CDC's Country Monitoring and Accountability System II

Country Monitoring and Accountability System Visit to Cambodia – August 12-16, 2013
Summary of Key Findings and Recommendations

Introduction

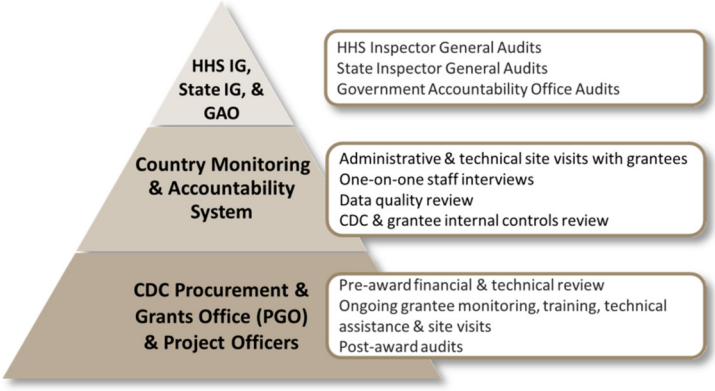
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global 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 Cambodia from August 12-16, 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, including strategic program direction, monitoring and evaluation, and scientific integrity.

The CMAS II team conducted a five-day visit to the CDC/DGHA office in Cambodia (CDC/Cambodia). Team members reviewed financial and administrative documents at CDC/Cambodia 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/Cambodia's operations.

Background on Country Program

CDC and the Royal Government of Cambodia began a partnership in 2002 to support HIV prevention of mother-to-child transmission of HIV/AIDS, blood and injection safety, and voluntary confidential counseling and testing programs; to strengthen clinical and palliative care and tuberculosis/HIV programs; and to build laboratory and strategic information capacity. CDC provides technical leadership and direct assistance to the MOH on epidemiology, surveillance, laboratory, operations research and workforce capacity. Furthermore, CDC/Cambodia has enhanced service delivery quality for HIV/AIDS and tuberculosis comorbidities and supported expansion of programs for the prevention of mother-to-child transmission of HIV.

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 CDC/Cambodia country office staff by holding one-on-one interviews with 22 current staff members, and conducting an online survey that was likewise completed by 23 staff members. The CMAS II team met with select CDC/Cambodia staff regarding management and leadership domains, completing 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 also conducted meetings with the Human Resources Officer at the U.S. Embassy.

Major Achievements

Of those interviewed, the average length of time working at CDC/DGHA was six years and five months. The low turnover of staff and high level of commitment to CDC's mission, goals, and objectives proved to be a major achievement of CDC/Cambodia. Staff's commitment to and satisfaction with their job was reinforced in the one-on-one interviews. Staff indicated an extraordinarily high job satisfaction rating, and also expressed a high level

of comfort speaking up and raising issues with their supervisors and colleagues.

On the online anonymous survey, 91% of staff felt that the leadership of the organization trusts them to do their job well. One hundred percent of staff viewed the organization as a good place to work and demonstrated commitment to CDC's mission, goals, and objectives. Finally, 100% of the staff understood the strategy of the organization, and 95.5% of personnel understood their jobs and how they contributed to the overall organizational effort.

Similar to the CMAS I findings, the CMAS II visit found that CDC/Cambodia has strong internal controls. The CMAS II evaluation concluded that all inherently governmental functions are carried out by appointed U.S. direct hires. Like CMAS I, the assessment of the motor pool demonstrated strong management, a committed workforce, and the reliable submission of appropriate documents to CDC headquarters. The information technology assessment showed strong information systems and reliable connections due to highly skilled staff who work in close coordination with regional support. Compared to CMAS I, the CMAS II team noted an improvement in the locally employed staff time and attendance files, demonstrating compliance with CDC regulations.

Major Challenges

CDC/Cambodia staff expressed concern regarding job security and their level of compensation, which could create internal challenges and dissatisfaction over time. Although the majority of staff indicated that they "somewhat agree" that salary and benefits are fair and appropriate, many expressed concern with rising inflation in relation to U.S. government salary freezes and how these combined create personal financial restraints. A few colleagues noted that they understand that this impacts everyone across the U.S. government, but would appreciate more open dialogue about the issue and its impact on locally employed staff.

The CMAS II assessment found that alack of clarity around training opportunities and the processes regarding who participates in training and related travel still exists. As noted in CMAS I, opportunities improved dramatically over the past several years, particularly with the increased trainings offered regionally in coordination with the CDC/Thailand/Asia Regional Office. However, staff in both CMAS I and CMAS II visits reported a desire for additional training and mentorship opportunities with more transparency around the process used to determine who is eligible for training and other developmental opportunities.

While improvements were noted in internal controls in the period between CMAS I and CMAS II, the office demonstrated insufficient practices in terms of time and attendance, as the Country Director needs to appoint the appropriate proxies in the Time and Attendance Assistance Network to ensure that forms can be completed on time. Time and attendance files for locally employed staff should be secured to protect personal information, and exemptions should be organized by name – not by date or pay period.

Recommendations

- Ensure that staff understand the process for requesting training and career development and that training opportunities are equally distributed across all levels of staff.

- Encourage cross-training in order to backfill absences or vacancies.
- Ensure that the Country Director has appointed a proxy (or proxies) listed in the Time and Attendance Assistance Network.
- Secure time and attendance files for locally employed staff and ensure that exemptions are filed by individual name and not by date or pay period.

Financial Resource Management

Major Achievements

CDC/Cambodia exhibited excellent budget formulation and execution tracking systems using Excel spreadsheets. Spend plans were reconciled with actual expenditures and tracked at the document level, as required. As with CMAS I, communication between the Budget Analyst at CDC headquarters' Program Budget and Extramural Management Branch, the Financial Management Office at the U.S. Embassy, and CDC/Cambodia proved to be strong. CDC/Cambodia demonstrated adequate controls for petty cash processes such as unannounced and announced cash counts, standard operating procedures, and separation of duties.

CDC/Cambodia continued to actively take steps to reconcile property items that are not listed in the Property Management Information System. All vehicles, laptops, and sensitive items listed in the system were accounted for during the CMAS II visit. The office conducted inventory more than once a year and the CMAS II team provided an updated spreadsheet for CDC/Cambodia staff to record the location of all equipment.

CDC's Office of the Chief Financial Officer conducted a desk review with CDC/Cambodia. This desk review primarily focused on post held funds and internal controls of financial activities occurring within CDC/Cambodia. 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. CDC/Cambodia was also sent a questionnaire to complete regarding fiscal activities at post.

Through the questionnaire responses and document review, CDC's Office of the Chief Financial Officer found the locally employed budget and financial staff members to be very knowledgeable of both DOS and CDC/Cambodia procedures. Staff demonstrated commitment to ensuring adequate procedures are in place and followed. Further, CDC/Cambodia took corrective action to address and/or resolve the key findings listed in the May 2012 Office of Chief Financial Officer CMAS I report.

Major Challenges

While CDC/Cambodia did not have challenges with the standards assessed during the CMAS II visit, such as budgeting, tracking expenditures, and reconciling unliquidated obligations, CDC/Cambodia's small budget does present unique challenges, especially with recent budget cuts to the country's Base allocation.

Furthermore, the only CMAS II standard not met was the frequency at which CDC/Cambodia obtains data from

the Embassy's financial reporting system (COAST) through the Financial Management Office.

Also, despite CDC/Cambodia's active efforts to reconcile items in the Property Management Information System, some of the issues found during CMAS I continued to persist during CMAS II. Delays from CDC headquarters and filling the in-country Deputy Director position contributed to this. However, CDC/Cambodia worked diligently to complete the requirements. More assistance from CDC headquarters proved to be necessary to ensure that these issues are resolved quickly and do not arise again. While it appears that there was proper separation of duties between ordering, receiving, and issuing, the process needs clarification.

CDC/Cambodia established routine procedures to review unliquidated obligations. At the time of the CMAS II assessment, the CDC office had a number of open unliquidated obligations line items.

Recommendations

- Continue communicating with CDC headquarters to ensure that any budget cuts in the Base allocation are appropriate and that the quality of services being provided by CDC/Cambodia is not negatively impacted.
- Request that the U.S. Embassy's Financial Management Office provide Consolidated Overseas Accountability Support Toolbox data on a bi-weekly basis. If this is not possible, documentation of this should be noted, and either the Deputy Director or Budget Analyst should look at obtaining direct access to the Toolbox.
- Work with the DGHA Country Office and the CDC Center for Global Health's Property Account Official to set a realistic deadline to resolve all issues found during the CMAS I and II visits.
- Compile a simple standard operating procedure clarifying who is responsible for ordering, receiving, and issuing to ensure that proper separation of duties exist.
- Continue to routinely monitor and review unliquidated obligations, and follow up with the U.S. Embassy's Financial Management Office staff to ensure appropriate action is taken to clear transactions in a timely manner.

Accountability for Extramural Resources

Grantee Management

Major Achievements

CDC/Cambodia continued to demonstrate good management of grantees, both internally and externally, with improvement since CMAS I. From an internal perspective, cooperative agreement files were available electronically via a shared drive with restricted access to safeguard sensitive information. As was found in CMAS I, excellent tracking systems existed regarding cooperative agreement information, point of contacts, budgets, restriction information, and post-award actions. CDC/Cambodia had also taken significant steps to create an internal cooperative agreement management standard operating procedure, which will be finalized within the next two months. From an external perspective, grantees reported stronger relations with CDC/Cambodia and

CDC headquarters, resulting in no known current issues regarding any budget or administrative matters. Grantee visits were performed on a quarterly basis and documentation of such visits were thorough and readily available on the internal CDC shared drive.

Major Challenges

CDC/Cambodia's cooperative agreement portfolio contained many different types of agreements. Some were DGHA managed, some were CDC Center for Global Health managed, and roughly 50% were DGHA Cambodia-specific cooperative agreements. Because of these different types of agreements, Project Officers did not always reside in-country for some cooperative agreements that CDC/Cambodia funds. CDC/Cambodia should to work with CDC headquarters to ensure they are clear on which documentation should be kept in the field. Given the small staff, the office experienced challenges finding a balance between documenting processes and executing the work. However, CDC/Cambodia improved significantly since CMAS I and created a cooperative agreement standard operating procedure. The electronic cooperative agreement files were created recently, but could benefit from better organization as certain post-award action documentation was not readily available. The new Project Officer or Deputy Director had not yet recertified a few courses that have expired, such as the International Project Officer training, Appropriations Law, and Contracting Officer's Representative I certification.

Recommendations

- Work with CDC headquarters to ensure clarity on which documentation is necessary to keep in the field for DGHA headquarters/Center for Global Health managed cooperative agreements. If documentation is not required to be kept in the field, files should be documented stating this.
- Finalize and implement the cooperative agreement management standard operating procedure and ensure it is followed.
- Implement an organized cooperative agreement file structure, by grantee and budget period, which clearly shows the chronological order of post-award actions.
- Require the new project officer or Deputy Director to re-take a few required courses that have expired like the International Project Officer training, Appropriations Law, and Contracting Officer's Representative I certification.

Accountability for Public Health Impact

Major Achievements

At the time of the CMAS II assessment, CDC/Cambodia demonstrated strong performance in strategic programming. CDC/Cambodia staff and national partners, including the MOH, exhibited a close working relationship ensuring strategic and joint planning along with effective communication. CDC/Cambodia additionally implemented strategies to ensure that Cambodian national partners are funded, which contributes to meeting national needs. Implementation of the site monitoring system, particularly in site and logistics evaluation, had additionally strengthened CDC's accountability efforts.

Significant technical engagement with national MOH colleagues and other key partners was also evident. Both CDC/Cambodia and implementing partners demonstrated knowledge of the monitoring process and value its role in the program, particularly in relation to PEFPAR reporting.

CMAS I documented that CDC/Cambodia effectively integrates with the national system to populate PEPFAR reporting data, where appropriate. This was also apparent within CMAS II. Additionally, CDC/Cambodia's adoption of the "Strengthening Laboratory Management toward Accreditation" approach was an internationally recognized best practice in building laboratory capacity and resulted in demonstrated achievements in laboratory skill and quality of testing. CDC/Cambodia continues to support this program, and some outcomes related to enhanced laboratory skills and improved testing quality were presented during the CMAS II visit.

Major Challenges

The HIV/AIDS epidemic in Cambodia is largely concentrated within key populations, primarily commercial sex workers, people who inject drugs, and men who have sex with men. It is not always apparent how CDC/Cambodia aligns its work with the needs of these key populations through its programmatic activities that provide technical assistance and contribute to health systems strengthening and capacity building.

Performing and using expenditure analysis, a CMAS II standard, proved to be challenging for technical assistance and capacity building programs such as CDC/Cambodia due to CDC funding that supports not only direct service provision, but also health systems strengthening.

CMAS I identified some challenges regarding assurances of data quality. While progress has been made, CDC/Cambodia needs to continue to document grantee data quality assurance processes. CMAS I and now CMAS II noted continued challenges with evaluating the impact of the provision of technical assistance and capacity building. This was also apparent for other CDC programs that predominantly provide technical assistance and capacity building in Cambodia. While process measures were often used to monitor CDC/Cambodia's programmatic activities, outcome measurement was less frequently achieved.

Recommendations

- Explore and define priorities with respect to key populations and CDC/Cambodia's contribution to meeting the needs of these groups.
- Examine how CDC/Cambodia can use expenditure analysis in a way that is relevant to its work in providing technical assistance and capacity building by working with CDC/DGHA headquarters' Health Economics Branch.
- Ensure that all grantees have data quality assurance plans or standard operating procedures to monitor data quality from the point of data capture to data release.
- Formalize a plan or process that details data quality assurance at three levels:
    - Facility level,
    - Aggregate grantee level, and
    - Aggregate CDC/Cambodia level – across all CDC/Cambodia grantees.

- Prioritize the inclusion of outcome measurement within all future funding opportunity announcements, cooperative agreement applications, and reporting.
- Align each cooperative agreement (and the overall CDC/Cambodia program) with potential outcomes.
- Prioritize the development of a high-level document that succinctly conveys the outcomes and accomplishments of the CDC/Cambodia program.
- Expand CDC/Cambodia and grantee capacity related to evaluation, since monitoring efforts appear to be strong.
- Ensure that an evaluation plan is developed that strategically articulates what key questions CDC/Cambodia wants to answer about its program.
- Develop evaluations to not only evaluate the effectiveness of programs but to also inform future investment strategies.
- Develop, disseminate and use evaluation findings.

Next Steps

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