TECHNICAL REPORT

USAID ASSIST Project Country Integrated Design: Strategic Approach and Country Examples

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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.

Recommended citation

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Acronyms

AIIMS All India Institute of Medical Science
ASSIST USAID Applying Science to Strengthen and Improve Systems Project
FANTA III Food and Nutrition Technical Assistance
HCI USAID Health Care Improvement Project
IID Improvement Indicator Database
LIFT II Project and Livelihoods and Food Security Technical Assistance
MOH Ministry of Health
MOHCDGEC Ministry of Health, Community Development, Gender, Elderly, and Children (Tanzania)
MNCH Maternal newborn and child health
MUAC Mid-upper arm circumference
NACS Nutrition assessment, counseling, and support
NICU Newborn intensive care unit
PDSA Plan-Do-Study-Act
PHFS Partnership for HIV-Free Survival
PMTCT Prevention of mother-to-child transmission of HIV
QAP Quality Assurance Project
URC University Research Co., LLC
USAID US Agency for International Development
WHO World Health Organization
WHO-SEARO WHO Southeast Asia Regional Office
I. Introduction

The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project built the capacity and capability of host countries to apply the science of improvement to improve health outcomes. The USAID ASSIST Project utilized a country integrated design to improve health outcomes, sustain improved outcomes, spread and scale up the results, institutionalize improvement, and generate and harvest learning from improvement activities. This integrated design, as well as the approach and methods used by the USAID ASSIST Project, is detailed in the technical report, “The USAID ASSIST Project’s approach to improving health care in low- and middle-income countries” [1].

With the background information described and introduced in the technical report, this paper was developed to provide practical guidance on ASSIST’s approach, using country examples to reflect the implementation of the approach and lessons learned. As will be demonstrated in this paper, while the activities conducted on the USAID ASSIST Project varies among the technical areas, countries, sites, and communities in which the project worked, the science of improvement and general approach remained the same but were adapted as appropriate to each context. This means that while the science of improvement for improved outcomes and health systems strengthening was at the center of our approach, the way in which the approach was implemented differed based on the response and results obtained from the changes introduced.

Following the structure of “The USAID ASSIST Project’s Approach to Improving Health Care in Low- and Middle-income Countries,” this paper provides background information, country examples, and practical guidance based on each example. Each section presents at least one country example from the USAID ASSIST Project that demonstrates the successful implementation of this guidance and practical lessons learned. The purpose of this paper is to provide insight as to what happened on the ground when the USAID ASSIST Project’s approach was applied in-country. Through the case studies with country examples, we explore the lessons learned and provide practical guidance by answering the questions:

1. Why were the activities in this example successful?
2. Why and how did they work differently from comparable sites/examples?

The country examples demonstrate that while the principles of quality improvement were the same and the steps for program design were similar, what differed in the successful examples of our work were contextual factors such as leadership, engagement, and politics. While the actions (implementation of quality improvement) were the same throughout our work, the reaction from the country, facilities, and communities in our work varied. Recognizing that every reaction may not be the same, the project maintained adaptability, reflecting on the results and introducing a different approach to yield improved results, when needed.

Given the scale and reach of the USAID ASSIST Project, the practical guidance and country examples provided in this paper are meant to be illustrative and are not exhaustive.

II. Program Design

Program design involved initial meetings with USAID, the Ministry of Health (MOH), and other stakeholders. Through these initial meetings, the USAID ASSIST Project was informed by USAID of the work to be done and worked with USAID, the MOH, and other stakeholders to decide on key priorities. The Program Design was, therefore, the first step in preparing for the start of improvement activities under the USAID ASSIST Project.

As detailed in “The USAID ASSIST Project’s approach to improving health care in low- and middle-income countries” [1], the USAID ASSIST Project utilized a country integrated design with six key elements:
1. Improvement Design
2. Implementation
3. Sustainability
4. Scale-up
5. Institutionalization
6. Learning

With key priorities in mind, the USAID ASSIST Project communicated with stakeholders including the MOH and USAID through in-person meetings, phone calls, and email correspondence to begin initial assessments for the work to clarify and agree upon the scope of work, priorities, and timelines for the activities to be conducted in-country, all of which informed the improvement design. As suggested by the six integrated elements, the program design also involved the implementation of the work itself as well as planning for and carrying out the scale-up and institutionalization of the work so that results obtained through implementation were spread, sustained, and integrated into the system. The USAID ASSIST Project sought to purposefully learn from these elements through an ongoing process of knowledge management and through research and evaluation activities.

Program Design: Practical Guidance

1. Provide a foundation for USAID ASSIST Project and relevant facility staff on quality improvement using courses or materials
2. Emphasize the importance of developing a measurable, achievable aim for improvement activities
3. Prepare USAID ASSIST Project and relevant QI team members at the facility level for developing indicators, collecting data, and monitoring results in improvement activities using real-time data
4. Ensure engagement of USAID, the Ministry of Health, and other stakeholders at the onset of improvement activities through in-person and virtual communications. Develop a clear timeline and scope of work for the activities that are agreed upon before the initiation of the work.
5. Recognize the importance of integration of the six elements of program design and plan for each from the beginning.

III. Improvement Design

Improvement Design is the first stage in preparing for a quality improvement activity. It provides the basis for planning and implementing the activity, creating a roadmap for the work to be implemented. To prepare our staff for improvement design needed for quality improvement work under the USAID ASSIST Project, the project provided staff with the foundations of improvement through the Quality Improvement Course and ensured that staff created an effective program design through communications with USAID, the MOH, and other stakeholders.

Providing Background: Quality Improvement On-Boarding and Training

While the work implemented in each country was dependent on context and was constantly adapted to improve efficiency and effectiveness, all senior USAID ASSIST staff received training on quality improvement through the “How to Improve Health Care” course either in-person or via the “Improving Health Care e-Learning Course”. The online version of this course, which provides more details and access to the full online course, can be found and downloaded from the link provided in the References [2].

As the use of the online e-Learning course become more widespread, the USAID ASSIST Project evaluated user experience for the First Quality Improvement eLearning Training for Public Health Leaders in Uganda.
Whether taken in-person or online, the quality improvement course set the foundation of our work and was used as the on-boarding and background training to prepare staff for the implementation of improvement work in the field. The online course also includes additional background on quality improvement. The online course applies the lessons and information to a case study example from implementing nutrition, assessment, and counseling (NACS) services in a health care facility in Uganda. The case study example mirrors the case study that was presented and used in the in-person course.

The key concepts from the quality improvement course were utilized in the implementation of USAID ASSIST Project activities. The six skills developed through the course are:

1. **Defining Improvement Aims**

All improvement starts with aim, which is a specific, measurable, and achievable goal that is to be reached through the improvement activity.

The following is an example of an aim statement: “In our clinic, we will improve the nutritional status of HIV clients by 90% within 6 months by assessing all our clients using mid-upper arm circumference (MUAC)”.

2. **Forming the Improvement Team**

Achieving an aim in an improvement activity requires teamwork to make changes to processes of care. Teamwork allows work to be aligned among team members and collaboration among team members to align the work towards achieving the aim. The members of the improvement team are those that are involved in the processes of care that is to be improved.

Examples of members of the improvement team: management, practitioners, patients or groups representing patients, or other people involved in the system of care. A representative of each function being addressed through the improvement activity should be on the improvement team.

3. **Understanding the Current Process**

To design an improvement activity to improve the outputs and outcomes yielded by the system, you must first understand the processes that yield those outputs and outcomes. The improvement team is essential in this stage as they are able to identify issues in the current processes that may lead to less than desirable outputs and outcomes and suggest ways to change the processes to yield improved outcomes and outputs.

The flow chart below illustrates the flow of HIV-positive patients in the NACS case example:

![Flow chart](image)

4. **Developing Indicators**

Indicators provide a means of measuring the progress and results of an improvement activity as changes are being implemented.

Examples of indicators used in the case example include:

- **Output/Outcome Indicator**: The percentage of HIV-positive clients in the clinic who are assessed for nutritional status using MUAC and found to be malnourished
- **Process Indicator**: % of HIV-positive clients assessed for malnutrition using MUAC
5. Plotting a Time Series Chart

Improvement activities rely on testing or implementing changes. The use of real-time data provides the opportunity to monitor the results of the tested changes. Plotting a time series chart provides a simple way to visualize the data, including the results of the changes over time.

An example of plotting a time series chart is included below:

6. Developing, Testing, and Implementing Change

Developing, testing, and implementing change is an iterative process in which a solution to achieve the aim must first be developed and tested. Changes based on the identified solution(s) are then implemented and additional changes can be made, as appropriate, to achieve the aim. Plan-Do-Study-Act (PDSA) cycles provide a means for learning and improvement in this process.

Improvement Design: Practical Guidance

Two points for practical guidance for improvement design are presented below:
1. Provide staff with the knowledge and capacity for improvement, encouraging them to use the tools as appropriate to their own context.

2. Understand the processes of care within the health system and focus on changes that are practical, doable, measurable, and likely to yield improved outcomes. Be sure to establish and engage the improvement team, being sure to involve on the team those that do the work within the focus processes of care.

IV. Implementation

The implementation of the work is the point at which the planned scope of work of improvement activities starts. Because health systems are complex, adaptive systems, implementation must be flexible enough to allow for change. Using the indicators and real-time data developed in the improvement design phases, the work is implemented but follows an iterative Plan-Do-Study-Act (PDSA) cycle to allow for changes to be made as the work progresses. Changes to the implementation of an improvement activity must be documented. Documenting changes in an improvement activity intervention is essential in determining what changes yielded improved results during the activity.

Implementation: Practical Guidance

1. Establish and maintain communication with the MOH, USAID, and other key stakeholders as soon as possible. Be sure to gain consensus and understanding about the role of the project, goals, and key priorities for the work.

2. Develop an agreed upon timeline and scope of work. Try to keep momentum, consensus, and transparency about the improvement work through ongoing communication, especially with stakeholders.

3. Make sure to do good work and establish good relationships with staff, partners, and stakeholders.

V. Rapid Start-up

Rapid start-up is important in yielding improved results and is imperative when dealing with an activity that demands an urgent response and in cases in which the timeline for implementation is short. To ensure rapid start-up of program activities, the USAID ASSIST Project began discussions with the MOH, USAID in-country, and other stakeholders as soon as the project was informed of the work by USAID. Initial discussions, including country visits, along with ongoing communication, were essential to clarifying the program design and connecting the key individuals needed to start the improvement activity. For the USAID ASSIST Project, rapid start-up required designating an empowered staff member or team to initiate the work, including engaging in conversations with USAID, MOH, and other stakeholders, including initial visits to the country for further discussions, visits to proposed sites, and clarification of priorities, timelines, and the scope of work.

As mentioned in the Program Design section, there must be a clear scope of work for the activities to be implemented. In the case of rapid start-up, Program Design often overlaps with program implementation to begin activities as quickly as possible. For the proper Program Design to be implemented, ongoing communication in refining the program design is necessary to prepare for implementation at the earliest opportunity.

Rapid Start-Up: Country Examples

Rapid Start-Up Country Example 1: Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda

Program start-up in the four island countries of Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda, provides an example of rapid start-up of USAID ASSIST Project activities. The USAID ASSIST Project was informed by USAID of the assignment to begin technical
activities to support these countries to improve service delivery in maternal newborn and child health (MNCH) and family health services, supporting improvement in the care of newborns and children potentially affected by Zika.

One week after being informed of the assignment by USAID, the project began introductory calls with USAID and the Pan American Health Organization to gather additional information about the work. Initial phone calls with each of the countries individually occurred within the first six weeks after being informed of the assignment, based on the availability of the countries to hold initial calls with the USAID ASSIST Project.

Antigua and Barbuda, St. Vincent and the Grenadines, St. Kitts and Nevis, and Dominica were countries in which the USAID ASSIST Project had no presence or previous experience. The USAID ASSIST Project developed a case study exploring the effectiveness of rapid start-up and multi-tasking in the implementation of quality improvement activities in these four countries. The case study is available at: https://f1000research.com/articles/9-251.

Lessons Learned: Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda

The success of rapid start-up of Zika activities in Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda demonstrates the importance of communication in beginning improvement work. Start-up required numerous calls with USAID (both in Washington, DC and in country), the MOH in each country, and other relevant stakeholders. The initial conversations provided the understanding for the work to be completed and increased the engagement of all parties to rapidly begin the work. The initial communications were quickly followed by several in-person visits to each country to develop a clearer agreement on the activities to be conducted, site locations, and timelines, in addition to laying the foundations for transition and handover of the work.

1. Why were the activities in this example successful?

As mentioned, the case study on the rapid start-up of activities under the USAID ASSIST Project in Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda found that the success of the activities was due to the design of the activities as short-term, rapid response activities from the outset. However, the success in beginning dialogue with the countries within one week of being informed of the assignment by USAID and planning for initial visits to the countries shortly after, played a large role in successfully beginning activities.

2. Why and how are they working differently from comparable sites/examples?

Because Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda are separate countries with different structures, actors, contexts, and priorities, it is important to note that their responsiveness to the USAID ASSIST Project was each different. However, what remains the same across the four island countries was the need to start activities as quickly as possible to allow time for implementation of the work so that sites could yield results prior to project end. Because the activities were designed at the start to be short-term and were designed for rapid start-up, relevant actors were organized to develop a clear plan for specific activities that was feasible within the short timeline. Although the specific activities differed between the countries, they were each designed with the appropriate actors to be implemented effectively based on the priorities, contexts, and structures of each country, within a specific timeline. In other countries in which the USAID ASSIST Project functioned, projects were longer-term and were not designed as short-term, rapid response activities.

Rapid Start-Up Country Example 2: Tanzania

Another country example of rapid start-up is the work of the USAID ASSIST Project in Tanzania following the closing of the USAID ASSIST office in Tanzania. With the USAID ASSIST Project nearing the end, the project began to shut down country offices as activities ended and funds were utilized. The country
office in Tanzania was one of these offices, with all administrative and operations support in-country closing in August 2017.

After the closure of the Tanzania-based office, at the end of October 2017, the USAID ASSIST Project received a request to begin new activities in Tanzania. The request required the re-opening of an office in Tanzania, the rehiring of staff, and restart of office operations only months after closure. The request was for capacity building, in support of the President's Office - Regional Administration and Local Government, Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), and Walter Reed Army Institute of Research team. The purpose of the activity was to enhance the capacity of Regional and Council Health Management Teams in all 19 priority scale-up councils in the three Southern Highlands regions of Tanzania to be able to manage and lead quality improvement efforts [3].

The requirements for successfully re-opening the Tanzania office were to re-establish registration and a bank account in the country and re-hire staff for the office, some of whom remained in touch with the Chief of Party following the initial closure of the office. To prevent delays related to office space, the USAID ASSIST Project utilized a turn-key office space, which was readily available for staff to begin work once again. With the USAID ASSIST Project Chief of Party in Tanzania ready to resume activities and other staff members ready to onboard once again, the project was able to re-open the Tanzania country office in a matter of weeks. By quickly communicating with staff in-country, the project, with support of headquarters staff, was able to identify and lease fully furnished office space, re-recruit staff previously working on the project, and re-open the Tanzania country office to quickly resume activities under the new request.

With a Tanzania field office opened, the USAID ASSIST Project FY18 annual work plan was approved by the USAID Mission in Tanzania, and technical support from the USAID ASSIST Project began in March 2018. Work to build the capacity, competencies, and skills of Regional and Council Health Management Teams for quality improvement management began in May 2018 with rapid mapping of capacity-building needs in the regions of Ruvuma, Mbeya, and Songwe. Rapid mapping in these regions was followed by technical support to address identified gaps [3].

Lessons Learned: Tanzania

1. **Why were the activities in this example successful?**

   Reopening the Tanzania field office was a success story because the USAID ASSIST Project was able to reopen offices efficiently and quickly enough to develop a work plan and begin providing technical assistance. This was a feat given that the office had recently closed, including all closeout processes required of USAID and University Research Co., LLC (URC).

2. **Why and how are they working differently from comparable sites/examples?**

   As mentioned above, activities in Tanzania were able to start up again so rapidly by using a fully furnished “turn-key” office, to avoid delays related to locating office space, signing leases, and other similar administrative issues. The successful re-opening of the Tanzania office and operations in this way provided a lesson learned for future start-ups. Having staff available in-country and maintaining good relationships with previous staff and partners also contributed to the ability to not only begin operations in the office but to begin activities within a very short timeframe.

Rapid Start-Up: Practical Guidance

1. Be prepared to initiate conversations immediately after being informed of the assignment. Do not delay communications with the MOH, stakeholders, and donors.

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1 A “turn-key” office is an office space that is ready to use and allows for immediate operation. The term “turn-key” is based on the idea that the individual only needs to turn the key to unlock the door and begin work/operations.
2. Prepare a general scope of work and timeline as soon as possible. The scope of work should be reasonable given the amount of time available to start and implement the activity.
3. Begin discussions about priorities, handover, and transition at the start of the project to set clear expectations about the role of the project and next steps following the end of the project.
4. Be proactive and persistent about follow-up, even if response is not received to the initial request.
5. Finalize the scope of work after these steps are completed (i.e., number of sites to be supported, location of sites, etc.).

VI. Results and Real-time Data

As detailed in the background section, the use of indicators and real-time data to monitor and evaluate results is key to quality improvement. The collection of data for quality indicators was a standard element across the work on the USAID ASSIST Project. With a commitment to sharing information and learning from improvement work, the USAID ASSIST Project developed the Improvement Indicators Database (IID).

**Improvement Indicators Database**

The IID was developed to increase the ability of different countries and activities to learn from one another within the USAID ASSIST Project. Prior to the development of the IID, each country, activity, and facility or community utilized Excel spreadsheets to record and monitor the data from their quality improvement activities.

While Excel spreadsheets are functional for use in quality improvement work, they are not easily portable and require the sending of files between individuals to make updates, exchange information, etc. This not only creates difficulties in maintaining the quality of the data, but places restrictions on the portability and exchange and sharing of information, particularly as it relates to indicators, activity progress, and evaluation of quality improvement activity results.

As the IID was used across different countries, activities, and sites, the knowledge available grew, providing new opportunities for learning. Having the ability to access data from other improvement activities generated the ability to learn what worked and what did not work in different contexts and allowed those working on different activities to share their data and experiences with others working on similar activities. Encouraging the use of the IID was a useful tool for the USAID ASSIST Project in encouraging ownership of activities and data and demonstrating the power and importance of real-time data, especially in cross-sharing and learning.

While the USAID ASSIST Project encouraged the use of the IID and sharing of data, the privacy and protection of data was a top priority. To maintain privacy and protection of IID data, different levels of access were assigned to user of the IID, depending on what the user was accessing the IID for. The policy of the USAID ASSIST Project was that the data were private to the facilities and were only shared with others during learning sessions or other forums of learning exchange, such as coaching visits. The data were not shared within countries, unless they were being used in a learning forum.

The IID was developed to be accessible to anyone working on improvement activities. Because designing a database is time consuming and required contracting an external software engineering company, we do not propose the development of a database as a practical recommendation. Rather, the USAID ASSIST Project encouraged external projects, organizations, country governments, and others who were interested to utilize the database to download it at [https://github.com/urciid/iid_release_usaid](https://github.com/urciid/iid_release_usaid). By inviting others both within and outside of the project to use the database, those working on improvement activities could add their data to the greater body of improvement indicators and data available.
Improvement Indicator Database Country Examples: Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda

The use of the IID in the four island countries of Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda provided a challenge for the USAID ASSIST Project. As each of the island countries is different in terms of infrastructure, available technology, internet connectivity, and familiarity with quality improvement data, the USAID ASSIST Project experienced varying success in introducing the use of the IID in each of the countries. Furthermore, as the USAID ASSIST Project provided only short-term technical assistance in these countries, USAID ASSIST country teams were not established on the ground.

When introducing the IID in these countries, the USAID ASSIST Project staff came to realize that many of the nurses and health workers did not have the basic computer skills needed to utilize the IID. This created an additional challenge of introducing basic computer skills to the providers. To counter this challenge, the USAID ASSIST Project hired IID consultants in each country to assist with basic training of providers, including basic computer skills, and use of the IID to enter, analyze, and manage their quality improvement data.

In these four island countries, the health facility teams, which were made up of nurses, midwives, pediatricians and other health care providers, began collecting data in September 2018; however, the IID consultants were not onboarded until January 2019. To reduce the double burden of learning how to use a new system like the IID and also uploading large amounts of data into it, the IID consultants took on the task of collecting and entering data into the IID. This responsibility was handed over to the health facility teams once the IID consultants trained the QI coaches and health facility teams on how to use the IID to enter and analyze their data.

Again, the use and feasibility of the IID differed between countries and use varied based on individual capacity and skillset. Antigua has been a good example of use of the IID as the MOH was able to utilize data points generated by the IID to demonstrate progress in certain indicators during high-level meetings. In addition, the hospital coach in Antigua was able to enter data into the IID autonomously after one training session and provided direct training and support to her team on the use of the IID. The use of the IID allowed greater feasibility in viewing and analyzing progress in the activity over time based on the data collected.

The USAID ASSIST Project encouraged the use of the IID by utilizing run charts generated by the IID for learning sessions. Whether plotted by hand or by utilizing the IID, this exercise helped to encourage people to generate run charts of their own to identify gaps, strengths, and successful changes. After identifying these points, the learning sessions encouraged discussion and idea sharing on how to close the identified gaps.

Results and Real-Time Data: Practical Guidance

1. Emphasize the importance of collecting and using real-time data in improvement activities
2. Build the capacity of staff to collect their own data and monitor data for validity
3. Demonstrate the ability to use data to monitor results of improvement projects, especially when learning to use data in testing and implementing changes
4. Support ownership of data, whether the results are good or bad. Poor results provide the opportunity to introduce changes that are likely to yield improved outcomes. Good results provide the opportunity to learn from what changes worked and why they yielded improved results.
5. Encourage data-sharing, when possible, to provide the opportunity for sites to learn from one another. Building ownership and capacity early on is important so that sites and improvement teams will continue to gather data independently, beyond project end.
VII. Adaptation

With the health system being a Complex Adaptive System, quality improvement work requires adaptation to context and flexibility. The USAID ASSIST Project maintained flexibility by finding innovative solutions to challenges or barriers to activity implementation. Many of the solutions, such as the use of Expert Patients for task shifting in HIV and AIDS service delivery [4], are simple and can be found in-country by improvement teams. Others, such as the use of Zoom technology and the Project ECHO platform, can be found by collaborating with other projects and initiatives.

Adaptation: Country Examples

Country Example 1: Palestine (West Bank/Gaza)

In 2017, the USAID ASSIST Project received a request to begin work on hospital-acquired infections in the West Bank. While the number of hospitals in Palestine is few and the geography of the country is small, the politics within the country created logistic difficulty in implementing quality improvement activities while promoting collaboration between facilities. The work of the USAID ASSIST Project to successfully implement these activities required close collaboration with the Palestinian Authority and innovative solutions to facilitate collaboration between facilities in-country.

The USAID ASSIST Project, as anticipated, encountered challenges in traveling throughout the West Bank and even greater challenges facilitating communication between facilities. Country-wide collaboration and coordination to reduce hospital-acquired infections and reduce antimicrobial resistance is essential. Because much of the work on hospital-acquired infections required learning sessions and knowledge exchange between facilities, maintaining communication was essential. In addition to in-person workshops, the work in the West Bank included weekly web-based sessions utilizing the Zoom videoconferencing platform. The weekly videoconferencing sessions via Zoom provided facilities with the opportunity to learn from one another through knowledge exchange, while receiving technical assistance and support from the USAID ASSIST Project [5].

The use of the Zoom videoconferencing platform was supplemented by mobile communications using WhatsApp groups for questions and answers and technical assistance from the USAID ASSIST Project and from local technical experts, thereby ensuring regular support despite the logistical difficulties restricting the number of in-person visits.

Through the course of the USAID ASSIST work in the West Bank, hospital-acquired infections collaborative tools were created and made readily accessible on the USAID ASSIST Project. These tools can be found in Reference 6.

Lessons Learned: Palestine (West Bank/Gaza)

1. Why were the activities in this example successful?

By leveraging the use of the Zoom videoconferencing and WhatsApp technology, in combination with heavy support from USAID ASSIST Project headquarters staff, the reach of activities in West Bank/Gaza was expanded, despite logistic difficulties in physically traveling to the sites. Learning from the experience in West Bank/Gaza, the USAID ASSIST Project was also able to develop collaborative tools that were proven to be successful in the combination of in-person and virtual collaborations throughout the span of the work. The success of these activities in not only overcoming the logistical challenges but producing results and being able to cross-share and learn from the results demonstrates success and a learning opportunity about the importance of utilizing feasible technologies and resources to overcome challenges in implementing improvement work.

2. Why and how are they working differently from comparable sites/examples?

The use of technology also provided the opportunity for sites to learn from one another by cross-sharing their results, successes, and challenges on an ongoing basis. Such an opportunity for cross-sharing,
Adaptation: Practical Guidance

1. Be flexible in your approach – avoid “one size fits all” approaches.
2. Understand the context, identifying what works in a similar context and recognizing that what works in one context may not work in others.
3. Focus on engagement – engaging stakeholders is key to getting a better understanding of the context and how an activity may work within that context.
4. Recognize that not all sites will reach the same level of success; you must meet them “at their level” and in some cases may try many different interventions to yield improved results.
5. Utilize technology and available innovations whenever possible to overcome barriers. Seek guidance from similar projects and activities as to what worked in a similar context when exploring options to overcome barriers and alternatives. Zoom and WhatsApp are just a couple of examples of affordable and accessible technologies and are available in many countries as an alternative and/or supplement to in-person collaboration.
6. Recognize opportunities in failures. Learn from failures as they provide an opportunity to understand what does not work and why, which provides information about what may work.

Capacity-building, leadership, accountability, and country ownership: Country Examples

Country Example 1: Zambia

In Zambia, capacity-building and country ownership under the USAID ASSIST Project included the involvement and empowerment of health workers, particularly in improving NACS services. Beginning in 2014, the USAID ASSIST Project worked alongside the Food and Nutrition Technical Assistance (FANTA III) Project and Livelihoods and Food Security Technical Assistance (LIFT II) Project to support the MOH in Zambia to improve NACS services for HIV and AIDS patients [7].

By engaging health workers, the USAID ASSIST Project was able to identify issues in the system that needed to be addressed. For instance, at the start of the activities, the nutrition assessments were not being conducted regularly and, in some cases, the nutritional status of patients was not being documented and/or information was missing. Furthermore, teams were unaware of the nutritional status of the HIV clients and/or whether their nutritional status was assessed. By involving the workers in the quality improvement activities, sites increased their accountability for improvement work as well as their capacity and knowledge of quality improvement methods. They were also engaged in creating an action plan for quality improvement to improve the quality of NACS services, thereby improving the care outcomes for HIV and AIDS patients [8].

By engaging health workers in the quality improvement team, health workers were able to assist in identifying issues inhibiting improvement in NACS services for HIV patients and become part of the solution for improved results. The engagement of health workers also increased accountability by encouraging health workers to become part of the initiative to improve NACS services for their patients. The work in Zambia also included the specific involvement of community health volunteers and neighborhood health committee members to assess HIV clients, thereby reducing the burden on health workers and increasing the number of patients assessed using task shifting [8, 9].

Lessons Learned: Zambia

1. Why were the activities in this example successful?
   The USAID ASSIST Project in Zambia experienced success because of the engagement and country ownership of the work, which allowed teams to identify issues on their own and introduce changes to improve outcomes in NACS services. The USAID ASSIST Project was able to provide sites and teams with the tools they needed to implement quality improvement, thereby building their capacity to
implement the science of improvement. By working alongside other projects, FANTA III and LIFT II, the USAID ASSIST Project was also involved in increasing the comprehensiveness of the approach and preventing overlap of technical assistance offered by coordinating technical assistance with the other initiatives on the ground.

2. Why and how are they working differently from comparable sites/examples?
Not all countries, sites, and teams will respond to quality improvement in the same way. Zambia provides an example of an activity in which those involved built their capacity for quality improvement and through local leadership and individual accountability and engagement, decided to take ownership of the work to continue to identify gaps and areas in need of change in NACS services.

Capacity-building, leadership, accountability, and country ownership: Practical Guidance
1. Gather an understanding of the leadership and organizational structures impacting your improvement activity.
2. To build capacity, you must understand the current capacity of the individuals and sites in which you are working and build capacity from there. Cross-sharing provides an opportunity for individuals to learn from one another to build capacity.
3. Remember that capacity-building, leadership, accountability, and country ownership are key in sustainability of results, scale-up, and the institutionalization of improvement.
4. Foster buy-in as a component of accountability and country ownership. Buy-in is key to the sustainability of activities, especially beyond project end.

VIII. Sustainability, Scale-up, and Institutionalization
Activities under the USAID ASSIST Project were designed with the end in mind. For the results to be sustained from work initiated under a project, the activities must continue independently of the support from the project. For activities to continue, the USAID ASSIST Project recognized the importance of planning for sustainability, scale-up, and institutionalization as integrated elements of the program design. The USAID ASSIST Project focused on capacity-building, leadership, accountability, and country ownership of the work to increase the likelihood of sustainability and scale-up of the work following the end of the USAID ASSIST activity in-country.

To increase the likelihood of a smooth transition away from project dependence, we utilized a phased transition to handover the work of the project to the MOH and other stakeholders in-country.

Institutionalization is the degree to which quality improvement becomes integrated as part of the process of care delivery. In other words, institutionalization occurs when quality improvement becomes part of the way in which care is delivered. Achieving institutionalization was a goal of the USAID ASSIST Project because, like sustainability, it increases the likelihood that quality improvement will continue beyond project end.

Sustainability: Country Examples

Country Example 1: Honduras
The USAID ASSIST Project returned to Honduras in 2016 to begin work in MNCH related to Zika. Previously, URC had presence in Honduras under the Quality Assurance Project (QAP) and USAID Health Care Improvement Project (HCI), which terminated in 2012. Under QAP and HCI, URC was able to reduce maternal and child mortality in Honduras and provided technical assistance to develop a National Quality Health System in Honduras. The National Quality Health System was designed to improve the quality of maternal and child health services by through standards development, compliance monitoring, quality design, and quality improvement (QI) teams [10].

When we returned to Honduras to study the infrastructures still in place, we found that a lot of the quality improvement work in the country had continued beyond the presence of URC under the QAP and HCI
contract. Five years later, under the USAID ASSIST Project, a research and evaluation activity was conducted related to the institutionalization and sustainability of work in Honduras under QAP and HCI (see reference 10).

As detailed in the report, some of the key factors in the sustainability and institutionalization of the work in Honduras several years after the end of QAP and HCI were that:

1. The QAP improvement strategy was easy to implement, doable, and provided almost immediate results.
2. Authorities in Honduras were interested in quality improvement, leading to the adoption of quality projects such as QAP and HCI to improve quality in the health system, particularly in relation to health maternal and child health outcomes.
3. Engagement and support of the community, which was obtained by educating people about the project and its goals.
4. Key stakeholders were invited to be part of the process and the design of the project was discussed with local and national authorities, thereby generating consensus.

Overall, the report also noted the heavy influence of political factors in the success of QAP and HCI in Honduras, which included the climate for health reform, new national leadership, and population discontent. The introduction of QAP and HCI in Honduras during this period likely led to the adoption of interventions sponsored by QAP and HCI to improve maternal and child health outcomes. The success of the project as highlighted in the report is that the work under QAP and HCI fostered a “culture of quality,” which was maintained beyond the end of the project. However, it is important to note that while some of the work of QAP and HCI remained beyond project end and the “capacities” that were built under the project were maintained, the progress forward lacked as there was no clear “next step” available. Without the presence of QAP and HCI, while not all activities dissolved, the momentum and some of the activities also faded with the end of URC’s presence, which was attributed to the lack of financial and human resources [10].

**Lessons Learned: Honduras**

1. **Why were the activities in this example successful?**

   Although the work in this example is from work completed under QAP and HCI, Honduras represents ongoing success of the implementation of the elements of the science of improvement, which were central to the approach of the USAID ASSIST Project.

2. **Why and how are they working differently from comparable sites/examples?**

   Because a study was completed by the USAID ASSIST Project regarding the sustainability of the activities in Honduras under QAP and HCI, we had information about the extent to which activities continued as well as why and how they could be maintained beyond the end of QAP and HCI presence in the country. This example provided the unique insight for the USAID ASSIST Project to learn about what factors contributed to the sustainability of work beyond project end--learning that could be applied to work to increase the likelihood of sustainability beyond the USAID ASSIST Project.

**Country Example 2: India - All India Institute of Medical Science and WHO Southeast Asia Regional Office**

The involvement of the USAID ASSIST Project with the All India Institute of Medical Science (AIIMS) included workshops on quality improvement organized by the World Health Organization’s (WHO) Southeast Asia Regional Office (SEARO) and USAID. The workshops were led by staff from the AIIMS and the USAID ASSIST Project. These efforts led to the development of a self-sustaining quality improvement network. The activities began in May 2016 when the head of a newborn intensive care unit (NICU) at Ram Manohar Lohia Hospital at New Delhi attended a quality improvement workshop organized by AIIMS and the USAID ASSIST Project. Using the tools and skills learned from the
workshop, the head of the NICU increased the number of attendants complying with hand hygiene standards when entering the units [11].

Lessons Learned: India – All India Institute of Medical Science and WHO Southeast Asia Regional Office

1. Why were the activities in this example successful?

After achieving successes in her own facility, the head of Ram Manohar Lohia Hospital at New Delhi was inspired to use quality improvement in her own unit to improve outcomes. The successes in this example are reflective of the continued potential for success with the continuation of activities by AIIMS and WHO-SEARO. The continuation of activities by AIIMS and WHO-SEARO beyond the end of the USAID ASSIST Project provides a unique example of full transition of improvement work to an entity that independently continues the work beyond the support of the project. As mentioned previously, the goal of the USAID ASSIST Project was to handover the work to stakeholders within the country so that they could sustain results and continue to improve health outcomes and the quality of services beyond project end. However, depending on the response of the country and the progression of quality improvement work, not all activities can be successfully handed over in a way that increases the likelihood of continuation beyond the project end.

2. Why and how are they working differently from comparable sites/examples?

The success of the handover of activities in this case can be attributed to the collaboration between WHO-SEARO, the WHO Collaborating Center for Training and Research in Newborn Care (at AIIMS, New Delhi) and the USAID ASSIST Project, which resulted in a platform for quality improvement methods that could be used by the quality improvement network. By encouraging individuals to independently apply quality improvement methods to their own sites, the USAID ASSIST Project and partners helped to increase the likelihood that others will apply, spread, and scale up quality improvement methods successfully beyond project end.

Scale-up: Country Examples

Country Example 1: Tanzania

In the case of Tanzania, the work of the USAID ASSIST Project was able to support and scale-up quality improvement to a national scale in Tanzania, spreading the lessons learned from Tanzania to other countries and facilities. By June 2017, the USAID ASSIST Project had established 781 quality improvement teams throughout the country [12]. The work of these 781 quality improvement teams was across several different initiatives and involved 618 facilities and 260 communities. The results and key accomplishments in Tanzania through the work of these teams are detailed in the Tanzania Country Report for FY17, which can be found in reference 13.

Lessons Learned: Tanzania

1. Why were the activities in this example successful?

The success of Tanzania is reflected in the scale at which the Tanzania teams were able to operate over various activities and technical areas. In FY17, as detailed in the annual country report, several of the activities under the USAID ASSIST Project involved packaging and scaling up activities to other sites and regions in Tanzania. The success of the spread and scale-up of activities can be linked to the engagement and support of the Ministry of Health, Community Development, Gender, Elderly, and Children and other stakeholders in supporting the work of the USAID ASSIST Project, particularly in relation to scale-up and spread. The success of the scale-up and spread of activities can be linked to the focus of the USAID ASSIST Project on encouraging cross-sharing and learning between sites, communities, and facilities, to support the implementation of the activities in new sites [13].
2. Why and how are they working differently from comparable sites/examples?

Tanzania is unique in the large scale and number of teams which were operating in FY17. The size of the country on one hand is a contributing factor in the ability to work with so many teams, facilities, and sites. The scale of activities in Tanzania is also due to the involvement of the USAID ASSIST Project in the Partnership for HIV-Free Survival (PHFS), for which the USAID ASSIST Project provided technical assistance for quality improvement [13]. Another specific example of scale-up in Tanzania was work completed under the HCI Project, under which the project scaled up and evaluated activities in prevention of mother-to-child transmission of HIV (PMTCT) through the infant feeding counseling program [14].

Country Example 2: India

The USAID ASSIST Project implemented quality improvement work to improve newborn health services within six states in India: Delhi, Jharkhand, Haryana, Himachal Pradesh, Punjab, and Uttarakhand, introducing different changes as appropriate to each context. The changes were introduced in facilities in 27 high-priority districts in the six states and aimed to improve outcomes at the state level. Because the context differed between the states, different changes were introduced, with progress varying between the states. The change ideas introduced within the six states can be found in reference 15.

USAID ASSIST Project work in Himachal Pradesh, a northern state in India, represented some of the most successful work under the program. The USAID ASSIST Project provided technical assistance to the Government of India’s Reproductive, Maternal, Newborn, Child, and Adolescent (RMNCH+A) Health Strategy. Although six states demonstrated success under the USAID ASSIST Project beginning in December 2013, Himachal Pradesh experienced improved results in the Chamba District. Inspired by these results, the district government became involved in scaling up quality improvement at all levels (facility, district, state), using available resources [16].

Lessons Learned: India

1. Why were the activities in this example successful?

The success of the scale-up of activities in India was due to sites utilizing change packages for quality improvement experiencing successful results and being inspired to share their results and the quality improvement approach with others. As the results and approach were shared with other sites, they were spread throughout other areas of India, thereby allowing spread and scale-up of quality improvement in MNCH throughout the 27 high-priority districts. The work in India on the USAID ASSIST Project, as demonstrated by the number of districts in which activities were implemented, is reflective of the success of activities as improvement activities proven to be successful were able to spread and scaled up to other sites and districts.

2. Why and how are they working differently from comparable sites/examples?

Several different strategies were used in India, depending on the technical area, activity, and district. In some cases, the strategies proven to be effective in improving results in maternal and neonatal health were bundled as "change packages", which could be introduced to other sites and districts. As demonstrated in the implementation, results from and adaptations made to the change packages varied depending on the district in which they were implemented.

IX. Phased Transition

One of the goals of the USAID ASSIST Project was to ensure that countries can sustain and improve the results they achieved with the support of the project. Recognizing that the project needed to handover the work, the USAID ASSIST Project used a phased transition approach to gradually increase host-country accountability for the work and reduce dependence on the assistance received from the project.
Phased Transition: Country Examples

Country Example 1: Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda

Due to the need for rapid start-up and handover, the implementation of quality improvement activities related to Zika in Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda also highlighted the use of a phased transition approach by the USAID ASSIST Project. With the knowledge that activities in the four island countries would need to occur rapidly and that the activities were to occur on a short timeline, the USAID ASSIST Project designed the activities with a phased transition in mind. The phased transition included deliberate planning to review the progress of the work and concluded with handing over activities to the Ministries of Health and other relevant stakeholders in each country.

Lessons Learned: Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda

1. Why were the activities in this example successful?

The work in Dominica, St. Vincent and the Grenadines, St. Kitts and Nevis, and Antigua and Barbuda they provide an example of success in terms of phased transition because discussion and planning for phased transition occurred at the very start of the activities, with a plan for ongoing discussions for implementing the plans.

2. Why and how are they working differently from comparable sites/examples?

In the case of these countries, a short time period for project implementation, coinciding with the end of the USAID ASSIST Project, necessitated early discussions about handover and transition.

Institutionalization: Country Examples

Country Example 1: Uganda

Like Tanzania, the scale at which the USAID ASSIST Project was operating in Uganda in FY17 was significant, with 928 quality improvement teams supported in June 2017. One of the contributing factors to scale-up and spread in Uganda under the USAID ASSIST Project was institutionalization. The quality improvement journey in Uganda began in 1994 with the establishment of the Quality Assurance Program (QAP) by the MOH of Uganda. Over more than two decades, Uganda has continued its journey in quality improvement, institutionalizing quality improvement at multiple levels of the system. This growth has led to an increase in the number of quality improvement teams, technical areas, and activities [17].

Lessons Learned: Uganda

1. Why were the activities in this example successful?

As in the Tanzania example, the success in Uganda is evident in the sheer number of teams and sites that reflect the scale at which the USAID ASSIST Project was operating. Equally significant is the continuous involvement and support of the MOH of Uganda in quality improvement initiatives. Due to this commitment, Uganda has been an example of improved health outcomes at all levels of care [17].

2. Why and how are they working differently from comparable sites/examples?

While the successes in Uganda are comparable to those in Tanzania as described in the sustainability section, the context is different. Uganda has experienced much progress politically over the years in its initiatives in quality improvement and health systems strengthening, which helps to support further achievements, such as large-scale spread and scale-up of existing improvement initiatives. The leadership and support in Uganda are therefore a large factor in the successes that the USAID ASSIST Project had in scaling up proven, evidence-based practices to other sites, facilities, and communities throughout Uganda.
Sustainability, Scale-up, and Institutionalization: Practical Guidance

1. Design your improvement project with transition in mind and use a phased transition approach, if possible. Acknowledge potential barriers to sustainability, scale-up, and institutionalization.
2. Design your improvement project with scale-up in mind. Discuss with stakeholders the goals for spread and scale-up and develop a plan for spread and scale-up.
3. Engage stakeholders from the beginning, focusing on handover, capacity building, and local ownership of the work. Building local capacity is key to providing the skills needed for improvement work to continue independently.
4. Improvement should become the “way of doing things.” Focus on building a culture of improvement and integrating improvement into processes, rather than creating improvement as a separate or additional task for health workers.
5. Recognize the importance of the availability of financial and human resources in sustainability beyond project end. Identify resources and alternatives as much as possible.
6. When possible, look at the district level as an opportunity to develop, implement, and spread proven interventions.

X. Learning: Knowledge Management & Research

Key to quality improvement is understanding both the successes and failures of changes that are tested and implemented. Learning from quality improvement involves finding a way to document and share such information with others, in the hopes that it will increase the likelihood of success in the improvement activities of others. To effectively share the learnings from improvement work, documenting and sharing the data and results are not enough. Knowledge management and research were key to the USAID ASSIST Project’s work because they allowed the harvesting and spread of improvement work and facilitated sharing lessons learned with others.

Managing Knowledge for Improvement

Knowledge management in improvement work goes beyond reporting and includes interacting with improvers (those implementing the work) to extract in detail what the improvers did that worked and identifying what changes did not work. This information is then packaged in what can be used by and distributed to others as “knowledge products” that can guide others in improving similar care processes.

A large part of extracting this information involves convening people to learn from one another through knowledge harvesting and cross-sharing.

Research and Evaluation

Research and evaluation on the USAID ASSIST Project included answering the questions related to why and how interventions work, rather than simply whether they worked. This effort required gathering evidence not only about whether the implementation of quality improvement worked but how it was packaged and implemented in a way that was effective within the context.

Learning: Practical Guidance

1. Encourage cross-sharing of knowledge and experiences between different sites, countries, and technical areas. Cross-sharing provides the opportunity for other teams to learn about what may work in their context and helps to empower teams in their own improvement work.
2. Create opportunities to harvest knowledge from your improvement activities and package them in a way that can be shared with others, with a focus on providing guidance based on experience, such as in the form of knowledge products.
3. Make deliberate efforts to learn not only about whether the improvement activities worked, but explore how and why they worked, paying attention to the impact of context and other factors on the success of the activity.
XI. Conclusion

Providing practical guidance out of the work conducted under the USAID ASSIST Project presents a challenge. The challenge comes from the fact that discussing the successes of our work is usually expressed in forms such as improved health outcomes, successful spread and scale-up, or new knowledge products and reports. However, much more is involved once an assignment is received from USAID. Coinciding with the nature of health systems, the work of the USAID ASSIST Project was iterative and adaptive, including processes such as introducing quality improvement to a country, getting to understand the country’s priorities, and successfully implementing improvement to yield improved results. Within these processes are the communications, challenges, adaptations, teams, individuals, and contexts that both helped the USAID ASSIST Project be successful and presented new challenges from to learn and share that learning with others.
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