CDC's Country Monitoring and Accountability System II

Country Monitoring and Accountability System Visit to Zimbabwe – October 15-19, 2012
Summary of Key Findings and Recommendations

Introduction

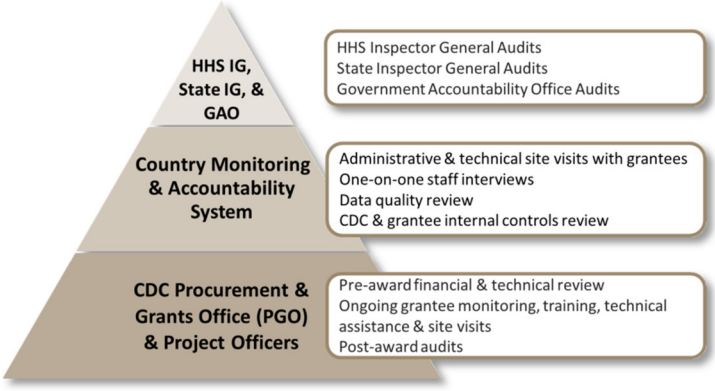
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global 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 Zimbabwe from October 15-19, 2012. 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 nine 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.

The CMAS II team conducted a five-day visit to the CDC/DGHA office in Zimbabwe (CDC/Zimbabwe). Following the core CMAS II visit, CDC's Procurement and Grants Office provided additional technical assistance in grants management. 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/Zimbabwe's operations.

Background on Country Program

CDC began working in Zimbabwe in 2000. It was the first country where CDC staff were assigned primarily to support the national response to HIV/AIDS. Zimbabwe has a severe generalized epidemic, with an estimated prevalence among adults of 23.7% in 2001. The prevalence has since declined to an estimated 13.1% in 2011. CDC has a strong program that targets health systems inputs (such as laboratory, health information systems, training, and other human resources interventions) that are directly linked to evidence-based HIV prevention and treatment programs. These evidenced-based programs include prevention of mother-to-child transmission of HIV, antiretroviral treatment programs, and most recently, voluntary medical male circumcision.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

Major Achievements

The CMAS II team gained in-depth feedback from country office staff by holding one-on-one interviews and conducting an online survey with all 29 available staff members out of 30 total DGHA staff members. CDC/Zimbabwe staff members consistently identified positive changes by the new senior leadership. They repeatedly noted that the new leadership has improved the office working environment by bolstering staff morale, defining scopes of work and responsibilities of staff at each level, improving intra-office communication, and stabilizing a previously fractious team setting. Senior leadership contributed to an improved sense of programmatic direction and a heightened sense of prestige for CDC/Zimbabwe in the country's public health community. Senior leadership exhibited inclusiveness in decision-making, empowers local staff in their job roles, and received consistent praise by staff from all levels for their accessibility and responsiveness. Staff also noted that in general CDC/Zimbabwe leadership communicates clearly, and many noted that leadership expresses appreciation for staff efforts through both public recognition and informal communication. Continuing this trend, staff reported feeling supported to make decisions, and a strong majority of staff said that the CDC was a

good place to work.

CMAS II team members found that CDC/Zimbabwe uses an emergency notification system with built-in redundancies to ensure that all staff members are reached through overlapping systems of texts, phone, intercom and radios. This is a noteworthy good practice.

While motor pool functions were not explicitly assessed during the CMAS II visit, no ongoing concerns about motor pool were mentioned in one-one-one staff interviews, nor anecdotally noted by the CMAS II team.

Major Challenges

Although staff generally appreciated the changes that new leadership brought to CDC/Zimbabwe, many expressed concern at the rapidity of operational adjustments, and some perceived that the directional shifts did not appropriately value the hard work conducted under prior leadership. Shifting strategies and processes also left some staff members confused about the overarching goals of DGHA and how CDC/Zimbabwe activities fit within the broader Divisional goals.

Training presented an area of concern; a large number of staff expressed that they have not received sufficient training, and a majority of the staff indicated confusion about how decisions around participation in training were made. A sizable majority of staff also voiced strong concern about salary and benefits, including the prolonged salary freeze despite notable inflation. Staff particularly identified problems with the changing medical scheme, indicating that rising premiums and reduced coverage amounted to a salary cut and noted the difficulty in covering large up-front payments that are reimbursed later.

A number of administrative operations also required attention. Staff expressed frustration with the speed in which position descriptions were revised due to backlogs at the understaffed Embassy Human Resources Office. Personal Service Agreements for locally employed staff did not properly identify CDC as the employer. Timekeeping practices exhibited some deficiencies with respect to pre-approval of overtime, electronic submissions, and approval of time and attendance for U.S. direct hires. The office's occupational safety assessment is out of date, and although CDC requested the assessment, the U.S. Embassy's Post Occupational Safety Health Officer had not yet scheduled a date for completion. Information technology systems also proved to be problematic, as internet travels through a slow satellite connection and internet VOIP phone lines routinely rendered indecipherable conversations.

Recommendations

- Encourage CDC/Zimbabwe leadership to sustain and foster the positive management approaches that have been well-received by staff and outside stakeholders.
- Devote greater effort to managing change by attempting to make program and operational shifts more consultative and by clearly communicating the motivation for changes that are implemented, including providing a brief overview to all staff to better frame CDC/Zimbabwe's current direction within DGHA's mission.

- Distribute the written training policy to address concerns regarding training accessibility and allocate time to present and discuss the policy with all staff.
- Continue to elevate the position description issues with the CDC locally employed staff advisory group and U.S. Embassy management, including the front office with the Embassy locally employed staff committee, which has been dormant for a number of months.
- Consistently pre-authorize overtime for locally employed staff.
- Amend the Personal Service Agreements for locally employed staff to list CDC as the employer and include a CDC signatory.
- Concerns around information technology systems will be highlighted by the CMAS team directly to Information Technology Services Office at CDC headquarters.

Financial Resource Management

Major Achievements

CDC/Zimbabwe leadership instituted changes to improve budget and extramural management. Oversight of budget operations improved due to the adoption of new templates and standard operating procedures.

The review of post held transactions was thorough. CDC/Zimbabwe checked the validity of post held obligations and unliquidated obligations weekly. Staff cited frequent communication with the Office of the Chief Financial Officer at CDC headquarters and the U.S. Embassy Financial Management Office, which helped to ensure quality of financial information. Petty cash management is a best practice for CDC/Zimbabwe. The CMAS II assessment found that both announced and unannounced petty cash counts are completed regularly, transaction logs exist, and a standard operating procedure is followed.

CDC/Zimbabwe managed its property adequately. Staff exhibited proper segregation of duties for asset management, performed an annual inventory assessment, and kept an internal tracking log. They have also transferred excess property to the U.S. Embassy since the last CMAS assessment.

The scope of the CDC's Office of the Chief Financial Officer desk review primarily focused on post held funds and internal controls of financial activities occurring within CDC/Zimbabwe. This involved document sampling and transaction-level detail analysis of all funds cabled to post, as well as requesting supporting documentation from the field as needed. The review also included a questionnaire to complete regarding fiscal activities at post.

Through the questionnaire responses and document review, the CDC's Office of the Chief Financial Officer found that locally employed budget and financial staff members are knowledgeable of both U.S. Department of State and CDC/Zimbabwe procedures. They demonstrated commitment to ensuring adequate procedures are in place and followed.

Major Challenges

During the previous CMAS assessment in March 2011, the management of headquarters held funds could not be assessed. Since then, the previous manager of CDC headquarters held funds left CDC/Zimbabwe without transitioning duties. The CDC/Zimbabwe Budget Analyst had the added responsibility of tracking CDC headquarters held funds without proper training or mentorship. The budget reports were incomplete, and the tracking and reconciliation of Country Operational Plans for previous fiscal years was not performed. The Country Operational Plan was used to make funding decisions in the current year; however, CDC/Zimbabwe did not track the remaining amount to be funded from the previous two fiscal years.

At the time of the CMAS II review, the Deputy Director had been in-country for less than five months. The process was started to change the custodian in the Property Management Information System, but was not finished during the review. CMAS II team members found that one barcoded vehicle was missing from the Property Management Information System asset register. Six computers, no longer used and found without barcodes, were scheduled for transfer to the U.S. Embassy.

The CDC's Office of the Chief Financial Officer's document review identified the purchase of seven conference packages, including food and beverage purchases during the review period. These conferences were held prior to the training on the Executive Order on Efficient Spending. Additionally, none of these conferences were approved through the on-line approval system; again, this may have been a timing issue related to training and awareness.

CDC/Zimbabwe paid for hotel accommodations, including meals, for twenty-one (non-CDC) participants in conjunction with a conference package (included above) for a five-day meeting held to facilitate the rewriting of the Global Fund Round 8, Phase 2 Tuberculosis Application. These expenses were paid via a purchase order with the hotel processed through the U.S. Embassy.

CMAS II team members found that CDC/Zimbabwe had established routine procedures to review unliquidated obligations and that the office had a number of open unliquidated obligation line items from fiscal years 2011 and 2012.

Recommendations

- Improve tracking of headquarters held funds by adopting a better template and by verifying all transactions are included in the reports.
- Update the Country Operational Plan reconciliation tracking template developed during the CMAS II review.
- Add the currently unlisted, barcoded vehicle to the CDC/Zimbabwe Property Management Information System custodial account.
- Continue the process of transferring the remaining excess property to the Embassy.
- In light of new conference policies, review updated conference communications and implement processes and procedures to ensure compliance with these new policies.

- Reconsider the process used to provide financial support for meetings/conferences to help ensure that the most appropriate and efficient methods are being used. If CDC/Zimbabwe continues to conduct these types of activities directly, separate invitational travel orders for each participant will need to be issued by the U.S. Embassy.
- Continue to routinely monitor and review unliquidated obligations, and follow up with U.S. Embassy's Financial Management Office staff to ensure appropriate action to clear transactions in a timely manner.

Accountability for Extramural Resources

Grantee Management

Major Achievements

For cooperative agreement management, grantees noted that communication between the CDC/Zimbabwe staff and the grantees is proactive, clear, and frequent. Site visit findings were documented and were shared with grantees. Grantee meetings included administrative and technical staff. Extramural operations have also expanded to review documents using a team approach where multiple levels of review occur. Project Officers have completed the required trainings (International Project Officers and Appropriations Law).

CDC/Zimbabwe met all standards for contracts management. At the time of the CMAS II visit, CDC/Zimbabwe had one task order. Staff adhered to a standard operating procedure for contracts management and maintained adequate files and document tracking for this task order. Contracting Officer's Representatives satisfied all the requirements for certification (Contracting Officer's Representatives certification and Appropriations Law).

Major Challenges

Document storage and security was an issue for cooperative agreement management. The CMAS II team found that documents stored on the shared drive are not secure, and some files are missing. Inconsistent naming and warehousing conventions of electronic documents also made it difficult to retrieve files when necessary. At the time of the review, CDC/Zimbabwe was in the process of reconciling cooperative agreement award restrictions with CDC headquarters. Their tracking system and corresponding standard operating procedure should be updated to better account for the remaining restrictions.

Recommendations

- Recommend that electronic cooperative agreement files are protected on the shared drive and only appropriate staff are given access and editorial rights.
- Update the current standard operating procedure for cooperative agreement tracking to include procedures for version control, document protection, and cooperative agreement file organization.
- Update the audit review and restriction tracking standard operating procedures.
- Contracting Officer's Representatives should contact the Procurement and Grants Office to complete contract acquisition management system training by December 2012.

Grantee Compliance

Major Achievements

All six of the partners interviewed demonstrated a clear understanding of U.S. government rules and regulations. Additionally, all had adequate policies and procedures in place that further demonstrated their understanding of compliance with requirements for audits, cash advances, facilities, direct costs, procurement practices, property, timekeeping, and travel. Monthly meetings with each grantee and close CDC reviews of the Payment Management System drawdown requests were helping to build and refine the capacity for proper budgeting and program planning on the part of the grantees.

Major Challenges

Although each partner interviewed could describe their processes for handling missing property, only one partner actually documented that process in a written standard operating procedure. Service fee collection and proper use of those funds for one grantee also proved to be problematic. This issue was been escalated to the Project Officer and CDC's Procurement and Grants Office for resolution.

Recommendations

- Ensure that each grantee develop a written standard operating procedure for property.
- Resolve issues associated with fee collections and ensure that these funds are used properly.

Accountability for Public Health Impact

Major Achievements

CMAS II team members found that CDC/Zimbabwe's operations are strongly aligned with the country ownership principles put forth by PEPFAR and the Global Health Initiative. Most CDC/Zimbabwe cooperative agreements were with local organizations, and the only international grantee had staff that were embedded entirely in Zimbabwe's Ministry of Health and Child Welfare (MOHCW). Zimbabwe's MOHCW mentioned that they are highly appreciative of CDC support, even though it is currently being provided indirectly. All participants reported that CDC/Zimbabwe took an active, collaborative role in HIV/AIDS planning from the highest strategic planning level down to highly technical workgroups. The Chief of the United Nations Programme on HIV/AIDS reported that CDC (and PEPFAR) had "exceptional alignment" with the government of Zimbabwe and other donors, which was unprecedented in their experience with multiple other countries. The HIV and Tuberculosis Unit identified CDC as their closest partner in working out technical strategies to respond to emerging health issues.

To further strengthen collaboration, CDC/Zimbabwe was working to develop letters of agreement describing the three-way roles, responsibilities, and expectations between CDC/Zimbabwe, the MOHCW, and CDC-funded grantees who had cooperative agreements that specifically supported Zimbabwe's MOHCW. These letters of agreement may represent an important new tool and template for other CDC offices.

In the past year, CDC/Zimbabwe became an active and engaged member of the government of Zimbabwe-led

process for setting targets for key prevention interventions (prevention of mother-to-child transmission of HIV, antiretroviral treatment, and voluntary medical male circumcision). CDC/Zimbabwe actively contributed to a gap analysis that successfully helped PEPFAR/Zimbabwe get substantial new resources, including the first ever voluntary medical male circumcision resources for CDC/Zimbabwe and the first resources in many years for antiretroviral treatment. Although CDC/Zimbabwe's own direct targets remained relatively modest for antiretroviral treatment, and may be overly ambitious for voluntary medical male circumcision, this "pivot" in programming toward high impact HIV prevention interventions strongly reflected the 2012 Country Operational Plan guidance. Again, strategic deployment of technical assistance from CDC headquarters had been a critical factor in allowing a small CDC office to have strong antiretroviral treatment, prevention of mother-to-child transmission of HIV, and voluntary medical male circumcision programs.

CDC/Zimbabwe contributed actively and collaboratively to identify and meet national targets. CDC/Zimbabwe was specifically supporting the national monitoring and evaluation system to incorporate a more effective reporting system for antiretroviral treatment service delivery through its cooperative agreement for strengthening the health information system. Important progress had been made in helping grantees identify measurable and meaningful objectives in cooperative agreements and tracking the progress toward reaching those goals. CDC/Zimbabwe implemented routine assessments of program-level data collected by CDC-funded grantees. This improved grantee performance as well as increased their level of accountability.

At the time of the CMAS II assessment, CDC/Zimbabwe designated an Associate Director for Science, and Science Office procedures were put in place and strengthened substantially since CMAS I. Early applications of economic analysis had begun, and CDC/Zimbabwe completed an important evaluation of the national antiretroviral treatment program, with another for prevention of mother-to-child transmission of HIV beginning.

Major Challenges

CMAS II team members found that the U.S. government's restrictions on direct funding to the MOHCW in Zimbabwe put CDC/Zimbabwe in a difficult situation. New letters of agreement were already helping substantially, but both country ownership and public health impact will be much more efficient when direct funding of Zimbabwe's MOHCW can be reinitiated. Although capacity building of local organizations was evident, it was not completely captured by measurable indicators.

The sharp pivot toward involvement in key prevention interventions of antiretroviral treatment, prevention of mother-to-child transmission of HIV, and voluntary medical male circumcision (plus HIV testing) will require knowledge of country context and programs in order to set achievable targets. CDC, the MOHCW, and other donors will need to collaborate to ensure national targets are reached, especially in male circumcision.

CDC/Zimbabwe and a number of other donors were supporting several projects that had impact on the health information system of Zimbabwe. Without leadership and an overall system design and standards (i.e., "enterprise architecture"), this approach could lead to independent non-communicative systems. The initial activities in economic analysis were excellent, but systematic expenditure analysis and the use of expenditure data for making program decisions had not yet begun at the time of the assessment. Despite strengthening the

Science Office, there was no dedicated administrative support for that office.

Recommendations

- Continue to develop and implement letters of agreement for cooperative agreements to non-MOH grantees for programs intended to support the Zimbabwe's MOHCW (which has been flagged as a potential best practice or re-usable model for CDC).
- Request support to re-examine proposed targets for male circumcision in consultation with CDC headquarters and perhaps a male circumcision technical working group in preparation for Country Operational Plan 2013 submission.
- Supplement CDC's strong work in health information systems through multiple cooperative agreements with efforts to assist Zimbabwe's MOHCW to articulate a common system design and standards across various health information system investments.
- Build on recent progress regarding custom indicators for CDC/Zimbabwe's work and begin reporting to PEPFAR.
- Request technical assistance from CDC headquarters to assist with program-level expenditure analysis using already available grantee-level cost data to inform Country Operational Plan 2013.
- Ensure that all relevant staff have appropriate science regulatory training, specifically scientific ethics verification and dual use research.
- Due to increased volume of documents for review and clearance, consider designating a full-time administrative assistant to be assigned to the Science Office.
- Develop an integrated evaluation plan for the CDC/Zimbabwe office. One specific project is an evaluation of health systems strengthening activities supported by CDC.
- Re-examine Zimbabwe's approach to DGHA site monitoring in light of increasing involvement with service delivery and quality assurance.

Next Steps

The CMAS II team shared their key findings and recommendations with the CDC/Zimbabwe 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.