to host leadership and team-building courses in Uganda in June, as well as host a CDC regional training in September. Ensure that supervisory personnel attend these events/trainings.
- Develop a timeline and plan to revise personal services agreements to ensure that they are properly executed and signed between CDC/Uganda and locally employed staff.
- Ensure that the CDC/Uganda Country Director complete time and attendance training for supervisors within the next 30 days.

Financial Resource Management

Major Achievements

Through interviews and document review, the CMAS II team found that locally employed budget and financial staff members were knowledgeable of both DOS and CDC/Uganda procedures. They demonstrated commitment to ensuring adequate procedures were in place and followed. The U.S. Embassy's Financial Management Officer expressed that CDC leadership is held responsible for ensuring that all transactions are consistent with applicable policies, authorities, and regulations and that they make a great effort to remain abreast of current legislation. They also noted that they have a very strong working relationship with CDC/Uganda.

At the time of the CMAS II assessment, CDC/Uganda maintained a large PEPFAR budget (approximately $146 million annually). CDC/Uganda did a good job of formulating the budget, which is developed in consultation with the in-country technical branches. The budget was tracked per CDC standards, and budget reports were reconciled monthly with data from CDC headquarters and Embassy financial reports (IRIS and COAST). In addition to the management and operations budget, the budget for cooperative agreements was also projected and tracked for all outstanding Country Operation Plan activities. The finance team utilized the Payment Management System to monitor grantee drawdowns. This information was then used to formulate the grantees' pipeline and to inform funding decisions.

CDC/Uganda performed inventory on an annual basis. There was a proper separation of duties for ordering, receiving, storing and issuing property. Thirty barcoded items were randomly selected from the CDC/Uganda assets report by the CMAS II team. All 30 items were located. Additionally, all vehicles were accounted for through visual inspection or proper documentation.

Major Challenges

An hour drive from the U.S. Embassy, CDC/Uganda maintained its own petty cash on-site. The office recently

underwent a reduction in workforce, and a large number of locally employed staff members were affected. As a result, the remaining employees took on additional duties to ensure that the office remained fully functional. Additional duties augmented stress levels for the staff.

Due to frequent travel to remote parts of the country, CDC/Uganda staff were often required to travel with large amounts of cash to pay for gas, food, lodging and other travel related expenses, causing a security risk to staff members. CDC/Uganda demonstrated diligent work to reduce unliquidated obligation balances.

The finance team played an active role in the management of cooperative agreements. The team reviewed the requested grantee budgets in the continuation applications. They also reviewed the quarterly Federal Financial Reports and worked with the grantees to resolve any discrepancies. However, the role of the finance team in cooperative agreement management was not well defined or formally documented. As a result, some efforts were duplicated, and not all information was properly shared between the finance and cooperative agreement teams.

The CDC/Uganda assets report included many items that were no longer in use; the office was in the process of disposing these excess items.

Recommendations

- Ensure that duties are adequately divided among remaining staff members so that no staff member's duties exceed those of one full time equivalent. Petty cash represents a high risk and extreme diligence must be taken to ensure it is managed properly.
- Explore other payment options for staff traveling to remote locations (such as the international debit card that is currently being used in Malawi) to ensure employees' safety.
- Continue to work diligently to reduce the unliquidated obligation balances at post.
- Perform a comprehensive review of the finance team's role in cooperative agreement management. Roles and responsibilities should be defined and documented.
- Continue to work with the CDC headquarters property manager to properly dispose of excess unused inventory.

Accountability for Extramural Resources

Grantee Management

Major Achievements

At the time of the CMAS II assessment, CDC/Uganda managed 31 cooperative agreements. While the cooperative agreement team was in a transition, staff were knowledgeable and adequately performed roles and responsibilities. CDC/Uganda leadership was also beginning to institute changes to improve cooperative agreement management, including tracking of cooperative agreement actions, and proper filing and documentation of partner monitoring. CDC/Uganda was in the process of reconciling hard copy cooperative agreement files with the electronic documents stored on the shared drive. The cooperative agreement team

also reconciled financial obligations against CDC/Uganda's annual Country Operational Plan as obligations occur to ensure spending occurs as planned. However, the office should develop standard operating procedures for cooperative agreement management.

In general, communication between CDC/Uganda and the grantees was frequent. Grantees noted that previous delays in processing grants actions have improved. Grantees also expressed an interest in participating in a regular forum to exchange best practices. Site visits were documented using a standard format, and results were shared with the grantees to resolve pending issues.

Major Challenges

The CMAS II team found that documents stored on the shared drive were not named in a consistent manner. CDC/Uganda was in the process of creating an electronic system that will track post-award grant actions. Project officers had not completed all of the required trainings (i.e. appropriations law refresher training). Although there was only one active contract, CDC/Uganda did not have a document tracking system or standard operating procedure for tracking contracts. The Contracting Officer's Representatives were not currently performing invoice approvals in the acquisition management system.

Recommendations

- Consistently name documents that are stored on the shared drive.
- Create and implement a standard operating procedure for updating the cooperative agreement tracking spreadsheet.
- Ensure that all projects officers complete the required trainings, including refresher training and recertification.
- Maintain a contract tracking system and standard operating procedure for updating the system.
- Utilize the acquisition management system to perform invoice approvals.

Grantee Compliance

Major Achievements

Each of the six grantees interviewed during the CMAS II visit demonstrated adequate policies and procedures for CDC requirements in the following areas: audits, cash advances, facilities, direct costs, procurement practices, property, timekeeping, and travel.

Major Challenges

Discussions were held with the Principal Investigators, Executive Directors, Financial/Account Managers and other key personnel within each partner organization. Although there were no significant findings, there were at least two common themes noted. First, a majority of the grantees interviewed raised questions about the ability to include indirect costs as a budget item. At least two of the six grantees applied what should be identified as

indirect costs inappropriately. One of the two corrected the issue, and the other was in the process of making the correction. Second, several of the grantees interviewed did not have a clear understanding of the 2012 funding decisions which, from their perspective, impacted their ability to perform activities as required under their agreement. A common theme in each of the scenarios was a lack of clear written guidance or explanations.

Other issues related to overdue audits, clarification needed regarding CDC's in-country occupancy arrangement, technical assistance for the Payment Management System, and CDC/Uganda's approach to supply chain management. Each of these issues presented challenges from the grantee's perspective that impacts their ability to perform adequately.

Recommendations

- Improve written and verbal communication between the grantee, CDC/Uganda office, and CDC headquarters regarding indirect costs, annual funding levels and audit requirements.
- Suggest the Embassy, host partner, and CDC/Uganda work together to coordinate and document the occupancy arrangement. If that has been has already been accomplished, suggest a copy be provided to the partner as a reminder.

Accountability for Public Health Impact

Major Achievements

CDC/Uganda exhibited a remarkably indigenous program, with most of its program dollars going to local organizations and the Government of Uganda. CDC technical and programmatic staff have a long-standing and close-working relationship with the grantees and MOH. All expressed an appreciation for increasing engagement in planning and rationalization of partner activities. The recent calculation of district-based HIV burden estimates improved resource planning and target setting for increased public health impact.

Grantees continued to improve both electronic and paper-based information systems, resulting in improved quality of data quality for reporting partner achievement and monitoring program progress and impact. CDC/Uganda consistently met all Data for Partner Monitoring requirements and demonstrated extensive use of results and expenditure data for program planning and improvement. The recent arrival of a full-time Associate Director of Science will ensure that the current manuscript and protocol approval process remains well-organized and continues to improve with electronic document management for document version control and on-line approvals.

At the time of the CMAS II assessment, CDC/Uganda was doing an excellent job of implementing DGHA's site monitoring system, with 122 site visits completed to date. CDC staff had a well-thought out and detailed strategy, supportive supervisory approach, and good rapport with facility staff. The standard report template developed was distributed to grantees after each site visit, and there was clear evidence that feedback from these site visits has resulted in site-level improvements.

Major Challenges

CDC/Uganda has a long history of close technical partnerships with the host country government and grantees. However, a large reduction in workforce of locally employed staff, a large number of currently vacant positions, and delays in funding were challenging CDC/Uganda's ability to fully engage the MOH and partners in planning and implementation of activities for public health impact. While appreciative of increasing engagement, the MOH and grantees expressed a desire for more frequent opportunities to engage CDC/Uganda in planning and creation of platforms for technical discussions and exchange. The recent reorganization created a need for strong CDC/Uganda leadership and management to refocus all staff on planning, implementation, and monitoring activities of public health impact.

Specific challenges facing CDC/Uganda in providing technical leadership and resources included: the on-going need for improved estimates of HIV burden by district; better monitoring or targets and results especially around the three World AIDS Day indicators; interruptions in supply chain for key commodities including anti-retroviral drugs, test kits, and male circumcision kits; more systematic approach to data quality assessment across grantees from service delivery up to national reporting levels; a comprehensive evaluation strategy; improved data structures for partner and program accountability, oversight and quality; and finally more systematic electronic process of manuscript and protocol review and clearance.

CDC/Uganda's site monitoring strategy did not include sites that provide exclusively voluntary HIV counseling and testing, prevention of mother-to-child transmission of HIV, or voluntary medical male circumcision. No documentation/feedback was left at the site immediately after the site visit, and no standardized documentation existed for assessment of progress on follow-up plans. There was also no CDC/Uganda site monitoring coordinating group with specific delineation of titles and responsibilities, including data entry and data management.

Recommendations

- To further engage the MOH, establish a list of all national technical working groups, assign CDC/Uganda participants and develop a meeting schedule. Promote routine meetings at least quarterly to ensure current strategies are reviewed and issues are addressed.
- Conduct twice annually or quarterly meeting with MOH for planning future activities and reviewing progress of current activities. These meetings can either cover the entire programmatic portfolio, or be conducted separately for larger program areas especially when new funding or activities are being planned.
- Conduct routine World AIDS Day partner meetings where progress towards targets are routinely reviewed and implementation issues are addressed. Consider increasing frequency of reporting of three World AIDS Day targets by MOH and grantees.
- Establish routine review of availability of key commodities and supply chain. Explore emergency solutions for procurement until new structure fully functional.
- Establish procedures to ensure grantees have a data quality assessment strategy and data validation for key indicators at least once every 12 months.

- Ensure that the strategic information lead responsible for newly reorganized monitoring and evaluation activities reviews existing evaluation plans and consult with CDC headquarters.
- Establish data structures for program and partner accountability, oversight and monitoring.
- Develop a detailed site visit registry that includes all sites that meet the site monitoring system site definition:
    - Patients/clients counted in CDC/Uganda numbers and/or
    - Facilities supported by CDC/Uganda
- Form a Site Monitoring System working group that includes a data steward and define post-visit procedures for development of follow-up plans and score remediation

Center for Global Health

CDC's Center for Global Health also joined the CMAS II visit. The Center for Global Health provides leadership and implementation guidance for several cross-cutting CDC program and policy initiatives, and it participated in the CMAS II visit to: assess the level to which all CDC programs are integrated in-country; obtain information on Center for Global Health-managed initiatives to contribute to transparency, accountability, and adherence to U.S. Department of Health and Human Services and Department of State regulations; acquire information on policy initiatives or best practices affecting the country office; and work with CDC and U.S. Embassy staff to provide technical assistance and guidance on operations and financial management.

Please note the following section pertains to all CDC/Uganda in-country programs; however, the previous sections primarily focused on DGHA programming only.

Major Achievements

One of the major achievements during this CMAS II visit was working with the Embassy Assistant Regional Security Officer to start the co-location notification process for CDC/Uganda staff working in two MOH facilities: the Uganda Virus Research Institute and School of Public Health. At the time of the CMAS II assessment, CDC/Uganda occupied seven structures at the Uganda Virus Research Institute and paid to have Embassy contract guards on the perimeter. Last year, the Defense Threat Reduction Agency paid for a new fence around the campus. Originally, CDC/Uganda hoped to move into a commercial facility in Kampala, but the likelihood of this occurring decreased due to reluctance on the part of other agencies, particularly the Department of Defense and the U.S. Agency for International Development. The Assistant Regional Security Officer agreed to do a site survey and did not anticipate any problems with the Uganda Virus Research Institute. In years past, the Embassy Regional Security Officer went to the School of Public Health and provided written approval for CDC/Uganda staff to use this space, but this should be formalized through the collocation notification process.

CDC/Uganda had an excellent motor pool team, which performed efficiently. They maintained good documentation and analyzed data, ensuring that it continues to run accordingly. The program utilized Drivecam to avoid accidents and for continuous driver improvement, and the motor pool supervisor was a certified

Drivecam trainer/coach.

Major Challenges

The location of the CDC/Uganda office in Entebbe posed a number of challenges given that the Embassy is located 20 miles away in Kampala. Many of the U.S. direct hire and locally employed staff also live in Kampala and commute to work. Since Uganda has challenging road conditions, the Embassy and CDC/Uganda had adopted a very liberal motor pool policy. This allowed for "other uses" of the motor pool, including transportation of staff from home to work. The CDC/Uganda motor pool provided a daily shuttle for U.S. direct hire and locally employed staff from Kampala to Entebbe, which was executed using a voucher system. Staff purchased vouchers from the CDC/Uganda sub-cashier or the Embassy cashier. These vouchers were regulated by the Embassy cashier, and the money from the vouchers went to the U.S. treasury.

One transportation challenge was that there appeared to be dedicated vehicles for individuals, and not everyone was participating in the voucher program. Although other foreign agencies and Embassy policy may allow for dedicated vehicles for certain individuals, the Department of Health and Human Service policy forbids this practice. Additionally, exempting individuals from the voucher system creates inequity within the office, which can affect morale.

In fiscal year 2013, CDC/Uganda did not use a cost sharing model because of staff transition issues related to the reduction in workforce. In fiscal year 2014, all relevant CDC programs will need to agree upon a cost sharing model and budget. Then, each program will need to sign a memorandum of agreement. The CDC Center for Global Health required model is based on using a headcount methodology. Program cost sharing is going to be challenging; the programs seem to be leaning toward funding their own positions and do not fully understand why services should be shared. Communication between the programs was not ideal and this was possibly related to the reduction in workforce and other immediate issues.

Recommendations

- Assign vehicles to offices rather than individuals to align with the Department of Health and Human Service policy. All staff should be using vouchers for transportation from home to work regardless of their position.
- Start working on a cost sharing model for fiscal year 2014. Identify which services are shared and then present that information to the other programs. Once shared services are agreed upon, develop a budget, and either use the recommended headcount methodology or justify any deviation.

Next Steps

The CMAS II team shared their key findings and recommendations with the CDC/Uganda office and CDC headquarters. The team also developed a scorecard for internal management use. The scorecard lists all of the issues identified during the visit, recommendations and due dates for their implementation, and primary point of contact for each issue. CDC headquarters will work with the CDC country office to create a plan and timeline to address and correct issues.