Country Monitoring and Accountability System Visit to India – February 3-7, 2014
Summary of Key Findings and Recommendations

Introduction

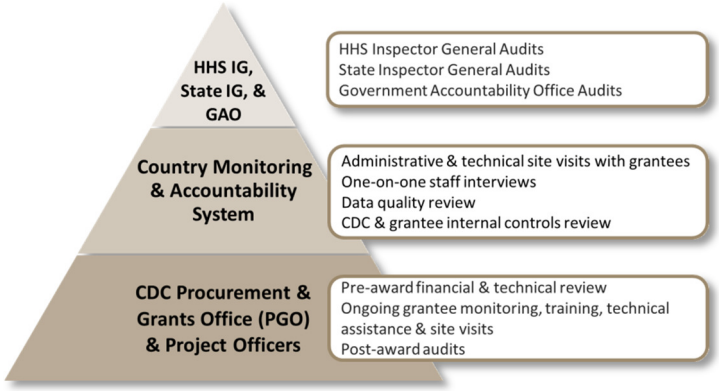
As the U.S. science-based public health and disease prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in implementing the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) under the direction of the Department of State's (DOS) Office of the U.S. Global 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 the CMAS II visit to India from February 3-7, 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 eight CDC subject matter experts in the following areas to perform the CMAS II assessment: financial management, program budget and extramural resources, grants management, country HIV program strategy, management and operations, and several key

technical program areas (e.g., epidemiology and strategic information).

The CMAS II team conducted a five-day visit to the CDC/DGHA office in New Delhi, India (CDC/India). In addition, team members visited the CDC/DGHA office and grantees in Hyderabad, India prior to the CMAS II visit.

CMAS II team members reviewed financial and administrative documents at CDC/India and grantee offices and conducted administrative and technical grantee site visits, one-on-one meetings with staff, and data quality spot checks. CDC headquarters Procurement and Grants Office provided grants management technical assistance to grantees following the CMAS II visit. 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/India operations.

Background on Country Program

CDC opened an office in India in 2001 to assist India's Department of AIDS Control. Today, CDC collaborates with the government of India, Indian institutions, and international organizations to address a wide range of infectious and non-communicable diseases, with a focus on India's leading causes of death and disability. CDC/India programs currently include the Division of Global HIV/AIDS, Global Disease Detection Branch, Global Immunization Division, and the National Center for Immunization and Respiratory Disease.

Summary of Key Findings and Recommendations

Accountability for Intramural Resources

Country Operations and Human Resource Management

Major Achievements

Based on a survey of all CDC/India staff, as well as one-on-one staff and stakeholder interviews, the CMAS II team found that CDC/India is task-oriented with clear guidance from leadership and that the organizational structure and internal communications facilitate work, information flow, and decision-making. The CMAS II team found that senior management interaction with staff is substantial and considered extremely valuable. These achievements are supported by strong administrative operations in all areas including the execution of inherently governmental functions, information technology, safety and security procedures, and maintenance of personnel records.

CDC/India staff rated job satisfaction highly, with an average rating of 4.46 out of 5. The staff noted that recognition from the U.S. Ambassador, CDC headquarters, and others is provided regularly, which boosts staff morale significantly. In terms of training and career development, 76% of CDC/India survey respondents agreed or strongly agreed that there is sufficient training available to improve their performance in their current job.

Major Challenges

Technical staff expressed a desire for additional professional development opportunities in order to connect with their counterparts at CDC headquarters and other country offices. This included a request for additional exposure to scientific writing and publication processes, which is a growing need. In addition, staff requested an orientation package on the CDC mission, structure, and programs to feel more connected to CDC headquarters as a whole.

In terms of administrative operations, the CMAS II team found that documentation of advance approval for compensatory time and overtime for CDC/India locally employed staff was not consistently available in time and attendance records. In addition, the team found that time and attendance for CDC/India U.S. direct hire staff is not approved in-country as required by CDC headquarters.

Recommendations

- Explore opportunities for technical training and professional development, including training in scientific writing and opportunities to share relevant publications.
- Ensure that requests for compensatory time or overtime for locally employed staff are submitted and approved in advance and that documentation is stored with time and attendance records.
- Ensure that required U.S. direct hire time and attendance training is complete and that time and attendance requests are approved in-country, as required by CDC headquarters.

Financial Resource Management

Major Achievements

CDC's Office of the Chief Financial Officer desk review primarily focused on post held funds and internal controls of financial activities for all programs within the CDC/India field office. In addition, CDC's Program Budget and Extramural Management Branch conducted a review of budget operations for CDC/India, finding that CDC/India meets nearly all CMAS II standards for budget operations.

CDC's Office of the Chief Financial Officer found locally employed budget and financial staff members are very knowledgeable of both DOS and CDC/India procedures. The office demonstrated commitment to ensuring adequate procedures are in place and sufficient documentation supports all financial transactions. CDC/India leadership was held responsible for ensuring that all transactions are consistent with applicable policies, authorities, and regulations and that they ensure staff remain aware of current legislation and protocol through appropriate trainings. The CMAS II review confirmed these findings and notes that the CDC/India team has positive working relationships with the U.S. Embassy Financial Management Office and CDC's Office of the Chief Financial Officer. Further, CDC/India financial management staff provide valuable support to other CDC PEPFAR countries.

At the time of the CMAS II visit, CDC's Office of the Chief Financial Officer found that CDC/India had sufficient

staff in place to ensure a segregation of duties and overall regulatory compliance. Additionally, the office had developed standard operating procedures for cooperative agreement management and established comprehensive policies which effectively guide the administrative operations and programmatic activities for the office. CDC/India successfully reduced the dollar amount of unliquidated obligations reported in the prior review by half. During the desk review for December 2012, CDC/India had numerous unliquidated obligations. The office reduced the number of unliquidated obligations since then. CDC/India no longer managed a petty cash fund nor had a designated sub-cashier, a change from the previous December 2012 desk review.

In addition, the CMAS II team documented that the country program has the ability to pull data from the U.S. Embassy and CDC financial reporting systems (COAST and IRIS). Status of funds reports were available for review dating back to fiscal year 2009, and standard operating procedures for budget operations were on the shared drive, which included instructions for cables (advice of allotment). The fiscal year 2014 budget was divided by object class based on inflation from the previous year's budget and was separated by object class with appropriate detail. CDC/India demonstrated Country Operational Plan reconciliation, tracking obligations for each cooperative agreement and reviewing the Payment Management System report monthly.

Major Challenges

CDC/India made a respectable effort in reducing unliquidated obligations with established procedures. Although post held unliquidated obligations proved to be well managed, they should be reviewed monthly at the beginning of the fiscal year to meet CMAS II standards.

Recommendations

- Continue to routinely review unliquidated obligations.
- Aggressively follow-up with U.S. Embassy Financial Management Office staff to ensure appropriate action to clear transactions in a timely manner.
- Review post held unliquidated obligations monthly during the entire year to meet CMAS II standards.

Accountability for Extramural Resources

Grantee Management

Major Achievements

CDC's Program Budget and Extramural Management Branch reviewed CDC/India's cooperative agreement management processes. Accomplishments in this area included: electronic standard operating procedures, cooperative agreement files that are available for all staff on the shared drive, secure storage of all proprietary information on a separate drive, and securely-stored hard copies of all documentation. Additional cooperative agreement accomplishments included completion of all required trainings by CDC/India Project Officers and a tracking system to monitor training compliance.

CDC/India held orientations for new grantees, which included the basic information in CDC's Procurement and Grants Office orientation presentation and described CDC/India's in-country internal and extramural operations.

Cooperative agreements were well-monitored through quarterly grantee meetings to discuss implementation and the budgetary pipeline. These meetings were documented by compiling meeting notes that were later stored in the program's cooperative agreement file and shared with CDC's Procurement and Grants Office. Restrictions and cooperative agreement award actions were tracked using a spreadsheet that was updated on at least a weekly basis.

Major Challenges

The CMAS II team noted a few minor challenges related to CDC/India cooperative agreement management. CDC/India did not currently track grantee audits and did not follow up with grantees on audit findings. In addition, the program did not have standard operating procedures for audit review and grantee financial and progress reporting.

Recommendations

- Track receipt and follow up of cooperative agreement grantee audits and their findings. The audit and all follow up documentation should be kept in the cooperative agreement file.
- Develop and implement standard operating procedures for audit review as well as financial and progress reports to ensure these reviews are done in a systematic and streamlined manner.
- Review audits and findings during at least one quarterly meeting each year with each grantee.

Grantee Compliance

Major Achievements

CDC's Procurement and Grants Office staff met with the cooperative agreement management staff, Project Officer, and five CDC/India grantees. Based on these meetings, CDC's Procurement and Grants Office found that CDC/India's grantees have a clear respect and positive working relationship with the DGHA Project Officer as well as in-country staff, and it was evident that CDC/India is providing substantial coordination and oversight for each project. All grantees expressed that both CDC/India and CDC's Procurement and Grants Office respond in a timely manner and communicate effectively. All grantees provided documentation and displayed their existing or potential capacity to effectively and adequately manage U.S. government funds.

Grantees expressed gratitude to CDC for its support and the CDC/India staff for its guidance and assistance. The Project Officer held quarterly meetings with all grantees and provided the meeting notes to CDC's Procurement and Grants Office to document the master files. The grantees welcomed this practice; it provided an avenue to identify any issues, concerns, or needs for technical assistance. Further, findings from CMAS I encouraged the incorporation of technical assistance into site visits to ensure that grantees are aware of and adhere to U.S. government regulations. Since then, CDC/India successfully implemented this system. As a result, CDC/India staff demonstrated familiarity with recipient issues, problems, and pending actions.

Major Challenges

Because most CDC/India grantees had headquarters that are based in the United States, CDC's Procurement and Grants Office CMAS II participant was only able to assess portions of the in-country CMAS II questionnaire. These grantees committed to submitting the remaining documents electronically to the Grants Management Specialist, but an evaluation of this documentation was not available at the time of this report.

Based on the in-country review, grantees with U.S.-based headquarters did not have official hard copies of required manuals and standard operating procedures, but were able to access these documents electronically. Similarly, some grantees did not have in-country standard operating procedures in place related to use of the Payment Management System, eRA Commons (Annual Federal Financial Report), Grants.gov, and SAM.gov (System for Award Management), as the responsibility for these processes was held by their U.S. headquarters offices.

Recommendations

- Ensure that grantees with U.S.-based headquarters offices submit requested documentation for review and that they can identify their headquarters liaison responsible for managing the federal electronic systems that are involved in managing a cooperative agreement.
- Recommend that grantees document best practices and success stories regarding management, administration, and implementation of CDC-funded projects.

Accountability for Public Health Impact

Major Achievements

CMAS I noted successful 10-year collaborations with the Department of AIDS Control and State AIDS Control Societies in India. CDC/India continued to demonstrate its ability to deliver high quality technical assistance in key areas of HIV/AIDS interventions with full host country ownership and implementation. CDC/India's technical contributions are highly-valued and respected by the government of India and other grantees. The CDC/India technical program was increasingly focused on the strategic priorities mutually agreed upon with the Department of AIDS Control and closely aligned to the National AIDS Control Program IV (2012-2017). CMAS I documented the development of a national quality assurance system for national and state HIV/AIDS reference laboratories in collaboration with the Department of AIDS Control. This program continued to be a significant achievement of CDC/India by promoting quality assurance in laboratory systems across India.

In addition, the CDC/India team has provided support the Department of AIDS Control to undertake critical assessments of the national antiretroviral treatment program, as well as HIV epidemiology in key populations through an integrated behavioral and biological surveillance survey. CDC headquarters technical assistance initiatives were recently launched to improve blood safety, and CDC headquarters staff provided technical support to India's expansion of its prevention of mother-to-child transmission (termed prevention of parent-to-child transmission) program, Option B+ (treating all pregnant women with antiretrovirals for the duration of their life, regardless of their CD4 count).

Major Challenges

CDC/India remained focused on providing technical assistance to the Department of AIDS Control in core areas including lab, strategic information, and health systems strengthening. One of the major challenges found was the lack of appropriate indicators to track CDC/India's contributions to India's response to its HIV/AIDS epidemic. Much of CDC/India's contributions have been in strategic information, lab, and health systems strengthening—all above the service provision site level. There was a lack of agreed upon, standard, and meaningful indicators that can be routinely tracked and reported to CDC headquarters to monitor CDC/India's contributions to the Government of India's response to its HIV/AIDS epidemic. The lack of a monitoring and evaluation plan for National AIDS Control Program IV and a PEPFAR/India monitoring and evaluation framework (which would be informed by the National AIDS Control Program IV monitoring and evaluation plan) also proved challenging since they would map out associated measures and targets at all levels (impact, outcome, output), and the routine data from these measures would provide the basis for accountability and informed decision-making at program and policy levels.

Recommendations

- Consult CDC headquarters for assistance with funding opportunity announcement design strategies.
- Continue to provide high quality technical assistance to the Department of AIDS Control to strengthen data analysis and use, with particular emphasis on:
    - Service coverage among high risk groups (by group and location),
    - Quality of services along the continuum of care, and;
    - Clinical cascades to determine overall patient outcomes (including antiretroviral coverage among HIV positive pregnant women, retention of antiretroviral treatment patients in care, and percent of people living with HIV with viral suppression, etc.).
- Map partner activities to illustrate how grantees strategically complement one another and support each other and the National AIDS Control Program IV priorities.
- Finalize and implement the monitoring and evaluation framework drafted in 2013 to strengthen tracking of outputs and linkage to program outcomes. This will help to operationalize the monitoring and evaluation plan previously developed with the PEPFAR strategy and can inform upcoming National AIDS Control Program IV monitoring and evaluation plan discussions.
- Consider sharing quality measures from the PEPFAR monitoring, evaluation, and reporting guidance with the Department of AIDS Control. This will further inform the National AIDS Control Program IV monitoring and evaluation plan.

<u>Center for Global Health and Division of Global Health Protection</u>

CDC's Center for Global Health also joined the CMAS II visit. The Center for Global Health provides leadership and implementation guidance for several cross-cutting CDC program and policy initiatives, and it participated in the CMAS II visit to: assess the level to which all CDC programs are integrated in-country; obtain information on

Center for Global Health-managed initiatives to contribute to transparency, accountability, and adherence to U.S. Department of Health and Human Services and Department of State regulations; acquire information on policy initiatives or best practices affecting the country office; and work with CDC and U.S. Embassy staff to provide technical assistance and guidance on operations and financial management.

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

Major Achievements

CDC's Center for Global Health and the Division of Global Health Protection met with various stakeholders in-country, including programmatic briefings on Division of Global Health Protection activities in India and meetings with several key health leaders from across the government of India. Major achievements noted by these participants include progress on discussions of 1) the process for co-location notification for CDC/India staff working in space outside of the U.S. Embassy, 2) the development of the National Centre for Disease Control campus in India, and 3) the documentation of fruitful partnerships with key stakeholders to advance the goals and objectives of global disease detection, global health security, and capacity building through support of the India Epidemic Intelligence Service Program. In addition, these representatives noted forthcoming efforts to share programmatic updates across CDC/India, including a planned monthly meeting (similar to "Grand Rounds") to present technical activities.

Major Challenges

Because of the physical separation of CDC/India program offices, the CMAS II team documented challenges associated with a "one CDC" governance approach and structure in-country, particularly related to cross-program information sharing, cost-sharing, and local transportation. In addition, as efforts were underway to fill a vacant Resident Advisor for Tuberculosis position at CDC/India, the CMAS II team noted a need to clarify the position description and align it with the goals and objectives of existing programs in-country.

Recommendations

- Follow up on the co-location notification process for the Division of Global Health Protection programs through coordination with the International Project Team, Regional Security Officer, and other appropriate U.S. Embassy staff.
- Continue efforts to ensure that CDC/India operates as "one CDC" working collaboratively across programs.
- Continue discussions with relevant stakeholders about the status of the vacant Resident Advisor for Tuberculosis position.

Next Steps

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