ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: INDIA

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ACRONYMS

ACP	ASHA and community processes
ACP-BT	ASHA and community processes block team
ACP-DT	ASHA and community processes district team
ACP-MG	ASHA and community processes state mentoring group
ACP-MT	ASHA and community processes management team
ACP-RC	ASHA and community processes state resource center
ANM	auxiliary nurse-midwife
APC	Advancing Partners & Communities
ASHA	accredited social health activist
AWC	anganwadi center
AWW	anganwadi worker
CDPO	child development project officer
CHC	community health center
CHS	community health system
FP	family planning
ICDS	Integrated Child Development Services scheme
IUD	intrauterine device
LHV	lady health visitor
MAS	mahila arogya samite (female health committee)
MOHFW	Ministry of Health and Family Welfare
MS	mukhya sevika (supervisor)
MWCD	Ministry of Women and Child Development
NGO	nongovernmental organization
NHSRC	National Health Systems Resource Center
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
PHC	primary health center
PHSC	primary health sub-center

RMNCH	reproductive, maternal, newborn, and child health
TB	tuberculosis
USAID	Unites States Agency for International Development
VHSNC	village health, sanitation, and nutrition committee
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

INDIA COMMUNITY HEALTH OVERVIEW

India has no single community health policy, but a multitude of strategies and guidelines incorporate community health. Together, the policies describe critical information about community health providers, including selection criteria, supervision, and referrals, and map community-level service delivery across many health areas including FP, maternal and child health, and nutrition. However, there is less guidance in some health areas, such as HIV and AIDS. While policies are widely available, information is not always clear; because the country has numerous and large-scale community health initiatives, guidance is spread across many documents.

The *Guidelines for Community Processes*, however, attempt to align efforts at the community level by clearly defining community health groups, leaders, and providers at all levels and their roles and responsibilities. *The National Health Mission: Framework for Implementation 2012–2017* is a high-level strategy that situates community health within the larger national health and development context. Other important documents that detail the roles of community health providers and structures are the *Home-Based Newborn Care Operational Guidelines*, the *Guidebook for Enhancing the Performance of Multipurpose Worker (Female)*, and the *Induction Training Module for ASHAs.*

Table 1. Community Health Quick Stats

Main community health policies/ strategies	*Guidebook for Enhancing the Performance of Multipurpose Worker (Female)*	*Guidelines for Community Processes*	*Home–Based Newborn Care Operational Guidelines*	*Induction Training Modules for ASHAs*	*National Health Mission: Framework for Implementation 2012–2017*
Last updated	Not specified	2013	2014	Not specified	Not specified
Number of community health provider cadres	3 main cadres				
	Auxiliary nurse midwives (ANMs)		Accredited social health activists (ASHAs)		Anganwadi workers (AWWs)
Recommended number of community health providers[1]	178,963 ANMs		961,113 ASHAs		1,366,766 AWWs
Estimated number of community health providers[1]	212,185 ANMs		859,331 ASHAs		1,174,388 AWWs
Recommended ratio of community health providers to beneficiaries	1ANM: 5,000 people (3,000 in hilly or hard to reach areas)		1ASHA: 1,000 people (rural); 1ASHA: 1,000–2,500 people (urban)		1 AWW: 1,000 people
Community-level data collection	Yes				
Levels of management of community-level service delivery	National, state, district, block/primary health center (PHC), community				
Key community health program(s)	Home-based distribution of contraceptives; Home-based Newborn Care Program; Integrated Child Development Services (ICDS) scheme; prevention of postpartum hemorrhage through community-based distribution of misoprostol; Rashtriya Bal Suraksha Karyakram; Universal Immunization Program				

[1] Data on ANMs and ASHAs are from 2015; data on AWWs are from 2012.

Integrated Child Development Services (ICDS) scheme is a combined health and social welfare initiative that relies on community health providers called anganwadi workers to improve health and nutrition in pregnant women, children, and adolescent girls.

In India, civil society and community groups are involved in designing, planning, and implementing community health programs, ensuring quality improvement, and conducting monitoring and evaluation activities. They also support community health provider selection, training, and supervision.

India has three main cadres of community health providers: auxiliary nurse-midwives (ANMs), who work out of community facilities primarily on reproductive, maternal, newborn, and child health (RMNCH) services; accredited social health activists (ASHAs), who principally work in communities and provide a range of health services from FP to selected newborn care services; and *anganwadi* or "courtyard shelter" workers (AWWs), who focus on nutrition and growth monitoring activities.

Table 2. Key Health Indicators, India

	India	Uttar Pradesh[1]
Total population	1,329 m[2]	199.8 m[3]
Rural population	67%[2]	78%3
Total expenditure on health per capita (current US$)	$68[4]	—
Total fertility rate	2.3[2]	3.4
Unmet need for contraception	13.1%[5]	20.7%
Contraceptive prevalence rate (modern methods for married women 15-49 years)	52.4%[5]	37.6%
Maternal mortality ratio	174[6]	258
Neonatal, infant, and under 5 mortality rates	28 / 38 / 48[7]	49 / 68 / 90
Percentage of births delivered by a skilled provider	52.3%[5]	—
Percentage of children under 5 years moderately or severely stunted	38.7%[9]	56.8%[10]
HIV prevalence rate	0.2%[11]	0.2%[11]

[1] Specific data for Uttar Pradesh is included in this profile since the state is a specific focus of USAID. Unless otherwise noted, data for Uttar Pradesh is from: Government of India 2014; [2] PRB 2016; [3] Census of India 2011. [4] World Bank 2014; [5] United Nations 2015; [6] World Health Organization 2015; [7] World Bank n.d.; [8] UNICEF 2016a; [9] Ministry of Women and Child Development, Government of India 2015. [10] UNICEF 2016b; [11] National AIDS Control Organisation and National Institute of Medical Statistics 2015.

The country also has many large-scale community health programs and initiatives. Examples include:

- ICDS, a scheme largely facilitated by AWWs which seeks to improve nutrition of pregnant women, children, and adolescent girls.
- Home-based distribution of contraceptives, for which ASHAs and ANMs provide information on FP methods and distribute condoms and oral contraceptive pills.

The Integrated Child Development Services scheme is a combined health and social welfare initiative that relies on community health providers called anganwadi workers to improve health and nutrition in pregnant women, children, and adolescent girls.

- Home-based Newborn Care Program, which aims to improve selected newborn care services in communities.
- Prevention of postpartum hemorrhage through community-based distribution of misoprostol, a recent initiative that allows ASHAs and ANMs to provide misoprostol to women who have home deliveries in areas where health services are poor.
- *Rashtriya Bal Suraksha Karyakram*, an initiative under the National Rural Health Mission (NRHM), a subunit of the Ministry of Health and Family Welfare (MOHFW) that focuses on health and nutrition in children 0–18 years, including screening for birth defects, diseases, nutritional deficiencies, and developmental disabilities.
- Universal Immunization Program, which aims to rapidly increase immunization coverage and improve quality of immunization service delivery.

The MOHFW is responsible for most of India's programs and initiatives, although the Ministry of Women and Child Development (MWCD) oversees the ICDS scheme, which links to the health sector. Many programs and initiatives have been active for more than a decade and operate nationwide or plan to scale up to that level. Though some exist only in rural areas, many are also in both rural and urban areas. The national government is the main funder of these programs, though some operate with international donor support.

LEADERSHIP AND GOVERNANCE

In rural areas, community health service delivery is managed and coordinated across the national, state, district, block/primary health center (PHC), and community levels under the NRHM, which sits within the MOHFW. In urban areas, community health is managed through city, PHC/unit, and slum/ward structures—which are comparable to the rural structures at the district, block/PHC, and community levels—under the National Urban Health Mission (NUHM). Together, the NRHM and the NUHM manage activities related to what is referred to as ASHA and community processes (ACP) through the structures described below and summarized in Figure 1.

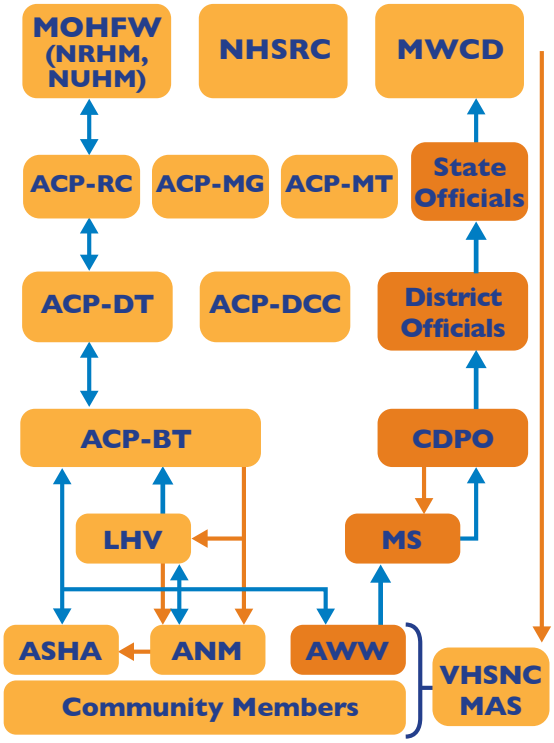
- At the national level, the NRHM and NUHM develop guidelines that include services at the community level with technical support from the National Health Systems Resource Center (NHSRC). The NRHM and NUHM approve state budgets for health activities, track expenditures on community-level services, and monitor health information.
- At the **state level**, the ACP is organized into three main bodies:
  - The management team (ACP-MT), which issues guidelines for implementation and oversees financing.
  - The state mentoring group (ACP-MG), which provides a technical and advisory role in ASHA curricula and training, supervision and mentoring, and evaluation.
  - The state resource center (ACP-RC), which establishes partnerships with organizations that can provide technical assistance for training, capacity building, developing educational materials, etc.
- At the **district level**, the district ACP coordination committee (ACP-DCC) oversees the administrative and financial aspects of health programming and ensures coordination between the state and district levels. The district team (ACP-DT) ensures quality in ASHA selection and training and conducts continuous monitoring and supportive supervision.
- At the **block/PHC level**, the block team (ACP-BT)—comprising ASHA facilitators, medical officers in-charge, community mobilizers, program managers, and nongovernmental organization (NGO) representatives—supports activities such as regular meetings, guideline dissemination, refresher trainings and supportive supervision for ASHAs and ANMs, ASHA payment processing, supply replenishment, and communication with the district. ASHA facilitators monitor ASHA performance, conduct supervision at the community level, and report to community mobilizers who then report to the ACP-DT.
- At the **community level**, ANMs, ASHAs, and AWWs conduct health activities and along with other community leaders, serve on village health, sanitation, and nutrition committees (VHSNCs), which support community health providers in health promotion and community mobilization activities. ASHAs are the secretaries of VHSNCs. In urban areas, *mahila arogya samiti* (MAS), or women's health collectives, play a similar role as VHSNCs. In some cases, ANMs may supervise ASHAs, though this is primarily the role of ASHA facilitators. ANMs report to lady health visitors (LHVs) who work at health facilities.

This list of structures is not exhaustive; there are many other critical entities at the state, district, and block levels working on various programs and initiatives. The MWCD directs and implements the ICDS scheme, one of the country's flagship community programs, following a different management structure. It has close ties to the health sector, particularly at the community level, where AWWs collaborate and share data with ASHAs and ANMs. AWWs report to *mukhya sevikas* (MSs), or supervisors, at anganwadi centers (AWCs). MSs report to child development project officers (CDPOs), which then report to the district, regional, and national levels. Periodically, teams from each of these levels conduct supervision at AWCs.

Figure1 summarizes India's health structure with specific attention to ACP and the ICDS scheme, including the managing bodies, service delivery points, and key actors at each level. In the diagram, ACP management is depicted in gold and ICDS scheme management in orange.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOHFW MWCD NHSRC	Medical Colleges and Institutes	
State	ACP-MG ACP-MT ACP-RC state officials	–	
District	ACP-DT ACP-DCC district officials	District Hospital, Sub-district Hospital	
Block / PHC	ACP-BT CDPO MS	AWC CHC PHC PHSC	
Community	ANM ASHA AWW MAS,VHSNC	ANM ASHA AWW	



* In large cities, community health management occurs through city, PHC unit, and slum/ward structures similar to those at the district, block/PHC, and community levels.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

In India, ANMs, ASHAs, and AWWs are the first stop for community health services. ANMs are formal community health providers responsible for health education, outreach, and services primarily related to RMNCH. ASHAs, who are volunteers, support ANMs with health and nutrition promotion, service provision, and community mobilization. The MWCD recruits AWWs, who provide nutrition services to children and pregnant and lactating women. They work closely with ANMs to prevent and manage malnutrition.

The three cadres organize and conduct village health and nutrition days at which they provide antenatal care, FP methods, and immunization, growth monitoring, and nutrition counseling activities. At the state and lower levels, the roles of these community health providers may be further defined based on local needs and current programs.

Table 3. Community Health Provider Overview

	ANMs	ASHAs	AWWs
Number in country	212,185	859,331	1,174,388
Target number	178,963	961,113	1,366,766
Coverage ratios and areas	1ANM: 5,000 people in the plains (4–5 villages) 1 ANM: 3,000 people in hilly or hard-to-reach areas Generally, one ANM covers a primary health sub-center (PHSC) in each village, though some areas require two.	1ASHA: 1,000 people (rural) 1ASHA: 1,000–2,500 people (urban)	1 AWW: 1,000 people
Health system linkage	ANMs work at public health facilities like PHCs and PHSCs.	ASHAs are voluntary workers within the formal health system; they collaborate with health workers at public health facilities.	The MWCD recruits AWWs to work on the ICDS scheme at the community level, which operates in conjunction with the MOHFW. AWWs work closely with ANMs and ASHAs.
Supervision	LHVs—nurses at PHCs— supervise ANMs. Members of the ACP-BT, including the block program manager, medical officer in-charge, the LHV and the village head, also may conduct annual ANM appraisals.	Each ASHA facilitator—a member of the ACP-BT—supervises approximately 20 ASHAs. On a day-to-day basis or in areas without ASHA facilitators, however, ANMs may supervise and mentor ASHAs. Members of the ACP-BT may also conduct supervision activities, though less regularly.	Each MS supervises about 20 AWWs. MS are in turn supervised by the CDPO. Teams from the IDCS scheme at all levels may conduct supervision visits at AWCs.
Accessing clients	On foot Bicycle Public transport Clients travel to them	On foot Clients travel to them	On foot Clients travel to them

Table 3. Community Health Provider Overview

	ANMs	ASHAs	AWWs
Selection criteria	17–35 years old Female Two years of schooling post grade 10 in arts or science from a recognized board of examination or the National Institute of Open Schooling	25–45 years old Female Minimum 8th grade education/10th grade in urban areas (guidance for age/education may be relaxed if no suitable candidate is available) Resident of rural village, urban slum, or vulnerable cluster Preferably married or previously married Has family and social support	18–44 years old Female 10th grade education Resident of the village Acceptable to the community in which she is expected to serve Representing a marginalized community
Selection process	ANMs must complete a two-year training from a school recognized by the Indian Nursing Council. Then they may apply for an ANM position.	A specially trained team including an ASHA facilitator and a community mobilizer from the district and block/PHC levels leads and facilitates ASHA selection. The team engages the community through meetings, focus group discussions, and mobilization events to explain the role of the ASHA and discuss the selection criteria. Then, the team includes community groups and local leaders to organize a community meeting to put forth the names of three ASHA candidates. The community then selects one of the candidates. States may modify the guidelines and the details of the selection process based on context.	A team comprised of district- and block-level actors within the MWCD, the PHC medical officer, and NGO actors selects the AWW.
Training	2-year training period (revised from 18 months in 2013)	Ranges between 20 and 24 days. During monthly meetings at the PHC, ASHAs may also engage in skill-building exercises led by district community mobilizers.	26-day initial training; 5-day refresher training

Table 3. Community Health Provider Overview

	ANMs	ASHAs	AWWs
Curriculum	The Indian Nursing Council prepares the ANM curriculum. Although the curriculum is not available, it may include the topics outlined in the *Guidebook for Enhancing Performance of the Multi-Purpose Worker (Female)*[1]: RMNCH services and education; skilled birth attendance; diagnosis and treatment of common ailments (fever, cough, diarrhea, etc.); and management of chronic illnesses (e.g., tuberculosis (TB), leprosy, diabetes).	*Induction Training Module for ASHAs.* Includes role/skills of the ASHA; definition of community health; basic information on health, hygiene, and illness; common health problems; infectious disease; maternal health; newborn care; infant and young child nutrition; and reproductive health, including FP. It also includes two refresher training modules on these topics. No publication year is listed on the available training guide.[2]	While the full AWW curriculum is not available, training and refresher schedules specify topics including information on social issues for women and children in India; ICDS; early childhood care and development; nutrition and health; communication, advocacy, and community participation; supervision, training, and management; supervised practice; and evaluation. No publication year is listed on the available training schedules.
Incentives and remuneration	ANMs receive financial incentives from the MOHFW, including a monthly salary and performance-based incentives. States may offer additional incentives. ANMs do not receive nonfinancial incentives.	ASHAs receive financial incentives such as per diems; incentives under various national health programs; and performance-based incentives that are tracked by the village leaders. Nonfinancial incentives include formal social recognition for service; opportunities for career advancement, such as priority admission to ANM and nurse training schools; and social security. The MOHFW provides financial and nonfinancial incentives.	AWWs receive honoraria of about $45 US per month and other monetary incentives determined at the state level and cash rewards for superior work. Nonfinancial incentives include formal social recognition; paid maternity leave for 180 days; life insurance; scholarships for their children; and uniforms. The MWCD provides incentives at the national, state, and district levels.

[1] The "multi-purpose worker (female)" is a recently developed title for an ANM, though it is not yet widely used in policy or practice.
[2] Although there is no date on the ASHA training guide, it has reportedly been developed in 2012 or after.

HEALTH INFORMATION SYSTEMS

ANMs, ASHAs, and AWWs in India collect community-level data. They maintain population registers to track births and deaths and record data on service provision, including home visits and outreach services, using monthly reporting forms. Some states in India have piloted the use of mobile health technology, such as text messaging and tablets for data collection.

ANMs and ASHAs submit monthly reports to block-level officials, who then enter the data into an online management information system along with data from community facilities. AWWs report to their MS and share information with ANMs and ASHAs. Although policy does not specify how community health data is to be used by communities, block and district levels discuss community data during monthly meetings, which helps them decide how to enhance service delivery.

Through the management information system, community health data flows to the district level, where it is combined with data from district and sub-district hospitals. Data then moves to the state and national levels, where program officers monitor implementation of health programs at the lower levels and provide feedback through reports. MOHFW staff and consultants from international donors, implementing partners, national NGOs, and civil society organizations undertake annual review missions to assess performance of health programs and initiatives in selected districts and states. States use feedback from the review mission reports to improve programming.

The blue arrows in Figure 1 depict the flow of community-level data.

HEALTH SUPPLY MANAGEMENT

According to policy, community health providers in India are expected to submit requests to replenish supplies and commodities with workers at higher-level facilities. For instance, ASHAs may place orders with ASHA facilitators during monthly meetings by completing a drug kit stock card to indicate which drugs need refilling. They obtain the commodities and supplies from medical officers at the block/PHC level, who receive them from state- and district-level warehouses, which procure them from either the national level or directly from manufacturers.

In some instances, workers at the community and block/PHC levels may obtain supplies and commodities using 'untied funds,' or small pots of money the NHRM or NUHM gives to VHSNCs/MASs to sustain their activities and for emergencies. Some states employ contraceptive management software to transfer commodities between facilities and health workers in the case of stockouts or emergencies. The government plans to scale up this software across multiple states.

Community health providers transport waste to the nearest PHC, community health center (CHC), or hospital with the appropriate waste management facilities. There, community health providers separate the waste into four categories—anatomical, recyclable, sharps, and glass—of bags or bins, which the facility disposes according to guidelines. ANMs may also carry hub-cutters for needles and small bags for other waste disposal.

Table 4 provides information about selected medicines and products that are included in India's *National List of Essential Medicines* (2015).

Table 4. Selected Medicines and Products Included in India's *National List of Essential Medicines* (2015)

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☐	Implants
	☐	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

SERVICE DELIVERY

Different service delivery packages are associated with India's various community-level programs and initiatives. Many relate to RMNCH. Table 5 outlines the ways that community health providers mobilize communities, provide health education, and deliver selected preventive and curative services.

Community health providers refer to the next level of care based on their training, experience, and by using job aids. They may refer clients to AWCs, PHSCs, PHCs, CHCs, and district hospitals depending on the treatment or services needed. ANMs, for instance, manage uncomplicated deliveries themselves but refer complicated deliveries to the CHCs that offer comprehensive emergency obstetric and newborn care.

For FP, community health providers may refer clients to:

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Door-to-door
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

- **PHSCs** and **PHCs** for CycleBeads, information on lactational amenorrhea method, condoms, oral contraceptive pills, emergency contraceptive pills, intrauterine devices (IUDs), postpartum FP services.
- **CHCs and higher facilities** for IUDs, permanent methods, and postpartum FP services.

In areas with poor health access, ANMs and ASHAs may distribute misoprostol to women who have had home births to prevent postpartum hemorrhage.

Policy does not explicitly mention where community health providers should refer clients for implants or injectable contraceptives.

Table 6 details selected interventions delivered by ANMs, ASHAs, and AWWs in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	ASHA, ANM	ASHA, ANM	Unspecified	Unspecified
	CycleBeads®	ASHA, ANM	ASHA, ANM	Unspecified	ASHA, ANM
	Emergency contraceptive pills	ASHA, ANM	ASHA, ANM	Unspecified	Unspecified
	Implants	No	No	No	No
	Injectable contraceptives	ANM	ANM	Unspecified	ANM
	IUDs	ASHA, ANM	ANM	ASHA, ANM	ASHA, ANM, AWW
	Lactational amenorrhea method	ASHA, ANM		Unspecified	ASHA, ANM
	Oral contraceptive pills	ASHA, ANM	ASHA, ANM	ASHA	ASHA, ANM
	Other fertility awareness methods	ASHA, ANM		Unspecified	ASHA, ANM
	Permanent methods	ASHA, ANM	No	ASHA, ANM	ASHA, ANM
	Standard Days Method	ASHA, ANM		Unspecified	ASHA, ANM
Maternal health	Birth preparedness plan	ASHA, ANM	ASHA, ANM	ASCP	ASHA, ANM
	Iron/folate for pregnant women[3]	ASHA, ANM, AWW	ASHA, ANM	ASHA, AWW	ASHA, ANM, AWW
	Nutrition/dietary practices during pregnancy	ASHA, ANM, AWW		Unspecified	Unspecified
	Oxytocin or misoprostol for postpartum hemorrhage	ASHA, ANM	ASHA, ANM	Unspecified	ASHA, ANM
	Recognition of danger signs during pregnancy	ASHA, ANM	ASHA, ANM	ASHA, ANM	ASHA, ANM
	Recognition of danger signs in mothers during postnatal period	ASHA, ANM	ASHA, ANM	ASHA, ANM	ASHA, ANM
Newborn care	Care seeking based on signs of illness	ASHA, ANM, AWW			ASHA, ANM
	Chlorhexidine use	No	No	No	No
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	ASHA, ANM		ASHA, ANM	Unspecified
	Nutrition/dietary practices during lactation	ASHA, ANM, AWW		ASHA	Unspecified
	Postnatal care	ASHA, ANM	ANM	ASHA	ASHA, ANM
	Recognition of danger signs in newborns	ASHA, ANM, AWW	ASHA, ANM, AWW	ASHA, ANM, AWW	ASHA, ANM, AWW

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	ASHA, ANM, AWW	ASHA, ANM, AWW	ASHA, AWW	ASHA, ANM, AWW
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	ASHA, ANM, AWW	ASHA, ANM, AWW	Unspecified	ASHA, ANM
	Exclusive breastfeeding for first 6 months	ASHA, ANM, AWW		Unspecified	ASHA, ANM, AWW
	Immunization of children[4]	ASHA, ANM, AWW	ANM	ASHA, AWW	ASHA, ANM, AWW
	Vitamin A supplementation for children 6–59 months	ASHA, ANM, AWW	ANM, AWW	ASHA	Unspecified
HIV and TB	Community treatment adherence support, including directly observed therapy	ASHA, ANM	ASHA, ANM	ASHA, ANM	ASHA, ANM
	Contact tracing of people suspected of being exposed to TB	No	No	No	No
	HIV testing	ASHA, ANM	ANM	ASHA, ANM	ASHA, ANM
	HIV treatment support	ASHA, ANM	ASHA	ASHA, ANM	ASHA, ANM
Malaria	Artemisinin combination therapy	ASHA, ANM[5]	ASHA, ANM	ASHA, ANM[6]	ASHA, ANM
	Long-lasting insecticide-treated nets	ASHA, ANM	ASHA, ANM[7]	Unspecified	ASHA[8]
	Rapid diagnostic testing for malaria	ASHA, ANM	ASHA, ANM	ASHA, ANM[9]	ASHA, ANM
WASH	Community-led total sanitation	No	No		
	Hand washing with soap	ASHA, ANM			
	Household point-of-use water treatment	ASHA, ANM, AWW			
	Oral rehydration salts	ASHA, ANM	ASHA, ANM	Unspecified	ASHA, ANM

[1] CycleBeads are not part of India's national FP basket, but they are part of the method mix in some states.
[2] Policy explicitly states that AWWs may conduct follow-up for women who receive IUDs; although it is not explicitly stated, it is possible that they may conduct follow-up for other methods as well.
[3] ASHAs and AWWs may provide information on and distribute iron/folate to non-pregnant women and adolescent girls.
[4] Also includes immunizations for newborns, including BCG, OPV, and Hepatitis B.
[5] ASHAs and ANMs may provide information on artemisinin combination therapy to the general population; target populations are not specified.
[6] ASHAs and ANMs may make referrals for artemisinin combination therapy for children under five years; other populations are not specified.
[7] ASHAs may provide insecticide treated nets for pregnant women and children under five years; other populations are not specified. ANMs may provide long-lasting insecticide-treated nets to children under five years and the general population; pregnant women are not specifically identified as a target population.
[8] ASHAs may conduct follow-up for long lasting insecticide-treated nets for pregnant women; other populations are not specified.
[9] ASHAs may make referrals for rapid diagnostic tests for children under five years; other populations are not specified.

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