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Welcome to the second issue of the International Institute for Primary Health Care-Ethiopia's (IPHC-E) Primary Health Care Digest! The purpose of the Digest is to share the latest news and research on primary health care from Ethiopia.

In this issue, we start with an editorial from senior IPHC-E staff on COVID-19 vaccine and the question of equity and fairness. Following that are an update on Health Sector Transformation Plan, and desk reviews on multisectoral collaboration, community-based health insurance, and community-based hypertension screening.

COVID-19 VACCINE AND THE QUESTION OF EQUITY AND FAIRNESS

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Introduction

The World Health Organization announced COVID-19 is a severe communicable illness caused by a newfound novel corona virus called Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV-2) [WHO (a), WHO (b)]. Following the pandemic, many health systems presumed to be strong enough to immediately mount the fight against COVID-19 collapsed in the eyes of the global community. The pandemic tested the resilience of health systems and judgements of political leaders to take appropriate measures timely, decisively and effectively. Although there were some countries disproportionately affected, the disastrous waves of COVID-19 were felt by all countries all over the globe. Besides its health consequences, COVID-19 damaged the global economy and many of the businesses, many people became unemployed, weakened social and family ties, limited mobility of people including tourism and social interactions, disrupted education systems and a number of other daily lifeline activities. The combined effects of the pandemic and their implications are yet to be seen but predicted to be bigger in the low and middle-income countries (LMIC) where gadgets to fight the pandemic are limited. The development and introduction of vaccines against the corona virus were among the hopes for people to return back to normal life. However, it remained challenging to turn these hopes into realities equitably and fairly to everyone on the globe.

What is the issue?

The advent of vaccines and realization of providing vaccines against corona virus was taken as a break through to the prevention and control of COVID-19 and was considered pivotal to bring about a significant impact on the spread of the SARS-COV-2 globally. However, this was subsequently complicated by inadequate production of vaccines, the need for efficient and specific logistics and emerging challenges related to vaccine deliveries in reaching out targets. This endeavor remained less successful especially in LMICs where resources and infrastructure are constraining factors. Furthermore, the tendency of priority to "my people", lack of rational behaviors of governments of rich countries and poor acceptance by communities have posed questions on the "token equity and fairness".

Currently, COVID-19 has also become a political playground where the rich countries agree to help poor countries to share vaccines but showing overt greediness and reluctance. Although the world leaders have pledged to avail vaccines to Africa, this outstanding moto has not materialized as planned due to "vaccine nationalism" and "vaccine hoarding" by rich countries (Boum II, 2021). However, this does not ignore acknowledging the support from wealthy nations to Low-income Countries (LICs) in terms of financial, technical and provision of vaccines though it falls short of the pledge.

What are the challenges to Africa?

The WHO Strategic Advisory Group of Experts for Immunization (SAGE) has put forward six principles for enhancing the decision-making and allocation of COVID-19 vaccines. These principles include considerations of 1) human wellbeing 2) equal respect 3) global equity 4) national equality 5) reciprocity (safeguarding the vulnerable) and legitimacy (WHO (c), 2020).

Low-income countries face many challenges including low purchasing power of vaccines, poor cold chain infrastructure, geographical inaccessibility, and lack of in-country manufacturing capacity. In addition, governments hesitate to make choices due to the emergence of new variants of COVID-19 and following the dilemma of investing meagre resources against questionable vaccine efficacy (Acharya, 2021).

In spite of the challenges, taking into account pledges of rich countries, Africa has set a goal of vaccinating 60% of its population. The goal and strategy were set by the Africa Centers and Diseases Control and the South African Medical Research Council (SAMRC) on 20 August 2020 with the leadership and endorsement of his Excellency President Cryil Ramaphosa, President of South Africa (Africa CDC, Jan 2021) where over 3000 political leaders and experts have participated. The objectives included in the strategy are:

- to ensure Africa gets sufficient share from the Global vaccine supply,
- to remove barriers to the delivery and uptake of the vaccine in Africa, and
- to accelerate Africa's involvement in clinical vaccine development

One of the critical activities to move forward is the development of a comprehensive vaccination strategy that takes into account local contexts. By local context, it means involving stakeholders and engaging local communities of respective countries. Some of the challenges that are complicating vaccination in Africa include:

1) the distribution of SARS-COV-2 in the continent is not uniform

2) new variants of the virus are emerging and spreading with little capacity to check this, and

3) the first roll-out of vaccines require stringent cold chain, limited shelf-life and administration of two doses. This is compounded by peoples' reaction such as vaccine hesitancy and resistance as observed in other countries (Boum II, 2021).

In light of this, the African COVID response strategy should seriously consider: local context/need, capacity, epidemiology, and community engagement. The strategy should also follow an integrated approach focusing on improving health outcomes. Moreover, learning from this, Africa must invest in vaccine research (Boum II, 2021) and manufacturing through building its capacity. This helps not only to strengthen its response to COVID-19 but also prepare itself for similar challenges in the future.

Among a number of vaccines in clinical trials, a few are approved by the US Food and Drug Administration through Emergency Use Authorization such as Pfizer-BioN-Tech, Moderna COVID-19 and Johnson and Johnson COVID-19. The Oxford-As-

traZeneca is additionally approved by European countries and is in use by many countries in Asia, South America and Africa. Additional vaccines approved by other countries for emergency use include: Sputnik V, BBIBP-CorV, CoronaVac, Ad5-nCoV, EpiVacCorona, and BBV152 (Acharya, 2021).

Ethiopia: At the start of the vaccination campaign, the COVAX facility shipped 2.184 million (AstraZenica) doses out of the total 7.62 planned to be deployed doses to Ethiopia by May, 2021 (Africa, 2021). Additional support was also gained in the form of a grant totaling $207 million by the World Bank to aid the financing and distribution of the Covid19 immunization and system improvement. This grant was part of a $12 billion envelope planned to assist developing countries in purchasing and deploying Covid19 vaccines fairly (World Bank, 2021). Furthermore, China has provided a total of 500,000 doses to Ethiopia, once in March and then again in July 2021 in an urgent effort to fight the pandemic (Ethiopian Red Cross Society receives Sinopharm vaccines from Chinese counterpart – Xinhuanet | English. news.cn, June 19, 2021)- http://www.xinhuanet.com/english/2021-06/19/c_1310017215.htm

As of 04/07/2021, Ethiopia has vaccinated over 2,036,792 people throughout the country (FMOH, 2021). One of the major challenges faced during this campaign is the lowering of prevalence of Covid19 vaccination acceptance rate (Mesele 2021). It was also found that willingness to receive the vaccine especially in employees of Banks, primary and secondary school teachers and university instructors was generally low according to a study done in southern Ethiopia (Zewude, 2021).

What lessons do we have?

Israel implemented a successful vaccination strategy. The strategies that worked well in Israel included the presence of a mass vaccination plan, a high degree of preparedness and political commitment (Mc Kee, 2021). The lessons are:

Prioritization: They prioritized four groups (age >60, Individuals with comorbidities, nursing home residents, and health workers). These groups were reached out using an integrated delivery system. It also included an excellent information system utilized to keep a registry on Convid-19 vaccinations, post-vaccination follow-up and assessment of adverse effects. At the same time, the data is planned to be used to study vaccine effectiveness.

Health cadres: They mobilized the highly trained and experienced cadre of existing community nurses.

Use of appropriate and effective communication: Combined traditional communication (for older population) and modern online platforms (younger population) were used for the campaign.

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Health Sector Transformation Plan (HSTP)

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Ethiopia has implemented the first health sector transformation plan (HSTP-I) from 2015/16 to 2019/20 and demonstrated remarkable progress in achieving key health targets. Some of the achievements include, improvements in life expectancy at birth, reduction in maternal (decreased 676 deaths per 100,000 live births in 2011 to 401 in 2017), under five and infant mortality (from 123 and 77 in 2005 to 59 and 47, respectively, in 2019). There were significant decrements in morbidity and mortality from common communicable diseases like malaria, HIV, tuberculosis (TB), and vaccine preventable diseases. Improvements in nutritional status and reduction in prevalence of stunting, underweight and wasting was reported (from 51% to 37%, from 33% to 21%, and from 12% to 7% respectively, between 2005 and 2019). Better utilization of certain health services like family planning (from 35% in 2016 to 41% in 2019), antenatal care (from 62% in 2016 to 74% in 2019 of first visit), skilled birth delivery (has increased from 28% in 2016 to 50% in 2019), safe abortion services and child vaccination was also documented (EDHS 2016, Mini EDHS 2019)

Provision of high-impact interventions free of charge through an exemption program, implementation of community-based health insurance (CBHI) schemes; and full subsidization of the very poor through fee waivers were some of the interventions have been implemented to enhance financial risk protection in accessing essential health services during the same period.

A three-tier system comprised of Primary Health Care Units (PHCU), general hospitals and specialized hospitals continues to be the major health service delivery and the health extension program has great contribution towards improvement of health indicators of the country (HEP Road map, 2020).

The implementation of four transformation agenda, namely; Woreda Transformation, Information Revolution, Transformation in Quality & Equity, and Compassionate, Respectful, and Caring Health Workers was key to achieve positive results described above.

However, there have been no significant reduction in neonatal mortality, rise in the prevalence of non-communicable diseases (NCDs), considerable proportion of people affected by neglected tropical diseases (NTDs), risks from water, sanitation and hygiene (WASH) showed lower reduction, injuries are on the rise and there is high disparity in health service utilization and outcomes among people based on different characteristics.

Nationally, the health system was challenged by situations like internal conflicts leading to population displacement and the COVID-19 pandemic during the period of HSTP-I.

Health sector transformation plan II (HSTP-II) is five years strategic plan from

2020/21- 24/25 and aligned with the country's overall macro-economic development framework and international targets such as Sustainable Development Goals (SDGs). It aims at improving the health status the people by sustaining the achievements of HSTP-I period and addressing challenges and incorporating lessons from first HSTP.

The general objective of HSTP-II is to improve the health status of the population–by accelerating progress towards universal health coverage (UHC), protecting populations during health emergencies, transforming woredas, and improving the health system's responsiveness. Fourteen Key strategic directions identified in the HSTP-II include;

- Enhance provision of equitable and quality comprehensive health service
- Improve health emergency and disaster risk management
- Ensure community engagement and ownership
- Improve access to pharmaceuticals and medical devices and their rational and proper use
- Improve regulatory systems
- Improve human resource development and management
- Enhance informed decision-making and innovations
- Improve health financing
- Strengthen governance and leadership
- Improve health infrastructure
- Enhance digital health technology
- Improve traditional medicine
- Enhance health in all policies and strategies
- Enhance private engagement in the heath sector

From the above 14 strategic directions, five priority issues were identified as part of the transformation agenda for HSTP-II.
The transformation agenda are:

1. **Quality and Equity:** Ensuring equity in delivery of quality health services by creating high-performing primary health care units, ensuring active engagement of the community in service delivery, and continually improving clinical care outcomes.

2. **Information revolution:** Significantly improving methods and practices for collecting, analyzing, presenting, using, and disseminating information that can influence decisions.

3. **Motivated, competent, and compassionate health workforce**: Ensuring equitable distribution and availability of an adequate number and skill mix of health workers who are motivated, competent, and compassionate to provide quality health services.

4. Health financing: Reforming public financial management and health financing to improve efficiency and accountability, while pursuing the agenda of sustainable domestic resource mobilization for health.

5. Leadership: Enhancing leadership and governance mechanisms at all levels of the health system to drive attainment of the national strategic objectives through activities to ensure alignment and harmonization, thereby creating an enabling environment for the translation of plans into results.

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Multisectoral collaboration in the health sector

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Introduction

As part of primary health care, Multi-sectoral action (MSA) or multi-sectoral collaboration is a strategic vision and evidence-based intervention among several sectors and stakeholders to address hazards to health and achieve optimal health for a specific population[1]. The importance of a multi-sectoral approach to health policy dates back as far as the Alma-Ata Declaration of 1978, where Article 4 called for the involvement of all related sectors in efforts to promote health[2]. The shared benefits of multi-sectoral collaboration in the framework of the sustainable development goals (SDGs) include combined programs for poverty reduction, improved health and wellbeing, and high-quality education [3,4].Commitment to multi-sectoral policy and action is essential to achieve SDG 3 (health) at both the national and district levels [5]. In view of this, Ethiopia is creating an approach to bring about sustainable development at the household level through transforming district development, inspired by the SDG declaration "Transforming our world: the 2030 Agenda for Sustainable Development" with the main purpose of alleviating nation's poverty, hunger and promote wellness via growth and development at the household level[6]. This review is aimed to assess previous global evidence, practices and experiences on Multisectoral collaboration and discuss examples of local projects performed through multisectoral actions.

Methods

The review was prepared by careful overseeing of 45 articles on health-focused multi-sectoral collaboration in different countries which we then extracted from 21 of the articles based on quality, relevance of data and well-put references. We then put together this review mainly on strategic approaches, monitoring and evaluation, implementation, key outcomes and also challenges on both national and international context.

Current approaches and Successful experiences of multi-sectoral and intersectoral action for health and well-being

The 2030 Agenda has 17 Sustainable Development Goals (SDGs) and 169 goals for Member States to meet. With 13 specific aims, Goal 3 focuses explicitly on health; Almost every other aim, on the other hand, is tied to or contributes to health and well-being [2].

A Multisectoral (in) action: Towards effective mainstreaming of HIV in public sector departments in South Africa study has shown that the public sector is hugely involved in the response to HIV and AIDS in South Africa. Progress has been made in mainstreaming HIV and AIDS through the development of HIV plans or strategies in non-health sectors. Such an approach is limited in its ability to augment the multisectoral response to HIV, and in its contribution towards realizing the SDG agenda and the global targets on HIV [2].

The fight against human papillomavirus (HPV) to reduce cervical cancer incidence among girls in Malaysia can be another exemplary multisectoral effort. There were social, religious and sexual misconceptions about the vaccine administered in the immunization programs which in turn created a public wariness that required a large-scale intervention. The government, in collaboration with stakeholders, was able to provide funding and technical support that created a significant decrease in cervical cancer incidences [7].

The Basic Package of Health Services (BPHS) program is a successful illustration of addressing primary health care to the peace and stability-neglected people of Afghanistan. The program was mainly organized by the Ministry of Health along with other ministries/sectors in 2003 to facilitate basic health needs of the people. It was able to provide Primary health care services to 31 of the 34 provinces of Afghanistan [8].

Malawi launched a free health and nutrition hotline project called Chipatala Cha Pa Foni (CCPF)—Chichewa for "health center by phone" in 2011. It was tested in one of the districts and is now available to anyone with access to one of the two major communication providers in the country. It was achieved by the public, private, government, community, donor and non-government's unified effort and encompasses topics such as Pregnancy (Antenatal and postnatal advice), Youth-centered sexual and reproductive services, nutrition and hygiene related inquiries and even emergent cases like outbreaks [9].

The effort to control the Ebola outbreak in Sierra Leone, the 'Chile Grows with You' initiative in Chile to advance the optimal development for all children and the US's 'Voices for Healthy Kids' initiative that works on improving and achieving a healthy weight among children and adolescents are among the many successful examples of Multisectoral Collaboration [3].

Strategic Implementation, coordination and financing

The multisectoral approach to health and well-being presented was implemented in various ways, at different levels and in different contexts. They primarily took action plans, longer-term initiatives structures [2]. Key capabilities in multisectoral coordination include

1) Recognizing the importance of involving various sectors in the policymaking process and leveraging their respective strengths,

2) effectively engaging a diverse group of stakeholders and tailoring messages and approaches, and

3) successfully communicating to each sector the shared benefits of jointly achieving the targeted health goal.

When looking at finances, Inter-sectoral co-financing could be one of the funding instruments to enable intersectoral action and overcome the fragmentation and inefficiencies of silo budgeting. It could mean increasing the resource envelope for health spending by pooling funds with non-health sectors and thus leveraging additional investment in health, as well as more efficient purchasing of health-pro-

ducing interventions beyond the health system. Co-financing may be a tool to overcome barriers such as perceived risk and ambiguities, rigid budgetary structures and guidelines, and lack of historical collaboration between concerned sectors[10].

Monitoring and Evaluation

Monitoring & evaluation (M&E) is a key component of the project management cycle that encompasses the routine collection and assessment of data[11]. The multi-sectoral M&E framework is organized by taking into account current programs/interventions from various sectors that have an influence on households which can be implemented at various levels throughout hierarchies, including the community, service centers, and offices. Because of their influence or impact on households or the other sectors that directly provide services to households, sectors with activities or programs involving multiple woreda or regions are taken into account [12].

Planning and sustainability issues in a multi-sectoral approach

Planning tools are suggestions for techniques structured along the project life cycle such as 1) Prioritize cooperation in regards to the topic in hand 2) Create a practical approach 3) At all levels, communicate the strategy's goals and expectations 4) Hold all stakeholders accountable for the strategy's success 5) Share what you've learned and make adjustments as you go 6) Compile a report on collaboration activities. Due to a lack of widely acknowledged metrics, assessing cooperation is difficult, and as a result, cooperation is rarely measured [13]. Some Sustainability issues include emerging financial cuts to cope with a massive budget shortage that causes the health sector to be fragmented [14] and another issue is that an increased number of populations put pressure on multiple sectors by increasing demand for health services and technologies to prevent and treat disease[15].

Achievements and Challenges

One of the key achievements is preventing the occurrence of disease for example by providing safe drinking water, sanitation and immunization[16]. Furthermore, multi-sectoral collaboration has elevated human capital and fuel economic growth for generations to come [17]. Many of the challenges have to do with a lack of political will or dedication, lack of resources and coordination; failure to identify co-benefits and to act in win-win situations; poor communication and ambiguous use of language; and entrenched siloed thinking, where resources are restricted for use only within a specific sector or program. In a few cases, the health sector's own perceived superiority was mentioned as a barrier in collaboration with other sectors. In several cases, overcoming conflicting interests between sectors, power imbalances and competition for resources was a struggle. A change of government or ministers was also found to present a challenge in terms of continuity and sustainability of policies and initiatives [13].

Ethiopia's Projects (The Seqota Declaration and The Gimbichu Woreda transformation plan)

Seqota Declaration: With the main objective of abolishing childhood malnutrition (stunting) by 2030, the Seqota declaration, which was initiated in July 2015, states that they will not allow the current and future generation of children to be malnourished and face further upbringings. The Seqota Declaration Roadmap is planned to be executed in three phases over a 15-year period. It works with three main principles of 'one goal, one coordination plan, and one monitoring and evaluation system'. The implementation strategy will accompany 6 bodies of the federal level including the Ministry of Health[18]. Regarding finance, the country is expected to cover half of the estimated 58 million USD while the African Development Bank and Ministry of Finance have signed over a 31-million-USD grant agreement for the support of the declaration [19]. One of the achievements so far is the support given to the Ministry of water by big win in undertaking a comprehensive water management plan to ensure that 3 million people have access to clean water within a 5 km radius even though resources are limited [20].

Gimbichu MSWT (Multisectoral Woreda Transformation): Gimbichu, one of the districts in the Oromia region, has been chosen for the Proof of concept (POC) period in the implementation of MSWT which will then be followed by 100 Woreda demonstrations. During the POC and demonstration period, additional technical support from regions and federal level will be provided while all remaining woredas can start considering a more contextualized approach. Existing Multisectoral approaches such as Seqota declaration will be part of this approach serving as a learning platform. The pilot Implementation phase of Gimbichu was performed from September 2019- February 2020 [12].

Recommendation

We recommend creating a full-time implementation team and strengthening human resource capacities at all levels to facilitate technical and strategic support and coordination. Engaging with high-level decision-makers in government and partner organizations can also uphold the capacity of the MOH to address critical holdups via candid reporting, use of real-time progress markers, and the establishment of clear lines of accountability through leadership, partnership, inclusive community involvement, advocacy and mediation [16,21].

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Community-Based Health Insurance: the Need to See Beyond the Enrollment Coverage

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A health care financing system that relies on out-of-pocket payment at the point of service delivery is a significant barrier for health service utilization[1]. Attaining Universal Health Coverage (UHC) requires a health care financing system that responds to financial hardships at a point of care.[2] Ethiopian Government introduced community-based health insurance (CBHI) scheme to increase access to health services and protect households from the financial hardship associated with paying for health services[3]. As of 2020, nearly 7 million households in 770 districts were addressed through the CBHI scheme[4].

Community-based health insurance is a voluntary health care financing system developed for rural areas and informal sector works in urban areas. It is a yearly contract made by household members and the insurance scheme on annual advance payment[4]. The premium advance payment per family per year ranges between 126 Birr and 180 Birr[3]. Although there is an increasing trend from 2011 to 2020 in an enrollment rate, and the Ethiopia's CBHI scheme is considered a success in general, proportion of eligible households enrolled in CBHI is only 49%[4]. The Health Sector and Transformation Plan II aspires to increase this percentage to 80% by the year 2025.

Studies show that CBHI has a positive impact on health care utilization[3,6–9], improving quality of care, and patient satisfaction[3,6], and quality of life[10]. CBHI-contracted health centers also have an increased flow of outpatients compared to CBHI-non contracted facilities, with an improved patient's satisfaction which was observed to be higher in CBHI-contracted health facilities[6]. Although the positive benefits of enrollment in CBHI is visible, enrollment decision is affected by many factors at individual and health system level. Review of several literatures on CBHI in rural parts of Ethiopia shows that, demand for enrollment in CBHI is positively influenced by higher educational status[11,12], good awareness about CBHI[11–13], affordability of premium payment[11], higher wealth index[14] , and perceived quality of care[11].

It is important to note that while eligible households enrolled to CBHI is increasing in Ethiopia, the potential contribution of the existing CBHI scheme towards UHC is not clear. Empirical evidences[8,13,15,16] in rural parts of Ethiopia indicated that enrollment in CBHI scheme is linked to socioeconomic status where by low-income households are less likely to be enrolled in the scheme. These evidences highlight that, even with the CBHI scheme, the most disadvantaged groups remained excluded and the existing CBHI scheme may not be contributing to achieve universal health coverage as intended. In addition to promoting for the expansion of CBHI enrollment coverage, the CBHI scheme would be required to respond to this important factor and ensure the poor get equitable access to health care.

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Community-based Hypertension Screening as a means for Universal Health Coverage in non-communicable diseases

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Introduction

Hypertension, also known as high blood pressure, is the leading global risk factor for mortality from cardiovascular diseases, chronic kidney diseases and diabetes[1]. In the last four decades, the global prevalence of high blood pressure increased by 90%, with the majority of the increase occurring in low-and middle-income countries[2]. The shift in the burden of hypertension from high-income countries to low-income countries is largely driven by the occurrence of faster population growth, aging, and increased behavioral risk factors such as increase in tobacco use, excessive alcohol consumption, unhealthy diet, and physical inactivity [1,3,4]. The burden is further aggravated by weak health systems in those low resource settings where the number of people with hypertension who are undiagnosed, untreated, and uncontrolled is higher[5].

Prevention and control of hypertension

In order to prevent complications, reduce the need for hospitalization and premature deaths, a strengthened health system directed at early detection, treatment and sustained management of people at higher risk for noncommunicable diseases is required[6]. Early detection and treatment of hypertension is one of such key strategic areas. If hypertension is detected early, it is possible to minimize the risk of heart disease, stroke and kidney failure[5].

The global action plan for the prevention and control of non-communicable diseases calls for establishing and/or strengthening universal health coverage[6]. For this, expanding quality health service to primary health care level and integrating the service with secondary and tertiary care level must be established [5,6]. In most low-income countries, the major obstacle in controlling hypertension is the absence of appropriate services at primary health care levels[7].

Hypertension in Ethiopia

Like other low-income countries, the burden of hypertension in Ethiopia is reflected in terms of increasing hypertension prevalence, and the inability of the health system to early diagnose and manage hypertensive cases. A recent meta-analysis estimate showed that the prevalence of hypertension in Ethiopia was 21.8% [8], and the pooled prevalence of uncontrolled hypertension was 48% [9].

In 2018, Ethiopian Ministry of Health endorsed the World Health Organization's HEARTS* technical package that provides affordable and scalable solutions to improve control of hypertension at primary health care level. The HEARTS initiative was launched initially in 50 primary health care sites, across 5 regions and 2 city administrations and covered 72 primary health care sites in 2020. The program enabled health extension workers to screen people in their homes and link those with suspected high blood pressure to primary health care centers, which resulted in improved hypertension control rates[4]. A recent study in rural communities of North-west Ethiopia compared blood pressure measurements of trained health extension workers and trained clinicians. The results showed that there was a good inter-rater agreement (91.2%) between the measurements by the two groups of health professionals (unpublished report).

Even though the HEARTS initiative and the community-based study revealed a promising task sharing strategy for prevention and control of hypertension, such health system changes are not scaled-up nationally and are not reflected at the policy level yet. More investigation of this kind of approach may be required at multiple sites to provide policy recommendations for scaling up this promising solution nationally and ensure each community member have closer access to services they need.

*Elements of HEARTS (H= Healthy Life Style; E=Evidence-based Treatment Protocols; A=Access to Essential Medicines and Technology; R=Risk-based management; T=Team care and task shifting; S=Systems for monitoring)

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