ADVANCING PARTNERS & COMMUNITIES

COUNTRY PROFILE: INDIA

INDIA COMMUNITY HEALTH PROGRAMS
NOVEMBER 2013

USAID FROM THE AMERICAN PEOPLE

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Advancing Partners & Communities
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*Adapted from the Health Care Improvement Project's *Assessment and Improvement Matrix* for community health worker programs and PATH's Country Assessments of Community-based distribution programs.

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ANM	auxiliary nurse midwives
ART	antiretroviral therapy
ASHA	Accredited Social Health Activists
AWH	Anganwadi Helpers
AWW	Anganwadi Workers
CHW	community health worker
DMPA (IM)	Intramuscular Depo-Provera
FP	family planning
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
HRG	high-risk groups
ICDS	integrated child development services
IUD	intrauterine device
MCH	maternal and child health
MOH	Ministry of Health
NACO	National AIDS Control Organization
NGO	nongovernmental organization
ORS	oral rehydration salts
PMTCT	prevention of mother-to-child transmission (of HIV)
PPTCT	prevention of parent-to-child transmission (of HIV)
SACS	State AIDS Control Society
SDM/FAM	Standard Days Method/Fertility Awareness Methods
SP	Sulphadoxine-pyrimethamine (for treatment of uncomplicated malaria)
STI	sexually transmitted infection
TB	tuberculosis
VCT	voluntary counseling and testing

I. INTRODUCTION

This Country Profile is the outcome of a landscape assessment conducted by Advancing Partners & Communities (APC) staff and colleagues. The landscape assessment focused on the United States Agency for International Development (USAID) Population and Reproductive Health priority countries, and includes specific attention to family planning as that is the core focus of the APC project. The purpose of the landscape assessment was to collect the most up to date information available on the community health system, community health workers, and community health services in each country. This profile is intended to reflect the information collected. Where possible, the information presented is supported by national policies and other relevant documents; however, much of the information is the result of institutional knowledge and personal interviews due to the relative lack of publicly available information on national community health systems. As a result, gaps and inconsistencies may exist in this profile. If you have information to contribute, please submit comments to info@advancingpartners.org. APC intends to update these profiles regularly, and welcomes input from our colleagues.

II. GENERAL INFORMATION

There are three government-led community health programs in India, as described below.				
1	What is the name of this program*, and who supervises it (Government, nongovernmental organizations [NGOs], combination, etc.)? *Please list all that you are aware of.* **If there are multiple programs, please add additional columns to the right to answer the following questions according to each community health program.*	The **National Rural Health Mission** is supervised by the Government of India's Ministry of Health and Family Welfare. The program focuses on the home delivery of contraceptives by Accredited Social Health Activists (ASHA) at the homes of beneficiaries.	The **Integrated Child Development Services (ICDS) program** is supervised by the Government of India's Ministry of Women and Child Development.	The **Link Worker Scheme** is a program under the National AIDS Control Organization (NACO). It is supervised by the Government of India's Ministry of Health and Family Welfare.
2	How long has this program been in operation? What is its current status (pilot, scaling-up, nationalized, non-operational)?	The pilot phase of this program was initiated in August 2011 and fully scaled up in December 2012.	This program was initially launched in 1975; a new structure was introduced in 2009.	The Link Workers Scheme began in 2006.

3	Where does this program operate? Please note whether these areas are urban, peri-urban, rural, or pastoral. Is there a focus on any particular region or setting? *Please note specific districts/regions if known.*	The National Rural Health Mission program was implemented in 233 districts of 17 states of India. It has since been scaled up to all districts in the country. The districts are primarily rural.	The ICDS program operates mainly in rural areas; however, some urban areas also have Anganwadi Centers where the program is implemented.	The Link Worker Scheme was first implemented in 187 highly-vulnerable districts of the country. The program was then scaled up with Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Round 7 funding. Today the program is implemented in 219 districts in the country. This program focuses on rural areas.
4	If there are plans to scale up the community health program, please note the scope of the scale-up (more districts, regional, national, etc.) as well as location(s) of the planned future implementation sites.	The program is fully scaled and is implemented nation-wide.	The program is fully scaled and is implemented nation-wide.	The program plans to continue scaling up to more districts across India.
5	Please list the health services delivered by CHWs[1] under this program. Are these services part of a defined package? Do these services vary by region?	The Rural Health Mission program delivers a variety of services including: • Safe motherhood initiatives • Immunizations • Deliveries • Referrals and assisted referrals • Sanitation and hygiene services • Distribution of oral rehydration salts (ORS) • Family planning services. These services are part of a defined package and do not vary by region within the country.	ICDS delivers a defined package of services across the country. These services include: • Supplementary nutrition • Immunization • Health check-ups • Referral services • Pre-school non-formal education • Nutrition and health education.	The Link Worker Scheme focuses on three pillars of human immunodeficiency virus (HIV) service: community outreach, advocacy, and community mobilization. The specific service package includes: • Identify vulnerable and at-risk individuals or groups who are at present not able to access HIV-related information and services • Deliver risk-reduction messages and behavior-change communication • Refer individuals to available HIV services • Distribute condoms • Advocate for the availability of quality services and reduction of stigma and discrimination against people living

[1] The term "CHW" is used as a generic reference for community health workers for the purposes of this landscaping exercise. Country-appropriate terminology for community health workers is noted in the response column.

				with HIV at the community level • Facilitate the formation of youth groups, Red Ribbon Clubs and involvement of peers throughout the community.
6	Are family planning (FP) services included in the defined package, if one exists?	The program provides method counseling and distribution of some contraceptives.	Yes, the ICDS program provides some family planning services.	No.
7	Please list the family planning services and methods delivered by CHWs.	The program provides counseling and distribution of condoms, oral pills, and emergency contraceptives.	During *Village Health and Nutrition Days* condoms and oral pills are distributed.	The Link Workers Scheme distributes condoms and referrals; however, distribution of condoms is focused on HIV-prevention services.
8	What is the general service delivery system (e.g. how are services provided? Door-to-door, via health posts/other facilities, combination?)	Services are delivered door-to-door.	Services are provided through Anganwadi Centers. Anganwadi Centers are placed in the village common area or courtyard and are easily accessed by all villagers.	The Link Workers Scheme program delivers services through existing community groups such as self-help groups, Village Health and Sanitation Committees, Panchyati Raj Institutions, as well as other service delivery points.

III. COMMUNITY HEALTH WORKERS

9	Are there multiple cadre(s) of health workers providing services at the community level? If so, please list them by name and note hierarchy.	The National Rural Health Mission uses one cadre of community health workers to provide services. **Accredited Social Health Activists (ASHAs)** are the community health volunteers and backbone of the program.	The ICDS program has two cadres of community health workers. **Anganwadi Workers** (AWWs) are skilled workers. **Anganwadi Helpers** (AWHs) provide support the AWWs.	The Link Workers program has one cadre of community health worker, the **Link Workers.**
10	Do tasks/responsibilities vary among CHWs? How so (by cadre, experience, age, etc.)?	All ASHAs provide the same package of services across the country.	Tasks differ between the cadres, with AWWs requiring a higher skill level than AWHs. AWWs implement the majority of health programming, while AWHs provide support and direct child care.	No, all Link Workers provide the same services.
11	Total number of CHWs in program? *Please break this down by cadre, if known, and provide goal and estimated actual numbers. Please note how many are active/inactive, if known.*	There are 860,000 ASHAs working in India.	Across both cadres, there are 250,000 community health workers in the ICDS program. Information is unavailable by cadre.	Information unavailable.

12	Criteria for CHWs (e.g. age, gender, education level, etc.) *Please break this down by cadre, if known.*	**ASHAs** Must be female, 25-45 years of age, and completed Standard 8 (about eight years of formal education).	**AWW** AWWs must be females, within the ages of 18 to 44 years, and completed Standard 10.	**AWH** AWHs must be females, within the ages of 18-40, and literate.	**Link Workers** Link workers must be 20-29yrs. And have completed 10-12th grade.

13	How are the CHWs trained? Please note the length, frequency, and requirements of training. *Please break this down by cadre, if known.*	**ASHAs** ASHAs receive an initial training on their responsibilities and program guidelines. Updated information is provided at monthly block-level meetings, led by Medical Officers.	**AWW** AWWs receive an initial training on their service delivery scope, initial on-the-job orientation, and bi-annual refresher trainings.	**AWH** AWHs receive on-the-job training and bi-annual refresher trainings.	**Link Workers** Link Workers receive a two-week residential training programme at the District level. Participants cover seven modules over a period of approximately 80 hours. This includes time for practicing skills required for mapping, condom demonstration, and communicating effectively. The training also includes field visits to targeted interventions such as specialized health campaigns or community health days and health facilities.
14	Do the CHWs receive comprehensive training for all of their responsibilities at once, or is training conducted over time? How does this impact their ability to deliver services?	**ASHA** The initial comprehensive training lasts 23 days. The training covers all health services provided. Training on family planning services is 3 out of 23 days. The ASHAs also attend monthly meetings, led by medical officers. These meetings act as refresher trainings and ASHAs are informed of new guidelines on method counseling, eligible couple registration, stock maintenance, and implementation and program incentives.	**AWW** AWWs receive the majority of their training at the beginning of their service period. However, refresher trainings are conducted irregularly.	**AWH** AWHs receive comprehensive on-the-job training, with bi-annual refresher trainings.	**Link Workers** A two-day follow-up training for the Link Workers and Supervisors is envisaged at a gap of six months to one year after the initial training.

15	Please note the health services provided by the various cadre(s) of CHW, as applicable (e.g. who can provide what service).	**ASHAs** Responsible for safe motherhood initiatives; immunizations; deliveries; referrals and assisted referrals; sanitation and hygiene services; distribution of ORS; and family planning services. For family planning, ASHAs counsel all the eligible couples in their area regarding contraceptive choices; ensure appropriate screening by the medical officer or auxiliary nurse midwife (ANM) before selling oral pills to their clients; prepare and update lists of eligible couples in their village; and distribute condoms, oral pills and emergency contraceptives.	**AWW** AWWs are responsible for community mobilization; gather community-level data for child nutrition; refer children and mother's for nutrition care; host pre-school activities; organize supplementary feeding for young children and expectant mothers; health and nutrition education; home visits with parents; organize social awareness campaigns geared towards adolescent girls; identify emergency cases of diarrhea and cholera; maintain registers of child health for the community; and support other community health mobilization programs, including family planning counseling.	**AWH** AWHs support AWWs and ensure the Anganwadi Centers are prepared for health service delivery. AWHs do not directly provide health services. The AWHs responsibilities include cooking and serving food to children; keeping the Center grounds clean; and transporting children from the village to the Anganwadi Center.	**Link Workers** Health services focus on the provision of information, knowledge, and skills on STI/HIV prevention and risk reduction. This entails: Increasing the availability and use of condoms among high-risk groups (HRGs) and other vulnerable men and women. Establishing referral and follow-up linkages for various services, including treatment for STIs, testing and treatment for tuberculosis (TB), integrated counselling and testing, prevention of parent-to-child transmission (PPTCT) services, HIV care and support services including ART.

16	Please list which family planning services are provided by which cadre(s), as applicable.		**ASHAs**	**AWW**	**AWH**	**Link Worker**
		Information/ education	Condoms, pills, emergency contraception, IUDs, and permanent methods	n/a	n/a	n/a
		Method counseling	Condoms, pills and emergency contraception	n/a	n/a	n/a
		Method provision	Condoms, pills (re-supply only), and emergency contraception	n/a	n/a	n/a

		Referrals	Condoms, pills (first use), intrauterine devices (IUDs), emergency contraception, permanent methods	Condoms, pills, IUDs, emergency contraception, permanent methods	n/a	n/a
17	Do CHWs distribute commodities in their communities (i.e. zinc tablets, FP methods, etc.)? Which programs/products?	**ASHAs** Distribute condoms, oral pills, and emergency contraception. Though ASHAs distribute oral pills, they can only resupply; women must receive initial doses from the health center. ASHAs also distribute ORS in their communities.		**AWW & AWH** AWWs can function as the depot holder for the Reproductive Child Health Kit and Disposable Delivery Kits. However, actual distribution of delivery kits or administration of drugs, other than non-prescription drugs, would actually be carried out by the ANM's or ASHAs as decided by the Ministry of Health and Family Welfare. Auxiliary nurse midwives work at Primary Health Centers and Sub-Health Centers, and often receive patients via referrals from AWWs.	**Link Workers** Yes, condoms for HIV prevention.
18	Are CHWs paid, are incentives provided, or are they volunteers? *Please differentiate by cadre as applicable.*	**ASHAs** ASHAs receive payment for the family planning commodities they distribute, as follows: $.02 for a pack of three condoms, $.02 for one cycle of pills and $.04 for one emergency contraceptive pill.		**AWW & AWH** They are paid an honorarium and it varies by education and experience. AWWs are paid more than AWHs. AWW are paid about Rs. 1500, while AWH receive Rs. 750.	**Link Worker** They are paid an honorarium of Rs. 1500/ month.
19	Who is responsible for these incentives (MOH, NGO, municipality, combination)?	**ASHAs** Receive incentives in the form of fees for their services, paid by their clients. The level of incentive is based on the amount of health commodities they sell.		**AWW & AWS** The MOH.	**Link Worker** The MOH.
20	Do CHWs work in urban and/or rural areas?	**ASHAs** Rural areas.		**AWW & AWH** Both rural and urban areas.	**Link Worker** Rural.

21	Are CHWs residents of the communities they serve? Were they residents before becoming CHWs (i.e. are they required to be a member of the community they serve)?	**ASHAs** Yes, they are residents of the communities where they work. They are required to be members of their communities in order to be eligible for the role.	**AWW & AWH** Yes, the AWW and AWH are residents of the communities they serve; they are required to be a member of the community they serve.	**Link Worker** Yes, they are required to be a member of the community they serve and are also residents.
22	Describe the geographic coverage/catchment area for each CHW.	**ASHA** Each ASHA is responsible for a catchment population of 1,000 people.	**AWW & AWH** Anganwadi Centers serves a range of people from 400 to 1,000. This catchment area may differ based on geographic location (e.g. urban or rural).	**Link Worker** Link Workers serve village clusters, which are formed by four to six villages within one district. Each cluster covers a population of 5,000 – 10,000 people. Two link workers (one female and one male) are assigned to each cluster.
23	How do CHWs get to their clients (walk, bike, public transport, etc.)?	Each cadre of CHW walks to their clients.		
24	Describe the CHW role in data collection and monitoring.	**ASHAs** Expected to maintain an ASHA Register that records the contraceptive stocks they receive and sell.	**AWW** AWWs maintain files and records, and also survey their families once a year.	**Link Worker** Assist in conducting village-level social mapping (vulnerability mapping, community resource mapping, health services/facility mapping, and household mapping).

IV. MANAGEMENT AND ORGANIZATION

25	Does the community health program have a decentralized management system? If so, what are the levels (state government, local government, etc.)?	The National Rural Health Mission has a decentralized management system. The system is divided into: • State level • District level • Block level • Village Panchayat level.	The ICDS program has a decentralized management system. The system is divided into: • Central level • State level • District level • Block level • Village Panchayat level.	The Link Worker Scheme is a decentralized program. It is implemented through the National and State AIDS Control Societies (NACO/SACS). The different levels are: • National AIDS Control Organization • State AIDS Control Society • District • Block level • Village Panchayat level.
26	Is the MOH responsible for the program, overall?	The Ministry of Health and Family Welfare is responsible for the program overall.	The Ministry of Women and Child Development is responsible for the program. It is not implemented through the Ministry of Health.	The Ministry of Health and Family Welfare is responsible for the program overall. It is directly supported by NACO, however.
27	What level of responsibility do regional, state or local governments have for the program, if any? Please note responsibility by level of municipality.	The State level manages and monitors the entire program. The majority of monitoring is completed by the State Family Planning Officer. Additionally, the State level trains districts on appropriate program implementation. The District level provides communication materials and training for ASHAs. The District level is also responsible for collecting programmatic data. The Block level is responsible for the distribution of contraceptives to ASHAs and the monitoring of dispensed to user data.	The program is monitored at the National level. The State level is responsible for implementing the program throughout all Districts.	This scheme is implemented and managed at the National and State levels through the NACO/SACS. These groups identify lead agencies, which in turn are responsible for identifying and supporting district level NGOs for carrying out field activities.

28	What level of responsibility do international and local NGOs have for the program, if any?	International NGOs were involved in the process evaluation of the pilot project and developing recommendations for scale up. Currently NGOs have little involvement in the direct implementation of the program.	NGOs provide some technical and capacity building assistance for the AWWs. Additionally, NGOs assist in external evaluations of the program.	NGOs are identified by the government to implement the program at the District and village level.
29	Are CHWs linked to the health system? Please describe the mechanism.	**ASHA** ASHAs are a formal part of the health system. ASHAs are considered the lowest-tier health provider by the Ministry of Health and Family Welfare. Additionally, ASHAs are included in the health supply chain through a supply plan created by individual States.	**AWW & AWH** AWWs are considered a formal health service provider by the Government of India. The Anganwadi Center, where AWWs provide services, follows the Primary Health Center in the tiered delivery system.	**Link Worker** Link Workers work closely with Health Center staff to ensure appropriate service follow-up. Link Workers establish referral and follow-up linkages for various services.
30	Who supervises CHWs? What is the supervision process? Does the government share supervision with an NGO/NGOs? If so, please describe how they share supervision responsibilities.	**ASHA** Auxiliary nurse midwives or ASHA Supervisors supervise ASHAs. The program does not share supervision with NGOs.	**AWW & AWH** AWW Supervisors provide supervision for AWWs. One supervisor provides supervision for 25 Anganwadi Centers. AWHs are supervised by the AWWs at that center. The government does not share supervision with NGOs.	**Link Worker** The Link Worker Supervisor is designated by the implementing NGO. Link Workers receive supportive supervision.
31	Where do CHWs refer clients for the next tier of services? Do lower-level cadres refer to the next cadre up (of CHW) at all?	**ASHA** ASHAs refer client to a Primary Health Center or Sub-Health Center. Yes ASHAs refer to next cadre of health workers i.e. the ANMs.	**AWW & AWH** The AWW refer clients to a Primary Health Center, Sub-Health Center, or an ASHA working the community.	**Link Workers** Link Workers refer to Primary Health Center.
32	Where do CHWs refer clients specifically for FP services? *Please note by method.*		**ASHA**	**AWW**	**Link Worker**
		Standard Days Method/Fertility Awareness	n/a	n/a	n/a

		Methods (SDM/FAM)			
		Condoms	n/a	Primary Health Center, Sub-Health Center, or ASHAs	Sub-Health Center or Primary Health Center
		Oral pills	Sub-Health Center for screening and initial cycle.	Primary Health Center, Sub-Health Center, or ASHAs	Sub-Health Center or Primary Health Center
		Intramuscular Depo-Provera (DMPA [IM])	n/a	n/a	n/a
		Implants	n/a	n/a	n/a
		IUDs	Sub-Health Center, Health Center or Primary Health Center	Primary Health Center or Sub-Health Center	Primary Health Center or Sub-Health Center
		Permanent methods	Primary Health Center	Primary Health Center	Primary Health Center
		Emergency contraception	n/a	Primary Health Center, Sub-Health Center, or ASHAs	Sub-Health Center or Primary Health Center
33	Are CHWs linked to other community outreach programs?	Yes, The Rural Health Mission is linked to other community outreach programs.	The ICDS is linked to other community-level programs. Specifically, the ICDS works closely with the Rural Health Mission as AWWs refer clients to ASHAs for health services.	No, there are no community outreach linkages.	
34	What mechanisms exist for knowledge sharing among CHWs/supervisors?	Monthly meetings held at the Block level, called Sector Meetings, allow for ASHAs from each Block to receive updated information from their supervisors and share experiences among each other.	Information unavailable.	Link Workers attend monthly meetings where they receive supportive supervision. Additionally, information is shared through the program's reporting mechanisms.	
35	What links exist to other institutions (schools, churches, associations, etc.)?	Information unavailable.	Information unavailable.	Information unavailable.	
36	Do vertical programs have separate CHWs or do the programs share or integrate the CHWs?	India's community health programs are separate, with separate cadres for varying health sectors. There is minimal integration across the three programs, with the exception of ASHAs, who provide a wide variety of services. • ASHAs provide integrated services as a part of the Rural Health Mission.			

		• AWWs and AWHs provide childhood development services. • Link Workers provide HIV prevention and care services at the community level.		
37	Do the CHWs have data collection/reporting systems?	The program collects data using registers and formats.	The program collects data using registers and formats.	The program uses established reporting mechanisms.
38	Describe any financing schemes that may be in place for the program (e.g. donor funding/MOH budget/municipal budget/health center user fees/direct user fees).	The Rural Health Mission is financed through the Ministry of Health and Family Welfare's budget.	ICDS is financed through a combination of the Ministry of Women and Child Development's budget and the State's budget.	The Rural Health Mission is financed through the Ministry of Health and Family Welfare's budget.
39	How and where do CHWs access the supplies they provide to clients (medicines, FP products, etc.)?	ASHA's obtain the commodities they distribute directly from the Community Health Center or the Primary Health Center.	The food given to children at the Anganwadi Center is provided by the people served by the Center.	Link Workers collect the commodities they distribute directly from the Primary Health Center.
40	How and where do CHWs dispose of medical waste generated through their services (used needles, etc.)?	Information unavailable.	Information unavailable.	Information unavailable.

V. POLICIES

41	Is there a stand-alone community health policy? If not, is one underway or under discussion? *Please provide a link if available online.*	There is no stand-alone community health policy. Each program functions under a separate government policy, based on the intervention area. The National Rural Health Mission programmatic document outlines the Mission's goals and scope to deliver community health services, with a focus on the states with the poorest public health infrastructures. ASHAs are a part of the National Rural Health Mission. The National Rural Health Mission Program Document (2005-2012) can be found here. The Integrated Child Development Scheme 5 Year Plan (2012-2017), is a part of the Ministry of Women and Child Development. The plan can be found here. The Link Worker Scheme is included in NACO's operational guidelines (2009), and can be found here.
42	Is the community health program policy integrated within overall health policy?	These policy documents are not included in the national-level health policy.
43	When was the last time the community health program policy was updated? (months/years?)	The National Rural Health Mission Program Document was last updated in 2005. The ICDS 5 year Plan was last updated in 2012. The Link Worker Scheme Operational Guidelines were last updated in 2009.
44	What is the proposed geographic scope of the program, according to the policy? (Nation-wide? Select regions?)	The National Rural Health Mission is implemented nationwide. However, the document emphasizes a focus on 18 districts with the poorest infrastructure and health outcomes. The ICDS program is implemented nationwide. The Link Workers Scheme is implemented in rural areas with high prevalence of HIV.
45	Does the policy specify which services can be provided by CHWs, and which cannot?	The National Rural Health Mission provides a job description for ASHAs; it does not specify which services cannot be performed. The ICDS 5 Year Plan does not provide specific roles and responsibilities of AWWs or AWHs. However, a decree by the Ministry of Women and Child Development and the Ministry of Health and Family Welfare given in January 2006 is noted as providing clear guidance for AWW and AWH responsibilities. The Link Worker Operational Guidelines provide an overview of Link Worker tasks, but do not specify regulations regarding what can and cannot be provided.
46	Are there any policies specific to FP service provision (e.g. CHWs allowed to inject contraceptives)?	Information unavailable.

VI. INFORMATION SOURCES

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VII. AT-A-GLANCE GUIDE TO INDIA COMMUNITY HEALTH SERVICE PROVISION

The following table highlights the services and commodities provided by CHWs, by intervention area and cadre.

Intervention		ASHAs				AWWs				AWHs			
Family Planning	*Services/ Products*	*Informa-tion/ education*	*Counseling*	*Administered and/or provided product*	*Referral*	*Information/ education*	*Counseling*	*Administer-ed and/or provided product*	*Referral*	*Information /education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM*												
	Emergency Contraception	X	X	X	X				X				
	Condoms	X	X	X	X				X				
	Oral pills	X	X	X (re-supply)	X (initial only)				X				
	DMPA (IM)*												
	Implants*												
	IUDs	X			X				X				
	Permanent methods	X			X				X				
HIV and AIDS	VCT												
	Care and support												

	PMTCT												
Maternal and Child Health (MCH)	Misoprostol (for post-partum hemorrhage)												
	Zinc												
	ORS	X	X	X									
	Immunizations	X	X			X	X		X				
Malaria	Bednets												
	Indoor residual spraying												
	Sulphadoxine-pyrimethamine (SP)												
Nutrition	Meal planning					X	X			X	X		
	Child weighing					X	X	X		X	X	X	
	Food supplement					X	X	X		X	X	X	

*Not provided in the National Program.

Intervention		Link Workers			
Family Planning	*Services/Products*	*Information/education*	*Counseling*	*Administered and/or provided product*	*Referral*
	SDM/FAM*				
	Emergency Contraception				
	Condoms	X	X	X	
	Oral pills				
	DMPA (IM)*				
	Implants*				
	IUDs				
	Permanent methods				
HIV and AIDS	VCT	X			X
	Care and support	X			X
	PMTCT	X			X
MCH	Misoprostol (for PPH)				
	Zinc				
	ORS				
	Immunizations				

Malaria	Bednets				
	IRS				
	SP				
Nutrition	Meal planning				
	Child weighing				
	Food supplement				

*Not provided in the National Program.

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