Rapid Response Brief

August 2020

What can research evidence tell us about:

Strengthening Health promotion and prevention structures at the districts

Key messages

Several interventions in health promotion and prevention have several complex pathways of impact with only modest effects in the communities.

The following activities to improving health promotion and prevention can be considered:

1. How can the districts VHTs use in health promotion and prevention activities in the communities?
2. How can the districts strengthen the performance of VHTs and improve the effectiveness of health promotion and prevention activities in the communities?
3. What other interventions can districts implement to improve the structures and systems, and the health promotion structures?

Where did this Rapid Response come from?

This document was created in response to a specific question from a policymaker in Uganda in 2019.
It was prepared by the Center for Rapid Evidence Synthesis (ACRES), at the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative

+ Included:

- **Key findings** from research
- **Considerations about the relevance** of this research for health system decisions in Uganda

✕ Not included:

- Recommendations
- Detailed descriptions

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Summary

Background:

The Ministry of Health recently issued guidance to districts to increase health promotion and prevention expenditure in the primary health care grant from 10% to 30%. However, districts note several challenges in the implementation of current health promotion strategies in the communities. The current strategies are centred on the use of village health teams (VHTs) strategy, which is affected by several challenges in recruitment, training, provision of incentives and the structural framework.

Rapid response Question:

How can districts strengthen their health promotion and prevention structures?

Findings:

Health promotion and prevention interventions often have modest effects on several indicators, because they seek to improve complex situations.

The following health promotion interventions can be considered:

1) How can districts use VHTs in health promotion and prevention structures?

    a) Provide health education and counselling using a variety of formats and tools such as group or individual sessions, flip charts, posters, and leaflets. It can also involve targeting specific vulnerable groups.

    b) Provide additional psychosocial and emotional support to clients e.g., counselling, being a confidante, and helping to reduce stress.

    c) Participate in data collection of vital statistics and surveillance e.g., births and deaths registration.

    d) Provide healthcare services for specific disease/ sector-specific activities delivery e.g. malaria control, maternal and child health programmes, HIV/AIDs or TB.

2) How can districts strengthen the performance of VHTs and improve the effectiveness of health promotion and prevention structures?

    a) Provide quality supervision that includes support and feedback to the VHTs.

    b) Provide training to the VHTs to take on different roles using various formats- lecture or supervised hands and tools. These training have to be suited to the level of skills needed and context.

    c) Clearly define the roles and expectations of the VHTs in the community concerning health

promotion.

d) Provide monetary and non-monetary incentives to VHTs such as career progress, resources, or acknowledgement.

e) Integrate the services of the VHTs in policy development and implementation of health services.

3) What other interventions can districts implement to improve the structures and systems, and the implementation of the health promotion and prevention structures?

a) Implement environmental health interventions such as sprays for fly control, ventilated improved latrines, and safe water.

b) Interventions should target different stakeholders e.g., clients, providers and health systems interventions to improve and sustain immunization coverage.

c) Consider mobile health interventions for healthcare providers to improve their performance and expand their scope of services e.g. VHTs involved in data collection.

d) Transfer certain specialized tasks to lower cadre healthcare workers e.g. in psychological interventions. Consider the adverse effects of task shifting as well.

e) Provide outreach campaigns such as mobile clinics, health camps and house-to-house activities e.g., in TB case detection activities, breast cancer screening.

Conclusion:

Health promotion and prevention interventions are complex, often in packages, and seek to address challenges that have several potential causal routes. When implementing any interventions, districts need to consider the context of the communities, structural frameworks of using VHTs, available resources, and stakeholder views. There is also a need to have a robust monitoring and evaluation plan in place that also encourages learning.

Background

The Ministry of Health recently issued guidance to districts to increase the expenditure of health promotion and prevention activities in the primary healthcare (PHC) grant from 10% to 30%. This is line with the ministry's efforts to strengthen disease prevention and health promotion, improve the health of the communities and save costs associated with the provision of care in health facilities. The experiences of several past epidemics in the last decade informed the shift and the need to empower individuals and communities to increase their control over the influences of their health. There was also a formation of new health education, promotion and communication department at the ministry, which would further stress the need for more resources allocated to health promotion.

How this Rapid Response was prepared

After clarifying the question being asked, we searched for systematic reviews, local or national evidence from Uganda, and other relevant research. The methods used by the Rapid Response Service to find, select and assess research evidence are described here: www.evipnet.org/sure/rr/methods

The health promotion activities at the districts often include communication and health education, home visits, and health campaigns among others, and these often engage Village Health Teams (VHTs) [1, 2]. The VHTs strategy in Uganda has also been involved in advocacy, mobilisation of community resources, healthcare service delivery programs like immunisation, distribution of condoms, reproductive health, improving sanitation measures, increasing uptake and adoption of ITNs and tuberculosis programs and referral to healthcare facilities [1-3]. However, officers in the districts who are in charge of implementing health promotion and prevention notes several challenges faced by VHTs in executing their work. The challenges reported include low motivation, lack of monetary and non-monetary incentives, a voluntary model of operations, lack of support from healthcare workers at the facilities, inadequate training, huge workload, diverse ethnicities and languages in a district, poor coordination of stakeholders, and poor access to information communication and education materials. Therefore, the district health office at Mukono district is interested in evidence of effective strategies to improve the health promotion and prevention structures.

Rapid response question:

How can districts strengthen their health promotion and prevention structures

Summary of findings

Health promotion and prevention structures are complex, [4] and often have modest effects of the measured indicators. The evidence districts can consider and strengthen their health promotion structures can be summarised in three questions shown in tables 1-3 as:

1) How can districts use VHTs in health promotion and prevention structures? This highlights the scope of work and roles for the VHTs in health promotion and their effect thereof.
2) How can districts strengthen the performance of VHTs and improve the effectiveness of health promotion and prevention activities? This highlights interventions that specifically targeted VHTs to improve their functionality in health promotion.
3) What other interventions can districts implement to improve the structures and systems to achieve and strengthen health promotion and prevention activities? This considers the fact other interventions can be implemented to improve health promotion, and highlights those we found effective.

How can districts use VHTs in health promotion and prevention structures?

Table 1: Scope of work and roles of VHTs involved in health promotion and prevention structures

Intervention	description	Findings
Health education and counselling - 4 studies [5-8] *Quality*[1] ŧŧŧ ⊕⊕⊖⊖	○ Some several formats and activities can be used in interventions utilising education and counselling provided by VHTs. These include: i) group or individual sessions, ii) a demonstration or practise sessions and role-plays; iii) use of posters; flip charts; workbooks; booklets and picture books; flyers and leaflets; brochures and postcards; recommendations iv) peer support; women' group meetings; sharing meetings; village rallies; v) Videotapes; telephone counselling; text messaging and mail outs. ○ These interventions can also be tailored to match different target groups e.g. cultural or religious groups using innovative delivery strategies like the same gender or adapting specific advice e.g. dietary or disease conditions e.g. type 2 diabetes, HIV	Education and counselling interventions might generally modestly improve certain indicators for example, it increased the proportion of breastfeeding women with better hygiene practices such as safe preparation and storage of complementary foods increased. There was also an increase in ownership and appropriate use of ITNs when education about malaria was provided to parents or household heads.

	voluntary counselling.	
Additional Psychosocial and emotional support - 2 studies [9, 10] *Quality*[1] ~~ł ł~~ ⊕⊖⊖⊖	The activities involved in additional psychosocial and emotional support include: i) counselling, acting as a confidante, helping reduce stress and anxiety; ii) Providing instrumental and tangible support which includes home visits, telephone calls, bed rest, home or transport help, help with obtaining benefits/ housing/ shopping etc., regular meetings with social workers; iii) Providing informational support that includes appropriate use of social services, advice and health education.	VHTs providing additional psychosocial and emotional support might reduce the prevalence of depression among persons with mental illnesses especially women.
Specific disease/ sector-related activities 1 study [11] *Quality*[1] ~~ł ł ł~~ ⊕⊕⊖⊖	○ VHTs can provide healthcare delivery related to specific disease/ sector-related activities e.g. malaria control, breastfeeding, maternal and child health programmes or infectious diseases interventions such as HIV/AIDs and tuberculosis. ○ These are often complex interventions and might include health education, counselling, home visits, peer support, practical skills training, early mother- and baby contact and referral to health facilities for more complicated cases.	In different settings, VHTs interventions might have a significant positive influence on healthcare delivery programs. For example, there was an increase in the number of children receiving their immunisation on schedule, initiating and extending the duration of breastfeeding; there was a significant reduction in morbidity due to diarrhoea, fever and acute respiratory illnesses; the number of individuals cured of tuberculosis increased.
Surveillance 1 study [12] *Quality*[1] ~~ł ł~~ ⊕⊖⊖⊖	VHTs might at times be employed in data collection of vital statistics such as deaths, births, marriages, and pregnancies in communities. VHTs can reach households and connect with individuals/ families to report events which might include monitoring of disease outbreaks in the community.	Using VHTs might improve the quality of data with an increase in completion rates, consistency and accuracy of data.

Quality of evidence. The quality of systematic reviews was assessed using AMSTAR 1 checklist. The rating used is as follows:
~~łł~~- high-quality reviews rated as AMSTAR score >8/11
~~ł~~- moderate-quality review, AMSTAR score 5-7/11
~~ł~~- low-quality review, AMSTAR score ≤ 4/11.
The quality of evidence of the outcomes was rated using Grade and summarised as follows:
⊕⊕⊕⊕; high quality – there is a high degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;

⊕⊕⊕⊖- moderate-quality- there is some degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;
⊕⊕⊖⊖ low quality- the results are likely to change if the interventions are repeated elsewhere
⊕⊖⊖⊖ very low quality- the results are very likely to change if the interventions are repeated elsewhere.

How can districts strengthen the performance of VHTs to improve the implementation of health promotion interventions?

Table 2: Interventions to strengthen the performance of VHTs to improve health promotion and prevention structures.

Intervention	Description	Findings
Supervision *Quality*[1] ⧺ [13] ⊕⊖⊖⊖ [14] ⊕⊖⊖⊖ [15] ⊕⊖⊖⊖ [16] ⊕⊖⊖⊖	○ Routine supervision visits from health staff at the district include activities such as oversight, support and feedback to the VHTs. ○ The number of supervision visits can vary from one per year quarterly or monthly depending on available resources.	There was an improvement in the functionality of the VHTs, however, one supervisory visit a year achieved similar impact as was observed in more frequent visits.
Provide training *Quality*[1] ⧺ [17] ⊕⊖⊖⊖ [18] ⊕⊖⊖⊖ [19] ⊕⊖⊖⊖ [15] ⊕⊖⊖⊖ [16] ⊕⊖⊖⊖	○ VHTs can be trained to improve on their performance or take on different roles within the health system such as screening for different illnesses, management of illnesses, health education, health promotion activities, among others. ○ The format of the training included lectures, workshops or supervised hands-on training. The training can be done within the health facility or in the community.	When used as part of an intervention package involving other healthcare workers, and education and awareness campaigns, it resulted in reduced perinatal mortality, neonatal mortality, stillbirths, and maternal morbidity. When VHTs were trained in malaria treatment following presumptive or confirmed malaria diagnosis, there was a reduction in all-cause mortality and malaria-related hospitalisation.
Defined roles *Quality1* ⧺ [14] ⊕⊖⊖⊖ [15] ⊕⊖⊖⊖	○ VHTs require a clear and defined set of roles expected of them and known to them and the community. These roles are developed either by the central Ministry of Health or by the district health teams and should align with the needs of the community and be within the confines of the law. ○ There should be deliberate measures to disseminate the developed roles of VHTs widely through sensitisation, training, use of booklets or brochures, refresher training, and supervision	A lack of clarity on the role of VHTs among the VHTs themselves and the community was shown to affect their performance.

	visits.	
Provide incentives *Quality* Ⱨ [14] ⊕⊖⊖⊖ [15] ⊕⊖⊖⊖	○ The incentives considered for VHTs include career prospects, policies, financial incentives, access to training, supervision and supplies, and community trust, respect and recognition.	Most of the VHTs indicated that financial incentives would be important towards their improved performance, however other forms of incentives were also significant such as supervision, access to training and community trust and respect.
Integrate VHTs into health service *Quality1 above* Ⱨ [15] ⊕⊖⊖⊖	○ This involves integrating VHTs in policy development, planning and implementation of health service, and getting all health programs and workers to recognize VHTs as part of the health system and the role that they play towards disease prevention and health promotion.	VHTs reported that better integration into the health service would lead to better execution of their expected roles.

Quality of evidence. The quality of systematic reviews was assessed using AMSTAR 1 checklist. The rating used is as follows:
Ⱨ- high-quality reviews rated as AMSTAR score >8/11
Ⱨ- moderate-quality review, AMSTAR score 5-7/11
Ⱡ- low-quality review, AMSTAR score ≤ 4/11.
The quality of evidence of the outcomes was rated using Grade and summarised as follows:
⊕⊕⊕⊕; high quality – there is a high degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;
⊕⊕⊕⊖- moderate-quality- there is some degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;
⊕⊕⊖⊖ low quality- the results are likely to change if the interventions are repeated elsewhere
⊕⊖⊖⊖ very low quality- the results are very likely to change if the interventions are repeated elsewhere.

What other interventions can districts implement to improve the structures and systems, to achieve and improve health promotion and prevention

Table 3: Interventions to strengthen the health system and structures that improve health promotion and prevention activities.

Intervention	Description	Findings
Environmental health interventions 2 studies [20, 21] Quality[1] Ⱨ ⊕⊖⊖⊖	These can include fly control interventions such as the use of insecticide sprays, provision of latrines, provision of refuse dumps and animal pens away from households. Other interventions included: i) Providing safe and flowing water; chlorinated water for individuals, households and communities; ii) Providing health education and hygiene promotion interventions (software) to: promote the use of latrines and hygiene practices within the community; improve disposal of child faeces. iii) Providing tools such as potties or scoops	Providing either education and information (software) and tools such as potties and scoops (hardware) singly or in combination led to a reduction in the prevalence and incidence of diarrheal diseases. The use of insecticide spray and latrines led to a reduction in the number of houseflies, and a reduction in incidence and prevalence of trachoma from the studies.

	(hardware) for faecal disposal.	
Interventions targeting different stakeholders and levels *Quality1* ~~III~~ [22] ⊕⊖⊖⊖	Recipient-oriented interventions; interventions to improve communication about childhood immunisation such as recipient information or education, reminders or recalls, teaching skills, providing support. Provider- oriented interventions; interventions to reduce missed opportunities for childhood vaccination such as health education, training and refresher courses. Health system interventions; These are aimed at improving the quality of services in the health system such as; a reliable cold chain system, vaccination transport, outreach programmes, vaccine stock management, budget considerations, integration of immunisation services with other services and use of both monetary and non-monetary incentives.	The interventions that recorded significant improvements in boosting and sustaining immunisation coverage were home visits, community-based health education, integrating immunisation services with the malaria prophylactic treatment, regular once monthly reliable immunisation outreach programmes. A combination of immunisation outreach campaigns with non-monetary incentives also demonstrated significant improvements in immunisation coverage.
Mobile Health (mhealth) Interventions *Quality*[1] ~~III~~ [23] ⊕⊖⊖⊖ [24] ⊕⊖⊖⊖ [25] ⊕⊖⊖⊖ [26] ⊕⊖⊖⊖	The intervention included any use of mobile devices (mobile phones and tablets) by health workers to provide and support any type of PHC services and offer breastfeeding support. This included uni- and bi-directional communication between health workers, health workers and clients and health workers and respective program staff.	Health workers report better connection amongst themselves, between health workers at the same level and between lower-level and higher-level health workers and thus better delivery of care. mHealth enabled health workers to expand the scope of services they offered such as risk factor assessment for different diseases and accessing the internet for health information. It also reduced the travel time, which increased access to care for the clients. For the recipients of care, the intervention resulted in more people stopping smoking over a 26weeks period, better adherence of chemo-prophylactic interventions, reduced anxiety among pregnant women who received communication from their health workers via mobile messages and increased number of women attaining 4 ANC clinic visits.

Transfer some specialised services to lower cadre healthcare workers in the community *Quality*[1] Ⅲ [10] ⊕⊖⊖⊖	None-Specialist Health workers (NSHW) and health workers performing other roles including lay health workers led or added to teams of specialists to supplement specialist work. This approach was used in providing psychological interventions such as general counselling and economic skills building, delivering psychosocial counselling and problem-solving. The interventions were delivered in groups or community centres in health facilities and homes through home visits.	LHW led interventions successfully reduced depression among women, individuals with PTSD symptoms, and in women with perinatal depression. Combination of NSHWs to specialist health workers or LHWs led interventions reduced functional impaired among patients with common mental disorders in 12 months and improved the severity of the symptoms, but the effect was lost over a longer duration of time. The intervention also improved PTSD symptoms. These results were observed in both public and private health facilities.
Outreach campaigns *Quality*[1] Ⅲ [27] ⊕⊖⊖⊖ [22] ⊕⊖⊖⊖ [26] ⊕⊖⊖⊖	These might include the use of mobile clinics, health outreach campaigns, house to house activities, and can be combined with educational or health promotion activities. These activities can be performed by formal or informal health staff.	Outreach campaigns, when used in TB case detection, resulted in an increased number of cases detected, however, this was observed in places with a high TB prevalence. It also resulted in lower treatment default rates and higher treatment successes. Outreach clinics resulted in higher TB case detection than routine house-to-house screening visits.

Quality of evidence. The quality of systematic reviews was assessed using AMSTAR 1 checklist. The rating used is as follows:
Ⅲ- high-quality reviews rated as AMSTAR score >8/11
Ⅱ- moderate-quality review, AMSTAR score 5-7/11
Ⅰ- low-quality review, AMSTAR score ≤ 4/11.
The quality of evidence of the outcomes was rated using Grade and summarised as follows:
⊕⊕⊕⊕; high quality – there is a high degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;
⊕⊕⊕⊖- moderate-quality- there is some degree of certainty that the results of the outcome might not change if the intervention is repeated elsewhere;
⊕⊕⊖⊖ low quality- the results are likely to change if the interventions are repeated elsewhere
⊕⊖⊖⊖ very low quality- the results are very likely to change if the interventions are repeated elsewhere.

Context considerations for using VHTs in health promotion and prevention

Table 4: context considerations for using VHTS in health promotion and prevention

○ **Applicability** [5-8, 11, 13, 15-18, 20, 26-37]**:**	○ There is a need to manage community expectations about the services provided by the VHTs. This is important to mitigate the demand for more services than what can be delivered and eventual loss of trust in the system. ○ The roles assigned to VHTs have to fit within the legal framework of the country and they need to have adequate skills and knowledge to execute the assigned roles. The current framework in Uganda is that VHTs are a voluntary stage and selected by the communities that act as a first contact with the health system within the community. Qualifications are not

	a requirement for recruitment. This has to be considered if districts are to introduce more tasks and monetary incentives. o The interventions were majorly implemented as part of a package e.g. i) Health education and counselling were part of the distribution of insecticide-treated mosquito nets to increase ownership and appropriate use. ii) Supervision was implemented together with training and the provision of supplies or healthcare services. o The interventions are often of varying intensities and frequencies e.g. duration of health education and counselling sessions, frequency of home visits and amounts used in monetary incentives in improving the use of latrines was different. o The effect of using VHTs in health promotion and prevention is often modest because there are several causal routes for the problems being addressed. There is, therefore, need to understand the other factors that affect the success of the intervention for which the VHTs are involved in health promotion and prevention intervention e.g. i) Behavioural change for both the providers and community: This might affect compliance to the intervention e.g. in a study of HIV VCT in the community over 65% rejected the intervention in both arms; use of latrines is problematic in communities where open defecation is the norm; providers' behaviour towards VHTs might demotivate the VHTs to engage with the healthcare system. ii) Geographic barriers: these might be a barrier during surveillance, community outreach programs; referrals by VHTs requires communities to have health facilities within their reach (<10km). iii) Community embeddedness is an important factor for VHTs to be accepted within the community. iv) The current health system capacity will affect the effect of the interventions e.g. several functional health facilities, healthcare workers at the healthcare facilities, effective logistical supply chain system and management e.g. for vaccines distribution and registers; available and accessible technical support. o The process of- and adherence to implementation of strategies involving VHTS in experimental studies significantly different from real-world settings e.g: i) VHTs will be more carefully selected; receive substantial training and support from highly motivated project leaders, and work with carefully selected recipient groups. ii) The studies are often of short duration and this does not provide substantial insight into the sustainability of the programs. o The baseline risk or burden of the condition/ disease affects the effect of the interventions involving VHTs e.g. i) In situations where the risk in the community is very low, the effect of the intervention will likely be very small or nonexistent e.g., The proportion of uptake of IUD in women increased by 100% but this only translated to an increase from 12

	to 24 per 1000 which is below Uganda's modern contraceptive prevalence rate at 34.6%; in TB, where the prevalence was 5 per 100 and below, there was no difference with not using VHTs. o The structure of the community can affect the effect of using VHTs to improve health promotion and prevention e.g. The outreach clinics recorded higher case detection compared to the house to house screening possibly because, during the day, most people are at work, whereas outreach clinics, families can adequately prepare and attend the clinic. o Using innovative solutions e.g. mhealth to improve performance of VHTs requires consideration of training for the users, access to and the speed of internet, access to smart devices and electricity that allow for use of mHealth technology. It also requires a paradigm shift among some health workers who might still prefer face-to-face interactions with peers. i) Using mHealth innovative solutions can leverage on existing programs using VHTs to improve health promotion and prevention.
o **Equity** [7, 9, 11, 15, 26, 29, 38]**:**	o VHTs are a valuable resource in ensuring vulnerable and minority groups receive healthcare services in their communities. o Most of the interventions were implemented where the risk of disease was very high or in poor communities. o Differences in gender norms of the VHTs and the target participants in the communities exist in many communities in Uganda. o It is also important to consider the ethnicity and vulnerability of the target communities to select the "right" VHTs who will emphasize and relate with the societies to ensure community embeddedness. o None of the reviews disaggregated the effect of these interventions by gender.
o **Cost considerations** [1, 2, 8, 13, 15, 18, 39]**:**	o The costs for using VHTs in health promotion and prevention activities include recruitment, remuneration/ incentives, training(s), community mobilization, community resources and supervision. o These costs have to be weighed in consideration to the intended outputs of using VHTs for example, in community outreaches or increasing coverage of immunization in the communities. o Also, consider the direct and opportunity costs of using VHTs: i) Most of them are peasant farmers and are volunteers and have to forego their main economic activity for the health of the community [1]. ii) Transport and facilitation costs incurred on supervision visits often make it costly, with some reports indicating supervision can represent over 40% of the VHTs costs. o WHO recommends that VHTs have to be remunerated with payments commensurate with the tasks provided, however, the negative effects have to consider, e.g., Results-based incentives can result into neglect of unfunded tasks and thus a negative effect on the health system.

○ **Monitoring and evaluation:**	○ Any program using VHTs should have a well-structured monitoring and evaluation plan that also encourages learning during implementation. ○ Several reviews report mild to moderate improvement in the target indicators measured. However, these indicators can be described as impacts and might take a while to occur. Also, these indicators are often influenced by many factors and therefore achieving significant improvements in health prevention and promotion will require a multi-pronged approach.

Conclusion

Health promotion interventions are complex and yet they seek to address challenges with several causal routes. The districts need to carefully consider the relevant context in the planning of their programmes:

i) Careful consideration of the available resources, the scope of the VHTs, structures and systems e.g. recruitment, training, motivation, technical support, supervision, and logistical supply system in health promotion and prevention.

ii) Integration into health services and community embeddedness of the VHT programme.

iii) The implementation of health promotion and prevention interventions are often as a package because of the complexity of the health system, for example, health education and counselling implemented together with the provision of ITNs, immunisation services or handwashing supplies like soap.

Finally, there must be a robust monitoring and evaluation plan since the effect of the interventions is often modest. This will encourage learning and allocating resources to more effective strategies.

*Judgements made by the authors of this response based on the findings of the research and consultation with others (see acknowledgements). For additional details about how these judgements were made see: www.evipnet.org/sure

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What is Rapid Response?

Rapid Responses address the needs of policymakers and managers for research evidence that has been appraised and contextualised in a matter of hours or days, if it is going to be of value to them. The Responses address questions about arrangements for organising, financing and governing health systems, and strategies for implementing changes.

ACRES – The Center for Rapid Evidence Synthesis (ACRES) is a center of excellence at Makerere University- in delivering timely evidence, building capacity and improving the understanding the effective, efficient and sustainable use of the rapid evidence syntheses for policy making in Africa. ACRES builds on and supports the Evidence-Informed Policy Network **(EVIPNet) in** Africa and the Regional East African Community Health **(REACH)** Policy Initiative (see back page). ACRES is funded by the Hewlett and Flora foundation.
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EVIPnet

Glossary

of terms used in this report:
www.evipnet.org/sure/rr/glossary

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Conflicts of interest

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