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USAID
ASSIST PROJECT
*Applying Science to Strengthen
and Improve Systems*

USAID ASSIST Project

India Country Report FY15

Cooperative Agreement Number:

AID-OAA-A-12-00101

Performance Period:

October 1, 2014 – September 30, 2015

DECEMBER 2015

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DISCLAIMER

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For more information on the work of the USAID ASSIST Project, please visit www.usaidassist.org or write assist-info@urc-chs.com.

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Abbreviations

ANC	Antenatal care
ASSIST	USAID Applying Science to Strengthen and Improve Systems Project
ASHA	Accredited Social Health Activists
BP	Blood pressure
ENBC	Essential newborn care
Hb	Hemoglobin
HP	Himachal Pradesh
IAP	Indian Academy of Pediatrics
ICU	Intensive care unit
LB	Live births
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organization
NICU	Neonatal intensive care unit
QI	Quality improvement
RMNCH+A	Reproductive, Maternal, Newborn, Child and Adolescent Health
URC	University Research Co., LLC
USAID	United States Agency for International Development

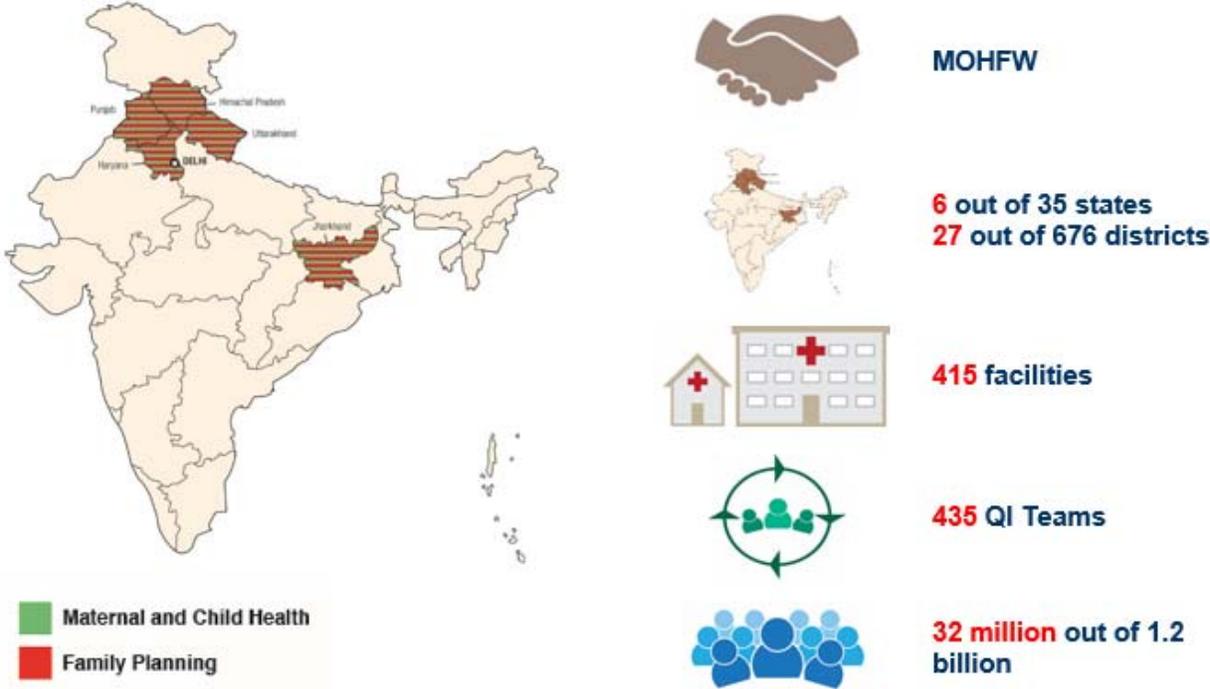
1 Introduction

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project started working in India in August 2013. The project is working in the six USAID-supported states to build improvement capability by enhancing the commitment and capability of leaders at the national, state, and district levels to lead health care improvement. In addition, the project is working to develop the capacity of health care workers to conduct improvement at national, state, district, and community levels, in public and private facilities, and along the continuum of reproductive health, maternal, neonatal, child, and adolescent health (RMNCH+A).

Twenty-five (25) out of 27 districts have requested support for scaling up improvement activities, while five districts have started using their own resources to scale up improvement support to 159 facilities. ASSIST is providing technical assistance as they build their capacities to do this independently.

In addition, ASSIST was approached by the All India Institute of Medical Sciences (AIIMS)—the largest medical college in India—to help them set up a system to support quality improvement (QI) in their institution as well as from the Indian Academy of Paediatrics (IAP) to teach them about QI. ASSIST has also been asked by USAID to teach a local non-governmental organization (NGO) – IPE Global – how to continue the QI work started under ASSIST after we close in December 2015.

Scale of USAID ASSIST’s Work in India



2 Program Overview

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Cross-cutting Activity
1. Enhance improvement capability in the Indian	<ul style="list-style-type: none"> Improve care along the R-MNCH+A continuum in priority USAID districts 	6 USAID-supported states, all 27 of the USAID-supported districts, and one “block” in each of the selected districts:	X	

Activities	What are we trying to accomplish?	At what scale?	Improvement Activity	Cross-cutting Activity
health system through conducting improvements in the “RMNCH+A” continuum in public and private entities	<ul style="list-style-type: none"> Develop the capacity to conduct improvement among health care workers at community, facility, district, state and national levels Enhance commitment and capability of leaders at the community, facility, district, state and national levels to lead health care improvement 	<ul style="list-style-type: none"> Delhi: 2 districts, 2 blocks Himachal Pradesh (HP): 4 districts, 6 blocks Punjab: 5 districts, 5 blocks Uttarakhand: 3 districts, 3 blocks Jharkhand: 6 districts, 10 blocks Haryana: 7 districts, 7 blocks Total number of facilities: 435		

= Improvement Activity

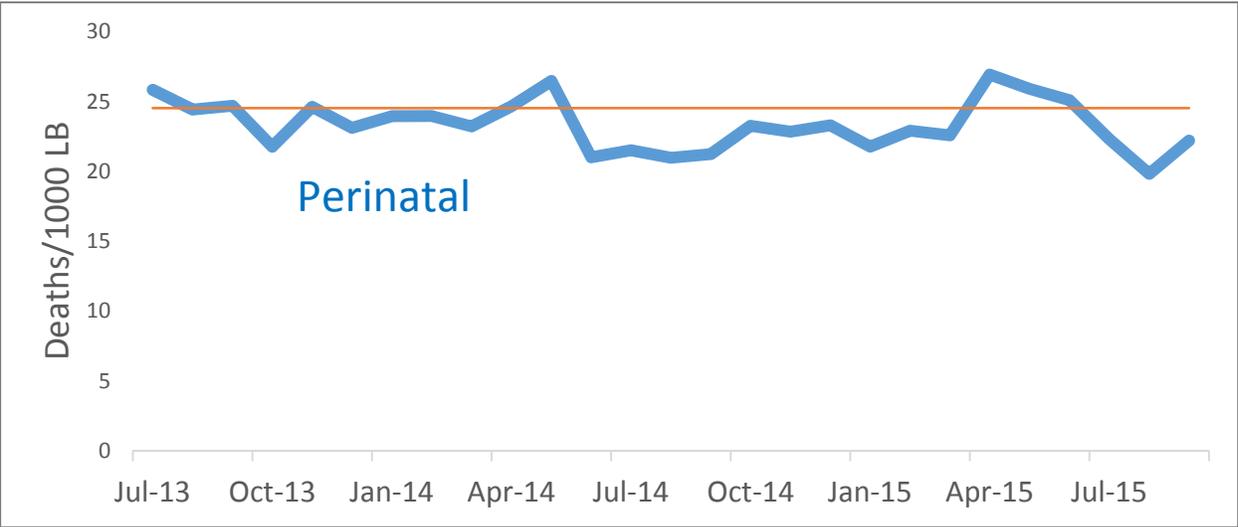
3 Key Activities, Accomplishments, and Results

Activity 1. Enhance improvement capability in the Indian health system

ACCOMPLISHMENTS AND RESULTS

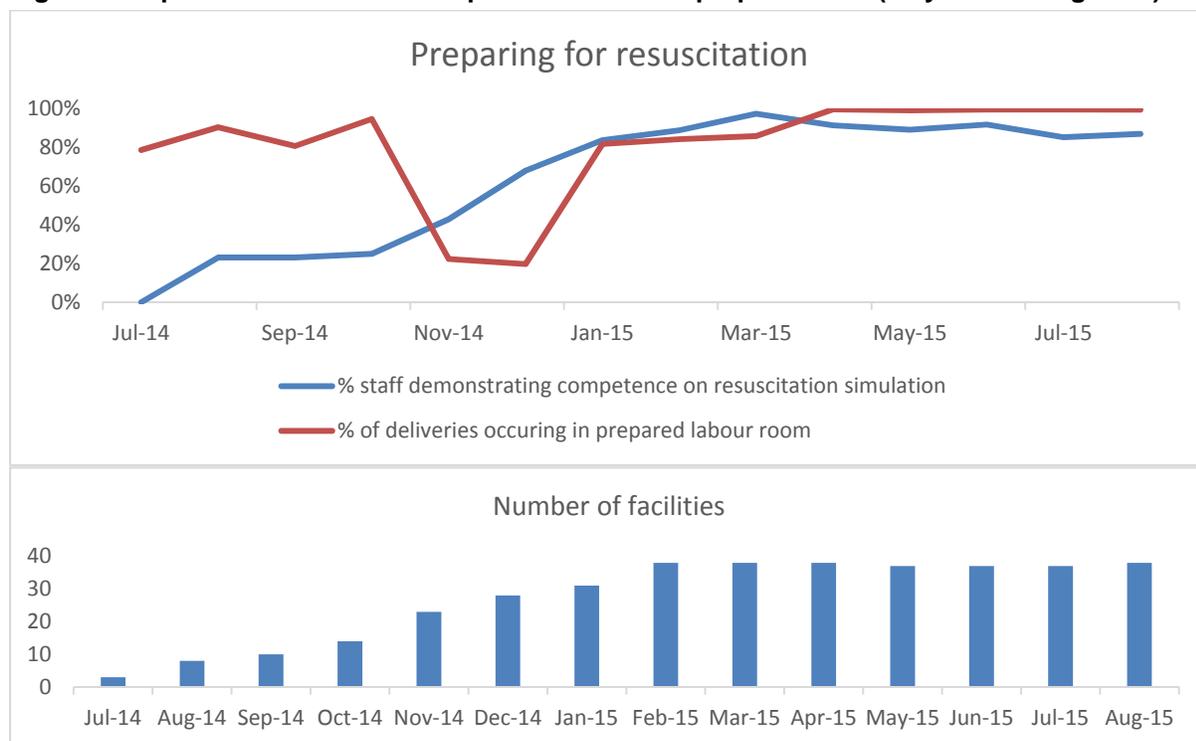
- Overall, perinatal mortality has decreased by 5.1% in the intervention period compared to the six-month baseline period before we started the project (Figure 1). This is due to a 13.7% reduction in neonatal mortality and a 2.7% reduction in stillbirths. This is the equivalent of 17 deaths being prevented each month. Figure 1 shows that there was an increase in perinatal mortality over the baseline median from April to June 2015. We believe that this was partially due to an ambulance strike in one state. It is also possible that there is some seasonal variation in stillbirths and neonatal mortality, which has been reported previously in other countries. We are continuing to analyze these data to better understand the variation.

Figure 1: Changes in perinatal mortality in approximately 15,000 deliveries per month in approximately 120 facilities in six states (stillbirths and in-hospital neonatal deaths per 1000 births) (July 2013 – Sept 2015)



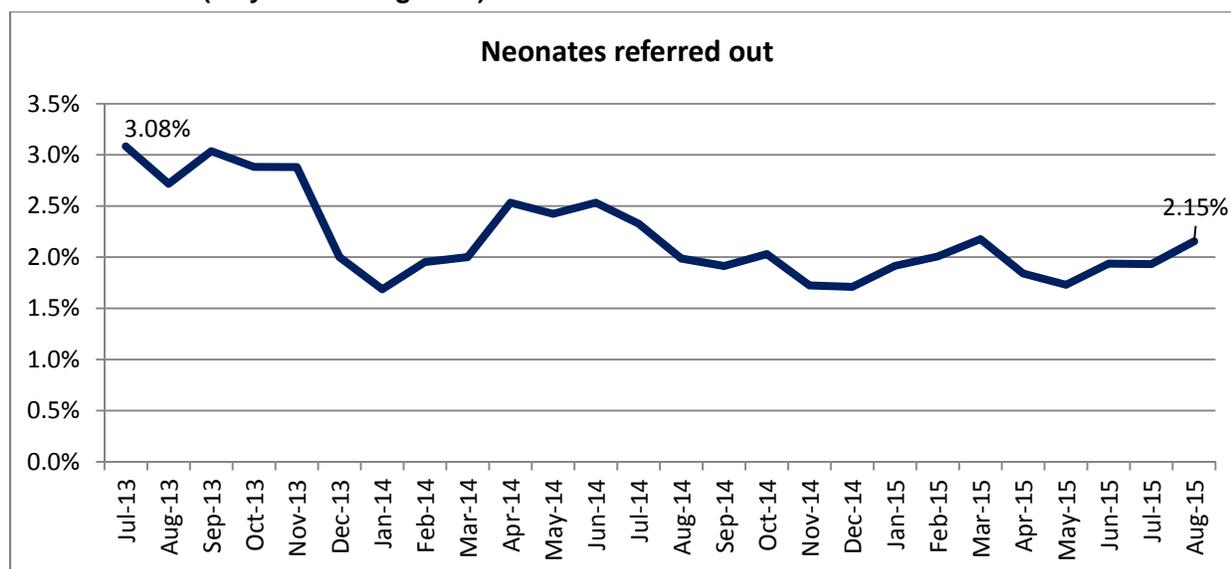
- The reduction in perinatal mortality was related to improvements in both maternal and neonatal care. Resuscitation was part of a priority focus area. Facility improvement teams focused on ensuring that their staff had the clinical skills to resuscitate asphyxiated babies and that they were preparing the required equipment ahead of time (**Figure 2**).

Figure 2: Improvements in staff competence and birth preparedness (July 2014 – Aug 2015)



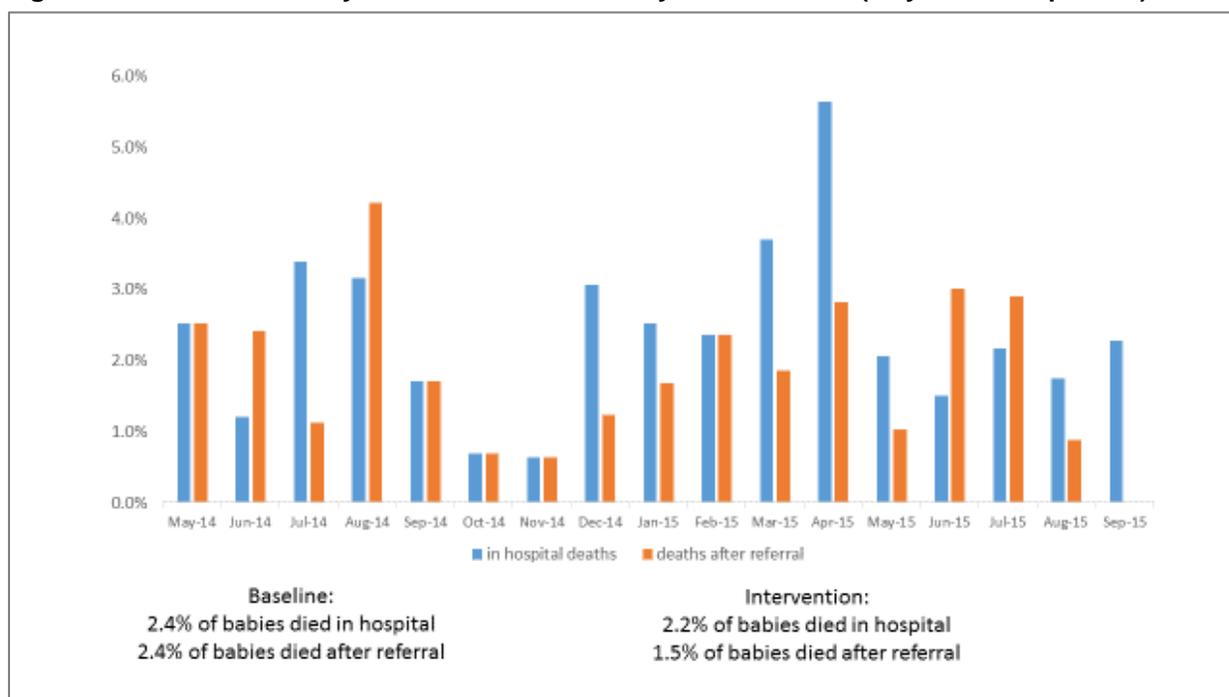
- In addition to fewer deaths in ASSIST-supported facilities compared to baseline, these facilities are also referring out fewer sick neonates (**Figure 3**). Anecdotally, this is due to staff in these facilities being better able to manage complications.

Figure 3: Sick neonates being referred out from all 150 ASSIST-supported facilities delivering babies in India (July 2013 – Aug 2015)



- ASSIST support is leading to improved survival:** In addition to a reduction in perinatal mortality across all ASSIST-supported facilities, we have compelling evidence from individual facilities that ASSIST support has contributed to improved perinatal survival. For example, in Jama Community Health Center in Jharkhand, since the team started working on better identification of danger signs during labor and on improving neonatal resuscitation, they have seen a 24% reduction in perinatal mortality from May 2014 to September 2015. Mortality has decreased from 2.4% for babies who died in the hospital or after referral before the improvement work, to 2.2% of babies who died in the hospital and 1.5% after referral after the improvement work. The bulk of this improvement is due to the facility staff better managing prolonged labor and asphyxia (**Figure 4**).

Figure 4: Perinatal mortality rate at Jama Community Health Center (May 2014 – Sept 2015)



IMPROVEMENT IN KEY INDICATORS

Indicators	Baseline (Dec 2013), approx 100 sites	Aug 2015, approx 150 sites	Magnitude of change
Proportion of newborns who were assisted for breathing out of total newborns reviewed*	17%*	2%	-15
Proportion of newborns made dry and provided warmth immediately after birth out of total newborns observed	47%	100%	53
Proportion of newborns who were provided sterile cutting and clamping of cord out of total newborns reviewed	47%	100%	53
Proportion of newborns breastfed within one hour of birth	87%	88%	1
Proportion of newborns given injection of vitamin K at birth	55%	98%	43
Proportion of vaginal deliveries for which oxytocin was administered within one minute of birth of baby	16%	99%	83
Average number of times vitals (both blood pressure and pulse) checked and recorded within first 6 hours post-partum	0.8	3.4	2.6

Indicators	Baseline (Dec 2013), approx 100 sites	Aug 2015, approx 150 sites	Magnitude of change
Proportion of antenatal care (ANC) visits during which hemoglobin of pregnant woman was checked and documented	59%	88%	29

**Data quality issues related to indicator definition at start of project. Some facilities were recording proportion 'assessed' rather than proportion 'assisted' for breathing*

SPREAD OF IMPROVEMENT

Twenty-five (25) out of 27 districts have requested support for scaling up improvement activities, while five districts have started using their own resources to scale up improvement support to 159 facilities. ASSIST is providing technical assistance as they build their capacities to do this independently.

- **Based on the improvements in processes and outcomes and feedback from staff at the facilities supported by USAID ASSIST staff, all districts in which we work have requested support from us to develop strategies to scale up improvement work through their own systems.** Five districts have already started providing support to 159 facilities using their own staff as coaches and supervisors instead of ASSIST staff.
- **Illustrative examples of progress in 38 facilities in Chamba District in improving ANC and intrapartum care and in 90 clinics in Jharkhand in improving institutional delivery rates are shown in Figures 5-6.**

Figure 5: Improvements in ANC and intrapartum process measures in 38 facilities supported by government coaches in Chamba District, Himachal Pradesh (June 2014 – Aug 2015)

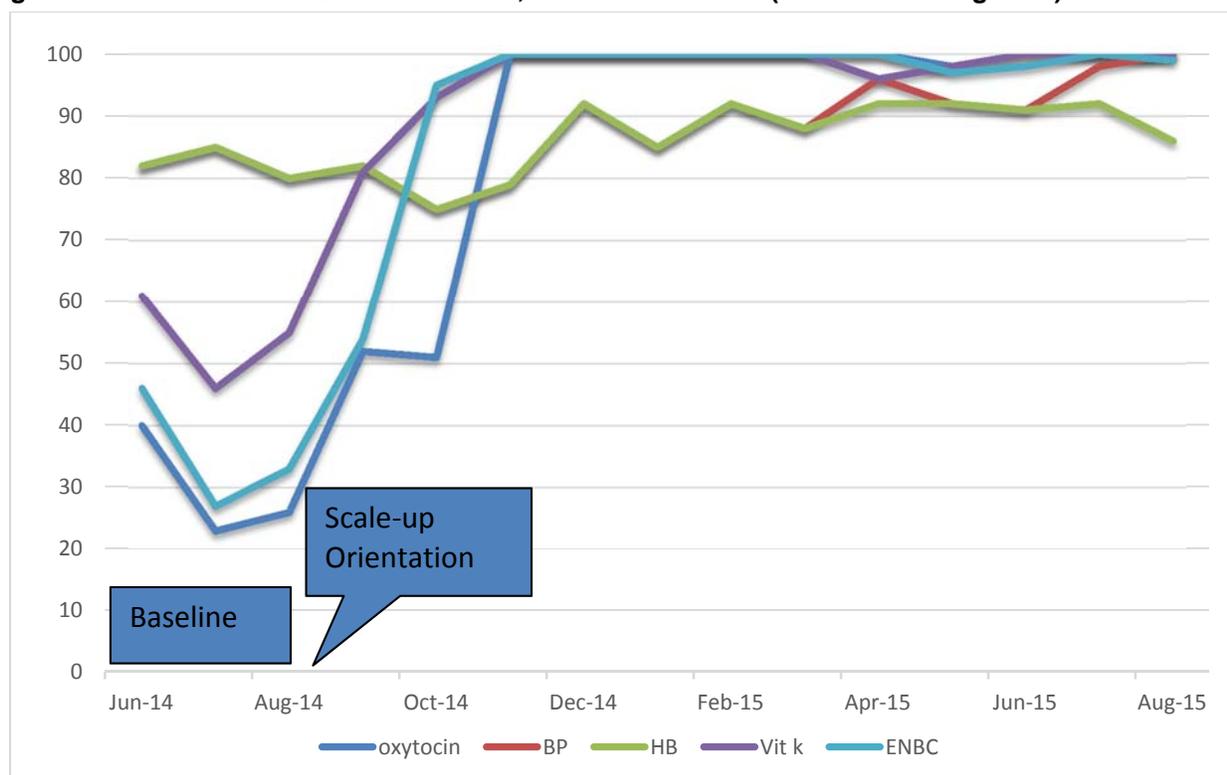
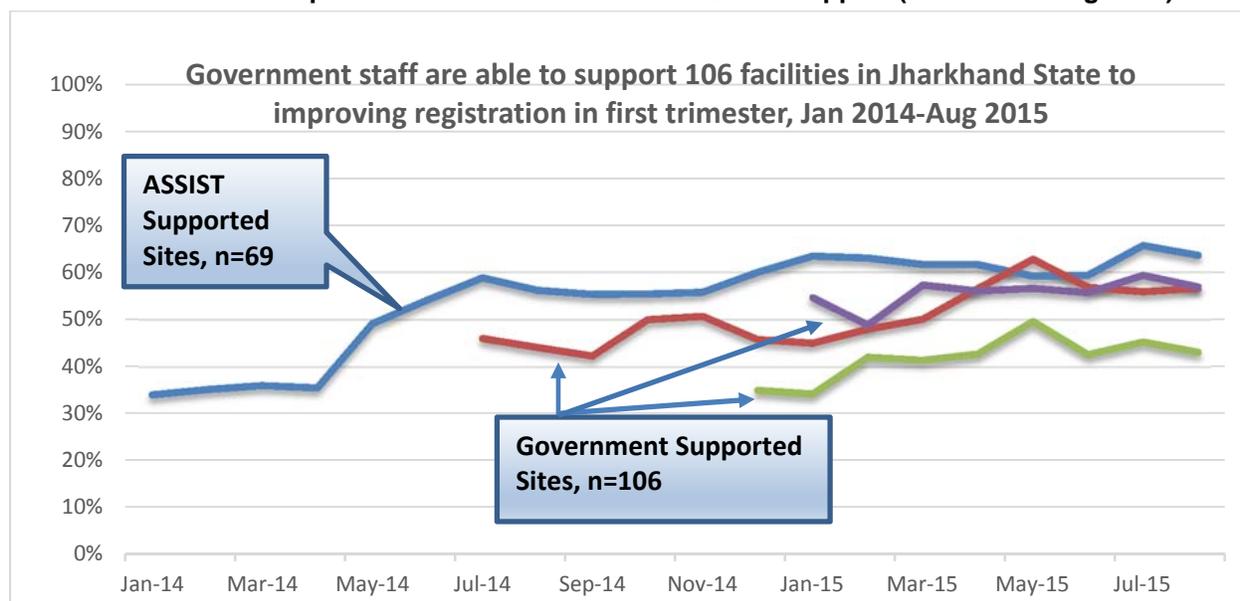


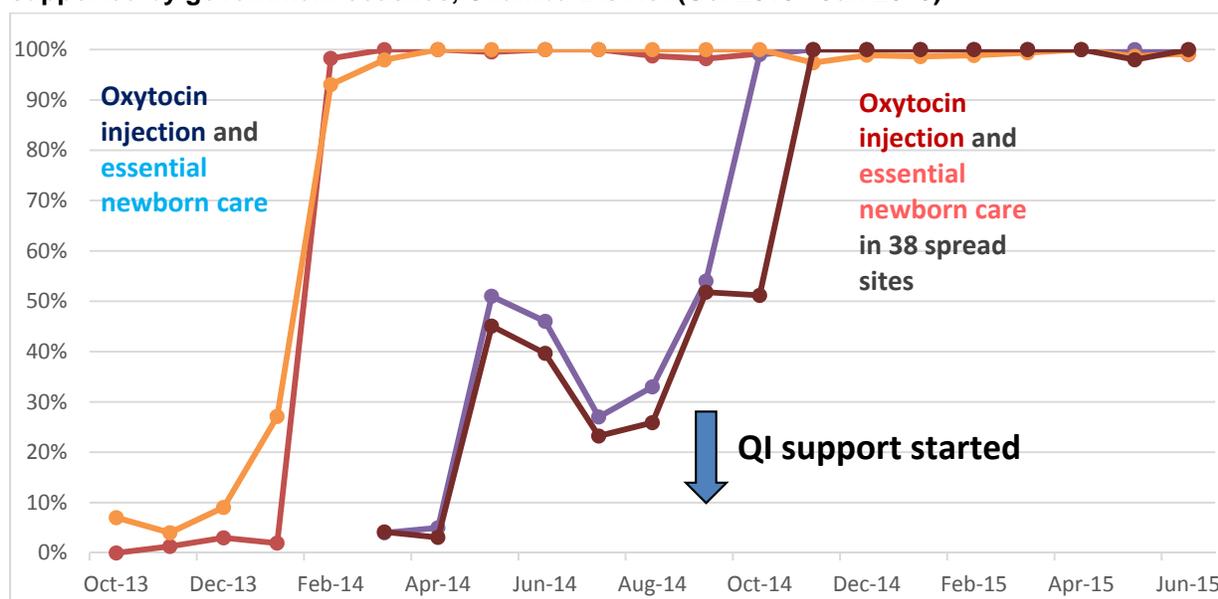
Figure 6: Improvements in early ANC registration in 106 clinics supported by government coaches in Jharkhand State compared to 69 clinics with direct ASSIST support (Jan 2014 – Aug 2015)



The pattern of the improvement is also of interest. For example in Chamba, ASSIST support started in December 2013. In May 2014, the district government saw the results and wanted to scale up the improvement work. During June to September 2014, ASSIST helped them plan to scale up. During this time the sites that the government was going to scale up to were trained on intrapartum and neonatal care and asked to submit monthly data on process indicators [percentage of women receiving oxytocin within the first minute of delivery and percentage of babies receiving essential newborn care (ENBC)]. Training and increased monitoring led to moderate non-sustained improvement but it was only when teams started using QI methods that they were able to get good, sustained results. In the words of one of the nurses at one of the scale-up facilities: *“On instructions of our Senior Medical Officer, we started giving oxytocin to mothers after delivery and vitamin K to newborns. There was a lot of improvement but for some reason, we were unable achieve the high levels of results as in the QI facilities. The Senior Medical Officer was keen to get the ASSIST Project working with us.”*

- This pattern is reflected in data from the 38 scale-up sites, which showed non-sustained moderate improvement after the facility staff were trained and had increased monitoring, but only when QI was introduced did they get significant improvement (**Figure 7**).

Figure 7: Improvements in intrapartum care in 5 clinics supported by ASSIST and 38 clinics supported by government coaches, Chamba District (Oct 2013 - Jun 2015)



4 Sustainability and Institutionalization

As mentioned above, through ASSIST, the majority of the districts we worked in requested support for scaling up improvement activities, and some have used their own resources to do so. In addition:

- **ASSIST has also been asked by USAID to teach a local organization, IPE Global, to advise them on how to continue the QI work started under ASSIST after we close in December 2015.**
- **ASSIST is providing additional support to the Himachal Pradesh government who want to scale up improvement work to all districts in the state and to make quality improvement a key component of their strategy to deliver better care.** We have advised them on developing a three-pronged strategy for improvement work:
 - 1) Health care improvement should be led from the top. Leaders need to provide strategic direction, support execution, and build system capacity to understand and manage improvement activities.
 - a. To build the capacity of leaders at the state level, the state has formed a QI resource team composed of senior staff in the Ministry of Health (MOH) as well as senior doctors from the medical colleges in the state. They will be undertaking a self-directed, two-year plan to learn about team-based QI and how to design and implement QI programs. ASSIST is helping them to develop the plan.
 - b. To build capacity on improvement throughout the system, the state has also recruited a Quality Consultant in each district who will serve as a resource for the district to train and support line managers and front line workers in quality improvement.
 - 2) Front-line health workers should be trained and supported to use quality improvement methods to fix problems at their level.
 - a. ASSIST is supporting Himachal Pradesh to develop plans to train staff in facilities across the state. The approaches will differ between districts where ASSIST has been working and new districts. The approaches are in the process of being developed.
 - 3) Support for front line health workers to run quality improvement projects should be integrated into existing line management systems.
 - a. Coaches for improvement projects will be existing supervisors of facilities.

- b. In addition to supporting teams to learn and manage quality improvement projects, line managers will also be responsible for helping teams fix problems that are not fixable at their level.
- **During the last quarter of this fiscal year, ASSIST received a request from the All India Institute of Medical Sciences—the largest medical college in India—to help them set up a system to support quality improvement in their institution as well as from the Indian Academy of Pediatrics to teach them about QI.** AIIMS has been the best-ranked hospital in India for 11 of the past 12 years and provides care to 3.5 million patient visits per year. It is also the leading academic and training facility in the country. After seeing some of our work, they invited us to come and present to their faculty and residents. After the presentation, they asked us to come back and help train teams from different departments that were interested in undertaking quality improvement projects. We met with Dr. Ashok Deorari, a Professor of Neonatology who spearheaded this initiative, three times over a period of two weeks to develop a training and implementation plan.
 - On August 22, 2015, ASSIST staff, an Institute of Healthcare Improvement consultant, and AIIMS staff led a two-hour session on the basics of improvement to staff from ophthalmology, obstetrics, paediatrics, the trauma intensive care unit (ICU), the emergency department, and the administration. We went over seven steps of improvement: 1. Pick an aim; 2. Form a team; 3. Develop some simple measures; 4. Analyze why you are not getting the results you want; 5. Develop some possible solutions; 6. Test these solutions on a small scale; and 7. Implement the solutions that work. We focused on helping them pick initial aims, think about who needs to be on the team, and come up with some outcome and process measures. After 10 days, we met again. All teams had started work, and some had initial results. For example, the ophthalmology team had reduced waiting time for their pediatric retinal surgery service by 40%. We reviewed their work and discussed how to analyze systems and develop change ideas. Twenty (20) days later we met again. All teams had made progress, and a seventh team also came along (see **Table 1** for results of improvement work by the department). Staff from the neonatal intensive care unit (NICU) had heard about this initiative and had started their own improvement project to increase the proportion of babies in the NICU who were exclusively breast fed. We are continuing to work with AIIMS to help them plan how to set up an effective and sustainable quality management program throughout the institution.

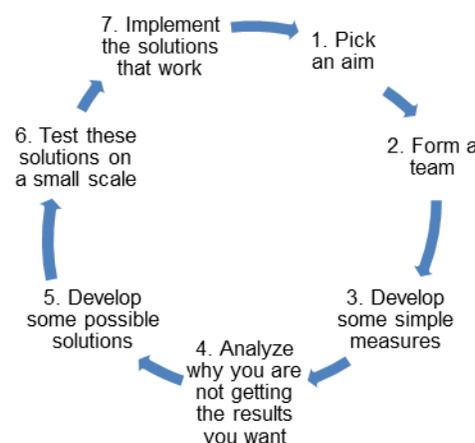


Table 1: Results of improvement work, by department, All India Institute of Medical Sciences (Sept 2015)

Department	Results at 30 days after initiation
Ophthalmology	87% reduction in waiting time to enter pediatric retinal surgery operating theater
Obstetrics	Percentage of babies born to low-risk women receiving immediate skin-to-skin care increased from 0 to 100%
Paediatrics	50% reduction in time to administer first fluid bolus to children coming to the emergency department in shock
Trauma ICU	Increase in compliance with hand hygiene from 30% to 80%
Emergency department	Increase in the percentage of patients being triaged correctly from 59% to 76% (around 800 patients come to emergency department each day)
Administration	Improved toilet hygiene protocol implemented in one ward
NICU	Percentage of babies exclusively breast fed at 5 days increased from 5 to 60%

5 Knowledge Management Products and Activities

The following are knowledge management products developed by the ASSIST India team during FY15:

Published seven case studies:

- Increasing institutional deliveries through improving community-facility linkages in Mewat, Haryana State, India (Sept 2015) <https://www.usaidassist.org/resources/increasing-institutional-deliveries-through-improving-community-facility-linkages-mewat>
- Increasing facility efficiency by improving triage of antenatal care of pregnant women in FRU Charkhi Dadri, Bhiwani District, Haryana, India (Aug 2015) <https://www.usaidassist.org/resources/increasing-facility-efficiency-improving-triage-antenatal-care-pregnant-women-fru-charkhi>
- Scaling up quality improvement to reduce maternal and child mortality in Lohardaga District, Jharkhand, India (June 2015) <https://www.usaidassist.org/resources/scaling-quality-improvement-reduce-maternal-and-child-mortality-lohardaga-district>
- Improving communication between nursing shifts to improve care in Hisar District Hospital, Haryana, India (December 2014) <https://www.usaidassist.org/resources/improving-communication-between-nursing-shifts-improve-care-hisar-district-hospital>
- Improving assessment and monitoring of women in labour at District Women's Hospital, Pauri, Uttarakhand, India (December 2014) <https://www.usaidassist.org/resources/improving-assessment-and-monitoring-women-labour-district-women's-hospital-pauri>
- Reducing post-partum haemorrhage in Ghuman Community Health Centre, Punjab, India (November 2014) <https://www.usaidassist.org/resources/reducing-post-partum-haemorrhage-ghuman-community-health-centre-punjab-india>
- Improving labour and postpartum care at Budhlada Sub-divisional Hospital in Mansa District, Punjab, India (October 2014) <https://www.usaidassist.org/resources/improving-labour-and-postpartum-care-budhlada-sub-divisional-hospital-mansa-district-0>

Developed country- and state-wide change idea documents (Quarters 3 and 4). The change ideas shared in a series of nine documents represent a compilation of ideas that showed success in changing important processes to achieve improvement in maternal and newborn services. These change ideas were successfully implemented in a select group of facilities in 27 high-priority districts in six states where the USAID ASSIST Project was providing technical support to the state governments in improving quality of maternal and newborn health services. The change ideas shared are aligned with the Government of India's guidelines for maternal and newborn care.

- Changes that improved maternal and neonatal health in six states of India (Aug 2015) <https://www.usaidassist.org/resources/changes-improved-maternal-and-neonatal-health-six-states-india>
- Changes that improved newborn health services in India (Aug 2015) <https://www.usaidassist.org/resources/changes-improved-newborn-health-services-india>
- Changes that improved maternal health services during postnatal period in India (Aug 2015) <https://www.usaidassist.org/resources/changes-improved-maternal-health-services-during-postnatal-period-india>
- Changes that improved maternal health services during intranatal period in India (Aug 2015) <https://www.usaidassist.org/resources/changes-improved-maternal-health-services-during-intranatal-period-india>
- Changes that improved maternal health services during antenatal period in India (Aug 2015) <https://www.usaidassist.org/resources/changes-improved-maternal-health-services-during-antenatal-period-india>

6 Research and Evaluation Activities

- The following research studies were conducted in India during FY15:
 - Field test of indicators to assess and improve their performance
 - Field test of change packages to assess their performance in a real-world setting
 - Qualitative study on "Examination of Accredited Social Health Activists (ASHA) workers' ability to perform services through an empowerment perspective"

- Study on “Validation of patient data in maternal and child health in six states in India”
- Study to investigate whether QI practices improve data quality
- Does quality improvement initiatives lead to improved work-culture? A qualitative study of six government health facilities in India

One paper from the study on ***Validation of patient data in maternal and child health in six states in India*** is currently under review. Three papers from the qualitative study among ASHAs are in the process of being submitted. Reports from the qualitative study on QI work culture and the field test of the change packages are currently being processed for publication by the ASSIST headquarters team.

RESEARCH STUDY SUMMARIES

Summary of study: “Validation of patient data in maternal and child health in six states in India”

For this study, external assessors visited 12 facilities (one district hospital and one community health center in six states). Twelve (12) trained researchers having medical qualifications observed 461 deliveries and reviewed the facilities’ self-reported data as well as data from individual patient records. We also analyzed the data to identify predictors of care quality and data quality.

The study found that self-reported data from facilities is significantly different from data gathered by external observers and overestimates actual care provided to clients. This is especially true in the case of data required by the government (early breastfeeding). Discrepancies between observed care and self-reported data were smaller than discrepancies between observed care and what was recorded in medical records. Despite the significant difference between self-reported and observed data, from a management point of view the differences are unlikely to change how an improvement team would function. We believe that the reason for the large discrepancy in the breastfeeding data is due to the fact that sites reporting poor breastfeeding data are scolded so the system has in-built incentives which negatively affect data quality. We plan to redo this survey in the future to see if the continuing QI support has any effect on data quality.

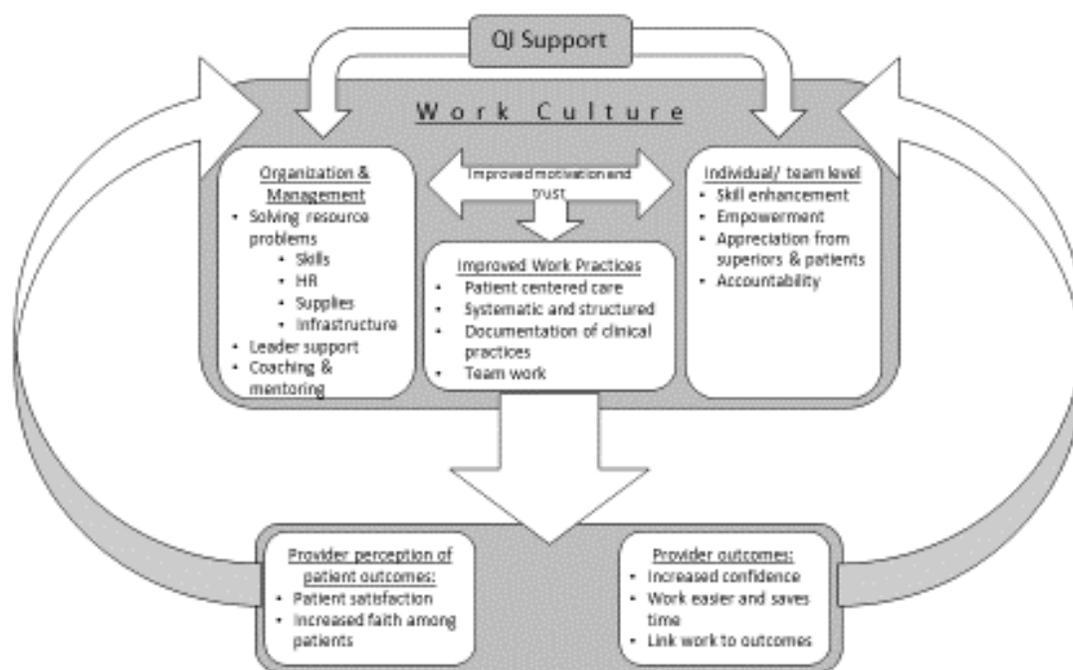
After controlling for all factors thought to influence care practices and data quality, actively working on an improvement aim is associated with better breastfeeding practice and postpartum vitals check in the first half hour. It is also associated with better reporting of practices like dry and wrap and cord care, which is generally unreported in health facilities. The effect of other variables on quality of care and quality of data are mixed. Level of facility, cadre and staff, years of experience, and time of day are all associated with better quality on some indicators and worse quality on others.

Summary of study: “Does quality improvement initiatives lead to improved work-culture? A qualitative study of six government health facilities in India”

While research into QI outcomes and factors affecting success of QI are widely available, none has comprehensively and qualitatively looked into what actually changes in work culture after QI implementation. A qualitative study was therefore conducted from December 20, 2014 to January 10, 2015, among 18 health care staff and six district coaches from ASSIST-supported facilities in order to understand: 1) perception of staff about QI; 2) changes in work practices as a result of QI; and 3) factors influencing these changes. In-depth interviews were conducted and data were analyzed through a grounded theory method. It was found that key changes in work practice after QI implementation included more patient-centered care, more structured and systematic way of working, teamwork, and accurate documentation of clinical practices. Factors that enabled these changes included leader support in solving problems of resources and supplies, mentorship, skill enhancement through peer learning, and sense of empowerment facilitated by non-punitive behavior of leaders. The staff perceived these changes in a positive light, reporting that work has now become easier, time saving, routinized, and systematic while they reported being more confident and motivated due to increased faith among patients.

The model in **Figure 8** describes the changes in workplace culture that occurs as a result of factors operating at the organization and individual level affected by QI support. These changes are hypothesized to lead to positive patient and provider outcomes that feed back into the work environment to sustain the organization and individual efforts through enhanced motivation. The model requires further testing to validate the pathways. The study findings also led to practical recommendations to strengthen the QI program. Currently, a scale on “attitude toward work” among health care staff is being developed for further validation. In the future, this scale can be part of the tools to compare QI intervention sites with control sites.

Figure 8: Explanatory model about changes in workplace culture affected by QI support



7 Gender Integration Activities

ASSIST supported 'exposure visits' for pregnant women to come to health facilities to learn about what will happen if they come to the facility for delivery. This innovation was developed by a QI team working in an area with a minority group who was very distrustful of the health service and in which over 80% of women did not deliver at the facility. This intervention addresses discrimination based on ethnicity and caste and also allows women to better negotiate with their family to get the best health care that they can. After piloting it in one facility (23 women came, nine were identified with severe anemia and treated, and 18 have delivered, including 12 who delivered in the facility). This has now been taken up by two districts who are encouraging all facilities to organize exposure visits.

8 Directions for FY16

- **ASSIST is closing out in December 2015. In addition to different organizations requesting support to set up improvement programs, ASSIST has also been asked by USAID to teach IPE Global how to carry on our work after we close.** This NGO is working in the same geographic areas as ASSIST, providing support on the government's RMNCH+A initiative. At USAID's request, ASSIST organized a training in October for their staff, including hands on support as they take over the coaching responsibilities from our staff.

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