CDC's Country Monitoring and Accountability System II

Country Monitoring and Accountability System Visit to Lesotho – April 7-11, 2014
Summary of Key Findings and Recommendations

Introduction

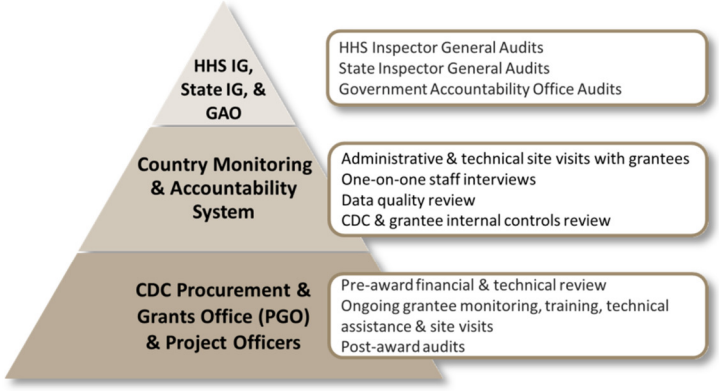
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global 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 Lesotho from April 7-11, 2014. 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 five 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 Lesotho (CDC/Lesotho). 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/Lesotho's operations.

Background on Country Program

CDC began working in Lesotho in 2007. The country has a severe epidemic, with an estimated prevalence among adults (ages 15-49) of 23.1% in 2012. CDC/Lesotho supports an integrated continuum of services that includes improvement in public health policies, prevention interventions, tuberculosis/HIV co-infection, care and treatment, health management information systems, blood safety, and improved laboratory capacity. This support is provided in close partnership with the MOH and its implementing partners.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

The CMAS II team gained in-depth feedback from country office staff by holding one-on-one interviews with all seven current staff members and conducting an online survey that was completed by six of the seven staff members. The CMAS II team met with select CDC/Lesotho staff to discuss human resource management and country operations and completed eight standardized checklists on subjects such as motor pool, time and attendance (U.S. direct hires and locally employed staff), inherently governmental functions, facilities management, information technology systems, and travel orders. The CMAS II team conducted meetings with the Deputy Chief of Mission/Chargé d'Affaires and the Human Resources Specialist at the U.S. Embassy in Lesotho, as well as PEPFAR colleagues, including the U.S. Agency for International Development Program Director and the PEPFAR Coordinator.

Major Achievements

The overall findings for Lesotho continued to reflect strong and supportive leadership. Staff members generally believed in the program's purpose and the meaningfulness of their work and exhibit a strong commitment to addressing HIV and improving public health in Lesotho. Staff reported feeling that their opinions were considered and valued in decision-making and that there was a strong degree of respect between staff and management. Staff members reported that they continue to receive useful training and career development opportunities. CMAS II team members found that the Lesotho PEPFAR team was a positive example of excellent interagency cooperation; CDC/Lesotho and U.S. Agency for International Development shared space and staff, and their collaboration appeared effective and focused foremost on achieving program impact.

Regardless of human resource delays, CDC/Lesotho maintained a collegial working relationship with U.S. Embassy stakeholders. In addition, despite limited staff, CDC/Lesotho conducted all inherently governmental functions appropriately. Travel orders were also well-documented.

Major Challenges

At the time of the CMAS II visit, CDC/Lesotho had three long-term vacancies, one of which was the Deputy Director (which should be filled several weeks after the CMAS II visit). In 2013, CDC/Lesotho conducted a major realignment of its technical programming. These two factors caused nearly all staff to express concerns about heavy workloads, too many priorities, and an ongoing high stress environment, which is challenging for team morale.

CDC/Lesotho employed a hybrid motor pool model by mainly utilizing the U.S. Embassy's motor pool, but also maintained one self-drive car; a consistent approach would be more efficient. Two minor safety and security issues were identified: staff members had not been issued encrypted thumb drives, and while participating in the U.S. Embassy's emergency drills, CDC/Lesotho lacked a CDC-level emergency notification system. Finally, time and attendance records did not prove to be systematically maintained by CDC/Lesotho.

Recommendations

- To address high workloads and to help strengthen management systems, leverage support through temporary duty assignments from CDC headquarters.
- Maintain time and attendance records within CDC/Lesotho.
- Obtain and exclusively use encrypted thumb drives.
- Introduce a CDC/Lesotho-specific phone or SMS emergency notification system.
- Ensure that all travel advances are repaid promptly.

Financial Resource Management

Major Achievements

CDC/Lesotho's Financial Management Specialist demonstrated a sound understanding of U.S. government and PEPFAR budget processes, regulations, and policies. CDC/Lesotho staff had access to the necessary budget systems and could access relevant data in a timely manner. Budget staff kept CDC/Lesotho's leadership informed of any budgetary issues. The office was also familiar with CDC's Office of the Chief Financial Officer and the U.S. Embassy's Financial Management Office and contacted them for assistance as needed.

The scope of CDC's Office of the Chief Financial Officer review primarily focused on post held funds and internal controls of financial activities occurring within CDC/Lesotho. 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 to provide additional information for specific situations. CDC/Lesotho was also sent a questionnaire to complete regarding fiscal activities at post.

Through the questionnaire and document review, CDC's Office of the Chief Financial Officer found that locally employed budget and financial staff members were very knowledgeable of both DOS and CDC/Lesotho procedures. The office was committed to ensuring that sufficient documentation supports all financial transactions. CDC/Lesotho financial transactions appeared adequately supported and consistent with applicable policies, authorities, and regulations.

At the time of the CMAS II visit, CDC/Lesotho had sufficient staff in place to ensure segregation of duties and overall regulatory compliance. A prior desk review dated December 2012 found a number of unliquidated obligations. The current desk review still indicated a number of outstanding unliquidated obligations for fiscal year 2013; however, CDC/Lesotho made significant improvements compared to the prior year in the management of those obligations.

Major Challenges

While there was an understanding of CDC/Lesotho's overall budget, tracking the information at a sufficiently detailed level proved to be a challenge. CDC/Lesotho should consolidate and organize their financial tracking information. There were various spreadsheets used to track the financial information, which should be consolidated into one budget spreadsheet. CDC/Lesotho did not currently track Country Operating Plan activities nor links them to implementing mechanisms.

CDC/Lesotho noted in the questionnaire response that there was no administration or policy manual onsite that reflects all of CDC's policies, requirements, and procedures. While international CDC country offices had access to CDC's policies, regulations, and standard operating procedures, immediate access to an onsite compilation of guiding policies, regulations, and procedures was essential to ensuring the greatest level of operational efficiency and regulatory compliance is practiced.

Recommendations

- Consolidate various budget tracking systems as well as follow the best practice guidance for reviewing and tracking current and past Country Operational Plans. In the budget tracking system, clearly indicate projected expenses, as well as actual expenses, to the specific funding source. Best practice guidance was provided by CDC's Program Budget and Extramural Management Branch participant for both Country Operational Plan reconciliation and budget tracking.
- In partnership with CDC headquarters, develop and maintain an onsite administration and policy manual, which includes all pertinent policies, regulations, and standard operating procedures essential to global operations.

Accountability for Extramural Resources

Grantee Management

Major Achievements

CDC's Program Budget Extramural and Management Branch CMAS II participant met with CDC/Lesotho staff regarding the management of cooperative agreements and contracts/procurement. Assessments focused on a review of documents in the CDC/Lesotho office to gauge the level of involvement in cooperative agreements. Strengths of the CDC/Lesotho staff included frequent communication and technical assistance to grantees. Project Officers were knowledgeable and adequately performed roles and responsibilities.

CDC/Lesotho initiated a potential transition from hard copy files to an electronic system with the regional information technology point of contact and scheduled a follow-up discussion. CDC/Lesotho received technical assistance from CDC headquarters to focus on developing specialized standard operating procedures for cooperative agreement management, as well as a tracking spreadsheet for post award actions and restrictions.

Major Challenges

Although staff carryout oversight duties, formal standard operating procedures and tracking systems for cooperative agreement management did not exist. In addition, reports and official correspondence were not sent to CDC's Procurement and Grants Office to be included in the official file. The current filing system for cooperative agreement management consists of separate folders and was manually updated by the Program Management Specialist.

While there were currently no active contracts, CDC/Lesotho does not have a certified Contracting Officer's Representative to perform invoice-receiving functions for future contracts/procurements.

Recommendations

- With support from CDC headquarters, establish and implement standard operating procedures for cooperative agreement management. The standard operating procedure should clearly delineate roles for specific team members and also define responsibilities for actions. Project officers and Activity Managers should submit site visit reports and correspondence from technical meetings to CDC headquarters for the official file on a regular basis. In addition, the tracking systems should be updated and reconciled with CDC's Program Budget and Extramural Management Branch tracking system.
- Confirm that certified Contracting Officer's Representative have access to internal systems in order to be able to perform invoice receiving functions for future contracts/procurements.

Grantee Compliance

Major Achievements

Some of the grantees demonstrated very good business practices with insignificant weaknesses. All the grantees requested cooperative agreement training, which was provided during the CMAS II visit. There were no audit findings to address since CDC/Lesotho resolved findings prior to CMAS II.

Major Challenges

The CMAS II visit identified some challenges. Project Officers did not receive or get involved in the grantees' audit reports. Some grantees had no knowledge of their audit findings since the program falls under a larger award headquartered in the United States, which received and controlled funding separately. Further, because funding was managed domestically, the CMAS II team found that there were delays due to required approvals from a third party to utilize U.S. funds from the cooperative agreement.

One grantee did not seem to have any understanding of how to manage federal grant funds and should become familiar with the Code of Federal Regulations, as well as adequate written personnel, travel, and procurement policies.

Furthermore, grantees drawing down funds were keeping these funds in bank accounts for approximately one month, which was much longer than the policy allows. Grantees should only have enough money for three to ten business days to expend their funds and should drawdown according to need only. Also, some grantees did not have an organizational chart for the cooperative agreement, written human resource policies and procedures in place, or time and attendance records. Some grantees did not conduct or perform annual evaluations of their employees.

One grantee's staff member was receiving salaries from multiple awards with CDC for 100% of time and effort on each award, thus claiming a salary of over $198,000 on the cooperative agreement; however, the Department of Health and Human Services salary cap is roughly $179,000. CDC's Procurement and Grants Office provided more clarity on the issue, advising the grantee to revise their budget and submit the revised version to the Grants Management Specialist at CDC's Procurement and Grants Office.

Furthermore, one grantee had no vehicle logs for the vehicles purchased with cooperative agreement funds and could not verify the location of the vehicles purchased from the cooperative agreement. When advised that the Grants Management Specialist would return the following day, the business official was not available for follow-up and could not provide proof at the time of the visit that the vehicles purchased with federal funds were utilized appropriately. The business official was the only person with access to this information. Although the grantee had a motor pool, the vehicles were not stored at the motor pool when not in official use.

Some grantees had a memorandum of understanding with other grantees but could function effectively when duties were not carried out fully. For example, the CMAS II team found that one grantee had an agreement with the local government; however, challenges kept the grantee from performing according to the outlined plan, thus preventing the grantee from accomplishing their tasks.

Recommendations

- Require grantees to complete time and attendance records, as well as employee evaluations, for all employees paid by the cooperative agreement.
- Ensure that Project Officers are aware of findings in grantee audits in order to provide guidance and advice to address any identified issues.
- Ensure the grantees correct personnel time and effort reported on the cooperative agreements for the individual receiving a salary over the Department of Health and Human Services limit and resubmit the revised budget to the Grants Management Specialist at CDC's Procurement and Grants Office by May 31, 2014.
- Require that grantees spend withdrawn funds from the Payment Management System within three days of receipt for activities agreed upon. However, considering the challenges, CDC's Procurement and Grants Office will allow up to 14 days to liquidate the funds.
- Continue to improve relations with in-country government and head offices by working with the U.S. Ambassador and Lesotho Minister of Health to maintain better management of U.S. government funding.
- Require grantees to complete and keep vehicle logs in every vehicle purchased with federal funds and park vehicles in the grantees' motor pool.

Accountability for Public Health Impact

Major Achievements

The CMAS II team found that CDC/Lesotho actively participates, facilitates, and supports the development of Lesotho's national HIV strategy with relevant MOH and national partners. CDC/Lesotho strived to maintain open communication with the MOH through regular meetings and ongoing technical and programmatic support to the MOH staff and its senior leadership. Approximately 30% of the country's program budget funding was directed to local and national partners. Consistent with national targets, programmatic planning, prioritizing, and target setting occurred with the engagement of local and national partners, was evidence based, and uses available tools and methods. Program results from recent years were on a trajectory to achieve key programmatic targets with monitoring systems in place.

Engagement and communication with key stakeholders and implementing partners was strong and occurred regularly through the use of email, phone, and in-person meetings. Since CMAS I, CDC/Lesotho and its implementing partners had established a comprehensive data quality assurance system with active follow-up occurring with partners and sites to resolve data quality issues. CDC/Lesotho also had established a comprehensive approach for the provision of technical input and review of publications, abstracts, reports, and protocols from partners prior to submission to the Science Office at CDC headquarters. Engagement with relevant partner and program staff on scientific documents occurred during the initial stage of development.

Major Challenges

While communication and collaboration were strong between CDC/Lesotho and MOH staff at the technical

level, decision-making at the policy and strategy level for approval of some cooperative agreement activities and national guidelines had been occasionally delayed. Although CDC/Lesotho had an approach for reviewing protocols and publications, the office lacked standard operating procedures documenting the process, and some staff had not yet completed the required training for certification for scientific ethics verification and/or dual use research.

Recommendations

- Continue to promote MOH to take an active leadership role in strategic planning of the national HIV response, programmatic implementation, and monitoring of achievements.
- Develop a standard operating procedure for publication and protocol clearance as well as establish an electronic system for tracking protocol and publication reviews and approvals.
- Ensure relevant technical staff members complete required trainings and earn certifications in a timely manner.

Next Steps

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