CDC's Country Monitoring and Accountability System II

Country Monitoring and Accountability System Visit to Democratic Republic of the Congo – January 28-February 1, 2013 Summary of Key Findings and Recommendations

Introduction

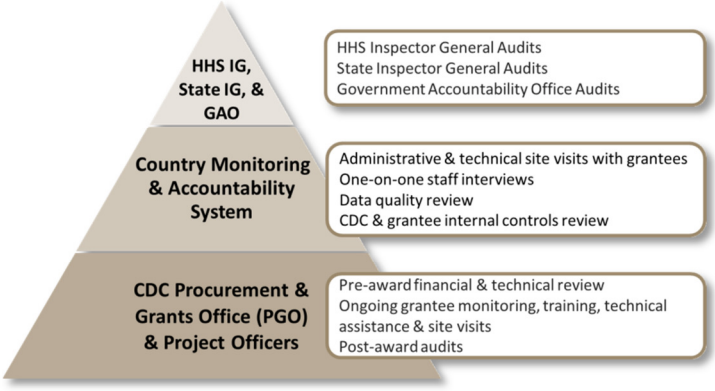
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global 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 brining 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 the Democratic Republic of the Congo from January 28 – February 1, 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 seven 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 the Democratic Republic of the Congo (CDC/DRC). Team members reviewed financial and administrative documents at CDC/DRC 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/DRC's operations.

Background on Country Program

The Democratic Republic of Congo (DRC) is one of PEPFAR's 16 long-term strategy countries. In collaboration with DRC's MOH and other governmental entities, CDC/DRC has worked to address the HIV epidemic by providing evidence-based technical leadership and assistance since 2002. Current HIV/AIDS activities are focused on the three most populated provinces of DRC: Kinshasa, Katanga, and Orientale. CDC/DRC provides direct technical and financial assistance to support specific program areas including: blood and injection safety; prevention of mother-to-child transmission of HIV; pediatric and adult HIV/AIDS care and treatment; tuberculosis/HIV control; laboratory infrastructure; HIV surveillance; and HIV/AIDS data management systems. CDC/DRC provides technical leadership in developing comprehensive, evidence-based, family-centered treatment, care, and support services. Cross-cutting focus areas of CDC/DRC include: advancing policy-level changes in key technical areas; incorporating measures against gender-based violence across program areas; developing human resources for health; promoting public-private partnerships for HIV prevention, care and treatment; strengthening , monitoring and evaluation, including the establishment of electronic reporting system.

CDC/DRC's activities align with the objectives of the Global Health Initiative framework and DRC's National Health Development Plan, which are geared toward sustainable health systems and health care services. CDC/DRC's main grantees include DRC's National AIDS Control Program and National Blood Safety Program, Kinshasa School of Public Health, Columbia University, Tulane University, University of North Carolina, Elizabeth Glaser Pediatric AIDS Foundation, and Family Health International.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

The management and leadership assessment of the CDC/DRC office included individual interviews with all 18 staff members, a meeting with the U.S. Embassy's Human Resources Officer, and reviews of inherently governmental functions – such as time and attendance (U.S. direct hire and locally employed staff), travel

orders, motor pool, and personnel files.

Major Achievements

The CMAS II team found that there is a strong working relationship between the CDC/DRC administrative team and the U.S. Embassy's Human Resource Office. Locally employed staff positions were filled in a timely manner using correct hiring mechanisms. Locally employed staff demonstrated leadership (e.g., serve as co-chairs of technical working groups and serve as supervisors), and staff members overwhelmingly felt that CDC/DRC is a good place to work. The CDC/DRC office was compliant with U.S. government regulations on the performance of inherently governmental functions.

Major Challenges

In the area of staff development, staff indicated that they would like more training to improve their current job performance. Despite the expressed desire for more training, staff reported low utilization of the online Health and Human Services' Learning Portal for training opportunities. Staff also desired increased transparency in decision-making around travel and training opportunities.

Through the interviews and the online survey, staff noted that the transition of the CDC/DRC Country Directors was a challenging period, but the situation was stabilizing. The growth of the CDC/DRC program also necessitated reorganization of work and responsibilities. Staff desired increased clarity regarding new roles and responsibilities that have developed in response to the expansion of the program, as well as better communication on new policies and procedures; the policy manual contained high level, complex legal language that was difficult to understand. Further, it did not provide details about how these policies are operationalized in CDC/DRC.

Many staff members – both locally employed and U.S. direct hires – felt that the office is understaffed and that the size of the office is insufficient to meet programmatic demands. There was also a perception that CDC/DRC staff receive fewer U.S. Embassy awards than other U.S. government agencies in DRC.

This assessment found that a majority of the staff were uncertain of how to obtain information about equal employment opportunity discrimination and general workplace protection, which is important for local in-country staff in order to address questions or concerns related to these issues.

The CMAS I visit identified language barriers as a challenge. Meetings continued to be conducted in English, even though local staff have varying degrees of comfort communicating in English. At the time of the review, there was no requirement that U.S. direct hire staff be conversant in French, and since CDC/DRC is considered a "hard to fill" post for U.S. direct hires, this challenge proved to require continued attention.

Recommendations

- Develop a procedure for equitable distribution of training opportunities and make sure the system is transparent.
- Strengthen the policy manual by:

  - Transforming legal language provided by the Center for Global Health in templates into more easily understandable language.
  - Including functional details about how policies are operationalized locally.
- Update position descriptions as staff members are promoted or job responsibilities shift to ensure mutual clarity about roles and responsibilities.
- With updated position descriptions, revisit Work Development Plans to ensure required trainings are offered in a timely manner.
- Address understaffing by including requests for new positions in Country Operation Plan for 2014. Ensure that roles are clearly defined.
- Consider more frequent participation in U.S. Embassy awards.
- Engage the U.S. Embassy's Human Resources Officer to participate in one or more staff meetings to present updates on current benefits and allowances, as well as any upcoming changes. The entire staff should receive training on equal employment opportunities from the Human Resources Officer.
- Strongly encourage U.S. direct hires not conversant in French to take advantage of French language training available to them at post or through self-study.

Financial Resource Management

Major Achievements

Through the questionnaire responses and document review, the CMAS II team found that locally employed budget and financial staff members were very knowledgeable of both DOS and CDC/DRC procedures. They demonstrated commitment to ensuring adequate procedures are in place and followed. The CDC/DRC Deputy Director provided excellent support to CDC's Office of the Chief Financial Officer and was very open to exploring ways of strengthening operations at CDC/DRC.

CDC/DRC addressed and/or resolved the key findings listed in the June 2011 Office of the Chief Financial Officer's CMAS I report. Substantial improvements were in program budget, and CDC/DRC was addressing outstanding issues regarding property.

Overall, both budget formulation and budget execution met or exceeded the standards set forth by CDC. For budget formulation, CDC/DRC had a detailed fiscal year 2013 cost of doing business spreadsheet with major costs broken out and estimates based on historical spending. Carryover funds from previous Country Operational Plans were being reconciled with the fiscal year 2013 Country Operation Plan. For budget execution, the recently revised "high-level" budget report accurately captured the projections, commitments, and expenditures for CDC headquarters and post held funds. The validity of expenditures, unliquidated obligations, and CDC/DRC and U.S. Embassy financial reports were reviewed and reconciled regularly. Overall, the CDC/DRC office maintained good communication with DGHA, CDC's Office of the Chief Financial Officer, and the U.S. Embassy's Financial Management Office.

At the time of the CMAS II review, all vehicles, laptops, and "sensitive" items listed in the Property Management Information System were accounted for, representing the majority of items in the Property Management Information System. Five of eighteen blackberries, however, were not accounted for. Inventory was conducted annually, and a separate spreadsheet identified the specific location of all property. An appropriate separation of duties existed between ordering, receiving, and issuing property and equipment. Surplus items were properly disposed of through the U.S. Embassy and CDC's Procurement and Grants Office.

Major Challenges

Financial training, specifically related to the CDC financial system for the Deputy Director, continued to be a need, as noted during the CMAS I visit. The Budget Specialist was tasked with tracking cooperative agreement management actions and despite assistance from the Deputy Director, had minimal support in filing cooperative agreement documents. CDC/DRC also did not have a standard operating procedure documenting the cable process, although the current staff could verbally explain the process.

Overall, property was accounted for despite some previous issues. Delayed responses from CDC's Procurement and Grants Office and Center for Global Health remained a challenge to reconcile actions in the Property Management Information System. CDC headquarters worked with CDC/DRC to create one list of outstanding property issues, including three pieces of equipment that belong to the MOH that are listed in the Property Management Information System and need to be transferred back to the MOH.

Recommendations

- Create a Cooperative Agreement Management Specialist position to help ease the Budget Specialist's burden.
- Obtain or create a cable process standard operating procedure.
- Integrated Resources Information System training is needed for the Deputy Director.
- Reconcile consolidated Property Management Information System "open actions" issues list with CDC's Procurement and Grants Office and Center for Global Health.

Accountability for Extramural Resources

Grantee Management

Major Achievements

At the time of the CMAS II review, CDC/DRC managed ten cooperative agreements, with two that are centrally managed. For external cooperative agreement management, grantees noted positive relations between CDC/DRC staff and CDC's Procurement and Grants Office. Technical and administrative support proved to be adequate and given as needed. Site visits occurred on a regular basis. For internal cooperative agreement management, both hard and electronic cooperative agreement files were available and largely complete. The CDC/DRC shared drive was well-organized and extensive. Cooperative agreement management standard operating procedures regarding office roles/responsibilities and processing standard cooperative agreement

actions were recently created. The Deputy Director and Country Director completed the CDC required trainings (International Project Officer and Appropriations Law).

CDC/DRC had two active task orders. The contract files were complete with all necessary documentation. The Contracting Officer's Representative had access to the acquisition management system, but acceptance/approval of invoices was conducted at CDC headquarters. The Deputy Director's Contracting Officer's Representative certification was current but will expire in December 2013. Informal feedback regarding employee performance was addressed directly with the contractor employee.

Major Challenges

The review found a need to hire a Cooperative Agreement Management Specialist (proposed in fiscal year 2013 Country Operation Plan). Duties were shared between the Deputy Director and Budget Specialist but do not adequately provide enough support to fully manage the cooperative agreement portfolio. Newly created standard operating procedures have not yet been implemented and may need substantial revision before implementation. CDC/DRC has spent a lot of time maintaining both hardcopy and electronic cooperative agreement files. The electronic filing system required revisions to properly document cooperative agreement files. No tracking system for cooperative agreements existed outside of a funding spreadsheet.

Recommendations

- Hire a Cooperative Agreement Management Specialist. When hired, clearly define roles and responsibilities within the cooperative agreement management team.
- Cease hardcopy cooperative agreement files, revise the electronic file structure and restore electronic files.
- Revise and implement cooperative agreement management standard operating procedures.
- Obtain cooperative agreement tracking systems from CDC headquarters on a biweekly basis (cooperative agreement summary spreadsheet and cooperative agreement outstanding post award documents) and bring them to the Deputy Director and Country Director for "high-level" budget meetings.
- Contracting Officer's Representatives should perform acceptance/approval of invoices in the acquisition management system (not CDC headquarters).
- Provide annual feedback regarding contractor employee performance to contractor and to CDC's Procurement and Grants Office Contracting Officer.

Grantee Compliance

Major Achievements

Most grantees provided documentation and displayed their capacity to effectively and adequately manage U.S. government funds.

Major Challenges

The visit to DRC revealed that the most consistent challenge was the inability to pay salaries and fees associated with trainers and/or "incentives" for government personnel, even the non-governmental award recipients. Essentially, DRC government personnel were not provided/afforded a living wage. Because of this, the government worked to institutionalize and mandate official mechanisms for channeling international aid from foreign donors as an immediate solution to augment wages and retain personnel. Until the current budget period, CDC/DRC projects allowed for these costs, if reasonable, but made a conscious decision to discontinue this practice. As a result, every grantee expressed substantial difficulty in providing effective training programs and government grantees struggle to staff personnel for PEPFAR projects.

Grantees also had minor problems ensuring the implementation of existing policies and procedures regarding timekeeping and inventory, including vehicle registers. Some grantees hired a locally-based audit firm. It was unknown if a U.S. Agency for International Development certified local vendor list existed. Also, a significant challenge for grantees was the transport of large sums of cash to distant rural areas for relevant project activities.

CDC/DRC team members periodically performed and documented technical and administrative site visits; however, reports of these site visits had not been submitted to CDC's Procurement and Grants Office. Also, the Project Officer was unaware of this new CDC requirement.

Recommendations

- Ensure that CDC headquarters clarify its policy on salary support for host nationals through their cooperative agreements.
- Determine if a U.S. Agency for International Development certified local audit firm vendor list exists. If it does, this list should be adapted for DRC/CDC use. If it does not exist, CDC/DRC should work with the U.S. Agency for International Development to develop a common list. CDC/DRC should work with CDC headquarters on documentation and guidance for an appropriate scope of work for audits meeting for U.S. government requirements.
- Provide CDC's Procurement and Grants Office with electronic copies of site visit reports within 30 days of completion.

Accountability for Public Health Impact

Major Achievements

CDC/DRC proved to be a major contributor to the evidence base for national strategic planning by funding strategic information activities such as surveys and surveillance, supporting the implementation of a national monitoring and evaluation reporting system as well as other capacity-building activities to strengthen this national system. In 2011, the CMAS I visit noted several grantees that were involved in antenatal HIV surveillance activities, yet a clear delineation of their roles and responsibilities did not exist. CDC/DRC resolved this issue, and roles and responsibilities of grantees in HIV surveillance efforts are now clear.

The DRC national partners and grantees valued and welcomed technical leadership and input from the CDC/DRC Country Director and staff, often calling on CDC/DRC staff to contribute to national strategic planning processes. Planning for the scale-up of activities towards the prevention of mother-to-child transmission provided a good model for joint planning with national and local grantees that could be expanded into other program areas, including strategic program planning and target setting within the continuum of response approach. At the time of the CMAS II visit, CDC/DRC was also working with DRC's National AIDS Control Program to conduct a rapid synthesis of existing program and surveillance data to inform HIV program planning decisions for the DRC's National AIDS Control Program, the Global Fund, and PEPFAR. During fiscal year 2013, additional efforts were made to develop a strategic information plan to systematically guide the coordination, collection, and use of strategic information.

CDC/DRC staff demonstrated substantial technical involvement with grantees through monthly meetings to monitor grantee performance of utilizing funds (pipeline) and achieving program targets. CDC/DRC was almost fully staffed, with most of the key positions filled. Given the difficulty of traveling within DRC, plans were in place to add staff to support the monitoring and implementation of activities in the provinces. CDC/DRC met Institutional Review Board review and compliance standards for Scientific Ethics Verification and Dual Use Research trainings.

CDC/DRC developed a thoughtful site monitoring system strategy that will exceed the site coverage requirements if continued at the current pace of visits. The logistics component was well-organized and incorporated into ongoing activities and visits, especially in areas outside of Kinshasa. CDC/DRC staff were involved in the site monitoring system, with well-defined staff roles and responsibilities that capitalize on differing areas of expertise.

The CDC/DRC site monitoring system team demonstrated appropriate scoring and assessment of the site monitoring system core essential elements. The team also exhibited a supportive approach with facility staff that encouraged active participation and learning. Visits to a large site in Lubumbashi, which had previously undergone a site monitoring system visit, revealed a positive impact at the site-level. For example, a new patient tracking system was implemented, site standard operating procedures were defined and posted, and documentation of nutritional status had improved.

Major Challenges

Following the CMAS visit in 2011, Science Office responsibilities were delegated to the direct hire medical epidemiologist position. However, that position will become vacant again in June 2013. The review found a general lack of timely processing of protocols submitted to CDC, limiting the availability of data for program planning and the spend down of strategic information funds in the pipeline. There continued to be limited attention to data quality, but plans were in place to request assistance from CDC headquarters and finalize dates for a data quality assessment after the approval of the 2013 Country Operation Plan.

While grantees valued a closer working relationship with CDC/DRC, some expressed concern about possible delays with implementation of activities and potential micro-management as a result of needing to receive

additional approval for activities before moving forward. One grantee's cooperative agreement will end in a few months, but it was not clear if there is a transition plan in place. At the time of the review, the grantee had about 3,000 patients on treatment. Progress was being made to improve internal communication among staff, as well as clarify roles and responsibilities, especially in the context of cooperative agreement management.

Additional challenges included a lack of country ownership strategy, as the majority of funding goes to U.S.-based non-governmental organizations. There was concern about efficient coordination among grantees working in the same program area with a move towards continuum of response approach and targeted health zone strategy. Also, the CMAS II review found potential for double counting, overlap, and questions on how to manage grantee performance.

DRC exhibited weak performance towards the World AIDS Day targets, due in part to the late arrival of funds and political instability. CDC/DRC lacked an evaluation plan with limited to no basic program evaluation activities. CDC/DRC needs to balance evaluation activities with monitoring activities to improve the quality of program implementation.

At the time of the visit, the site monitoring system's data entry tool assigned cross-cutting core essential elements to multiple service areas within a single site. Although this attention to detail was laudable, it created difficulties with CDC headquarters' data analysis and likely requires simplification.

The CDC/DRC site monitoring system team had not yet developed a detailed site visit plan to ensure consistent coverage of sites outside of Kinshasa, which will be necessary given significant transportation issues within DRC. Also, the office had no standard documentation for follow-up plans and score remediation reporting for those core essential elements that required further improvement. Well-organized monitoring, with CDC involvement, will be essential to ensure that appropriate actions are taken and documented.

Recommendations

- Follow-up with CDC headquarters to resolve any delays of protocols under clearance, and develop a surveillance strategic plan that addresses data gaps to support planning in health zone strategy (e.g., include national, provincial and health zone data as much as possible).
- Clarify for grantees on activities that either do or do not require CDC's prior approval to minimize delays with program implementation.
- Develop and execute a formal transition plan for the applicable grantee's cooperative agreement as soon as possible.
- Strengthen internal communication on roles and responsibilities by clarifying roles of the Cooperative Agreement Manager, Activity Manager, and Technical Specialist.
- Develop a long-term country ownership strategy to strengthen management and technical capacity of local grantees and align funding accordingly.
- Review and re-examine the grantee portfolio and service coverage in health zones to maximize efficiencies and minimize duplication and overlap.

- Ensure that obstacles to achieving World AIDS Day targets are resolved and make adjustments to improve performance in the 2013 semi-annual progress report.
- Work with CDC headquarters monitoring and evaluation point of contact to develop an evaluation plan. Consider south to south technical assistance with Cote d'Ivoire to improve skills in program evaluation.
- Simplify data collection and reporting to CDC headquarters, work to revise the current data entry tool so that only one score for each core essential element is reported to CDC headquarters.
- Ensure continued site coverage, development of a detailed site visit plan for Katanga and Orientale should be initiated.
- Develop standard documentation for follow-up of issues identified during site monitoring system visits.
- Define a post site monitoring system visit report template that delineates follow-up plans for each core essential element that need improvement, the person responsible, and a suggested timeline.
- Designate a CDC/DRC staff member to monitor progress when follow-up actions are delegated to grantees.
- Ensure standard procedures for dissemination of findings and plans are developed for awareness among stakeholders (i.e. site staff, ministry staff, and grantees).
- Develop routine procedures for documenting and reporting remediated core essential element scores.

Next Steps

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