ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: BENIN

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ACRONYMS

APC	Advancing Partners & Communities
ASCQ	qualified community health agent (agent de santé communautaire qualifié)
CA	arrondissement head (chef d'arrondissement)
CAD	departmental administrative conference (conférence administrative départementale)
CHS	community health system
C-IMCI	community integrated management of childhood illness
CoGEC	health center management committee (comité de gestion communautaire)
CoLoSS	health system local component (composante locale du système de santé)
CP	health center in-charge (chef de poste)
DDS	departmental health directorate (direction départementale de la santé)
DNSP	National Public Health Directorate (Direction Nationale de la Santé Publique)
EEZS	health zone management team (équipe d'encadrement de la zone sanitaire)
FP	family planning
IUD	intrauterine device
MS	Ministry of Health (Ministère de la santé)
NGO	nongovernmental organization
PASCom	National Community Health Support Program
PIHI	packages of high-impact interventions (paquets d'interventions à haut impact)
PNSC	National Community Health Policy (Politique Nationale de la Santé Communautaire)
RC	relais communautaire
RMNCH	reproductive, maternal, newborn, and child health
SNIGS	National Health Information and Management System (Système National d'Informations et de Gestion Sanitaire)
TB	tuberculosis
UASC	community health support unit
UCASC	commune community support unit (unité communale d'appui à la santé communautaire)
USAID	Unites States Agency for International Development
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 to 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.

BENIN COMMUNITY HEALTH OVERVIEW

Benin has a rich community health history. Following the Alma Ata Declaration in 1978 to strengthen community participation in primary health care, the country launched a strategy using village health workers and committees to deliver basic health interventions in communities. The Bamako Initiative a decade later resulted in an expansion of health activities, particularly related to immunization, which provided a stronger framework and more financial and logistical support for community-level structures and actors. In the early 2000s, the country's commitment to reducing child mortality led to renewed attention to community health providers delivering community integrated management of childhood illness (C-IMCI) interventions and introduction of a package of high-impact interventions (PIHI) in 2010.

Today, Benin's Community Health Support Program (PASCom) is the national community health framework. The Ministry of Health (MS) initiated the PASCom in 2015 to fill an array of service delivery gaps including unsustainable short-term programming; insufficient resource mobilization; weak supervision and monitoring systems; inconsistent strategies for motivating health workers; and an absence of community engagement in health. The program aims to build community capacity and ownership of health outcomes to reduce national morbidity and mortality.

Three main policy documents outline the PASCom. The *National Community Health Policy* (PNSC) lays out the key elements of the program, most notably establishing the main community structure, known as the health system local component (CoLoSS). The *Community Health Strategic Plan* is a strategic

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Package of High-Impact Interventions by Health Care Level to Reach the MDGs in Benin (Paquets d'interventions à haut impact [PIHI] par niveau de soins pour l'atteinte des OMD au Bénin)*	*National Community Health Policy* *(Politique nationale de la santé communautaire [PNSC])*	*National Directives to Implement the National Community Health Policy (Directives nationales de mise en oeuvre de la politique nationale de la santé communautaire [draft])*	*Community Health Strategic Plan (Plan stratégique de la santé communautaire 2017–2021 [draft])*
Last updated	2010	2015	2016	2017
Number of community health provider cadres	2 main cadres			
	Qualified community health agents (ASCQs)		Relais communautaires (RCs)	
Recommended number of community health providers	*Information not available in policy*		*Information not available in policy*	
Estimated number of community health providers	The ASCQ cadre is not yet operational		Approximately 13,000–15,000 RCs	
Recommended ratio of community health providers to beneficiaries	1 ASCQ: 1 village or neighborhood		1 RC: 30–50 households	
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, department, health zone, district, community			
Key community health program(s)	National Community Health Support Program (PASCom); other health area-specific programs			

framework for implementing the PNSC. Finally, the *National Guidelines for Implementing the National Community Health Policy* outlines the strategic axes on which the PNSC rests: institutionalization of the CoLoSS, community health governance, building capacity of health managers and providers, roles and responsibilities for capacity building, intra- and inter-sectoral collaboration, and securing financing and health supplies.

To enhance community participation in health, Benin established the 'local community system component,' or CoLoSS, which brings together community health providers, local leaders, and community members to plan and manage local health activities.

The PASCom is a public sector program led by the National Public Health Directorate (DNSP) within the MS. Nongovernmental organizations (NGOs) and civil society organizations are partners in planning, implementing, and monitoring the PASCom at all levels of the health system. Other sectors, including education, agriculture, finance, water, social promotion, and the private sector, support financing and implementation. Currently, the PASCom is still in planning stages and has not yet been fully scaled. It will operate nationwide in rural, urban, and peri-urban areas and will be funded by the national government, local government, international donors, and local NGOs.

The PASCom emphasizes community self-governance for improving health and capacity building for local actors via the CoLoSS. The CoLoSS comprises community health actors who are responsible for managing and implementing the PASCom in each village or neighborhood farther than five kilometers from a health center. The PASCom seeks to strengthen financing through municipal-level budgeting for community health activities, streamline the supply chain, and introduce a community health information system.

For many years, *relais communautaires* (RCs) have provided health and other services in Benin. In 2010, the MS developed the *National Directives for Community-Level Health Promotion* to define and harmonize the RC role within the health system, but RC responsibilities and training have varied across the country's 34 health zones based on local needs and partners' priorities and capacity. In 2015, the PASCom introduced another community health provider cadre called the qualified community health agent (ASCQ) who will collaborate with RCs once trained and deployed.

Table 2. Key Health Indicators, Benin

Total population[1]	10.8 m
Rural population[1]	56%
Total expenditure on health per capita (current US$)[2]	$38
Total fertility rate[3]	4.9
Unmet need for contraception[3,5]	32.6%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	7.9%
Maternal mortality ratio[4]	405
Neonatal, infant, and under 5 mortality rates[3]	23 / 42 / 70
Percentage of births delivered by a skilled provider[3]	84%
Percentage of children under 5 years moderately or severely stunted[3]	44.6%
HIV prevalence rate[5]	1.1%

[1]PRB 2016; [2]World Bank 2016; [3]INSAE and ICF International 2013; [4]World Health Organization 2015; [5]UNICEF 2013.

A multitude of health area-specific programs also serve communities, such as the National Malaria Control Program, the Hygiene and Sanitation Promotion Program, and the Integrated Family Health Program. Many operate in all areas of the country, though policy does not specify if they are coordinated.

Together, policies guide community health in areas such as FP, immunization, non-communicable diseases, and traditional medicine. However, policies lack key details on ASCQ and RC scopes of service and how they should manage and use data for decision-making. As a result, guidance for RCs is mainly from 2010 documents. There is also little information on referrals, supply management, and how many community health providers are required throughout the country.

Benin's health policies address gender issues. The *National Health and Development Plan 2009–2018* acknowledges that men normally have decision-making power—particularly regarding FP, health care-seeking, treatment, and the associated financial costs—and that women and children typically bear the consequences of these decisions. The document also indicates that few policies guide gender and health and that there is no mechanism for implementing or enforcing them. It recommends that future health activities include gender promotion but does not outline how this should happen. The PNSC suggests that the CoLoSS should promote women's leadership in health through participation in community-based organizations.

LEADERSHIP AND GOVERNANCE

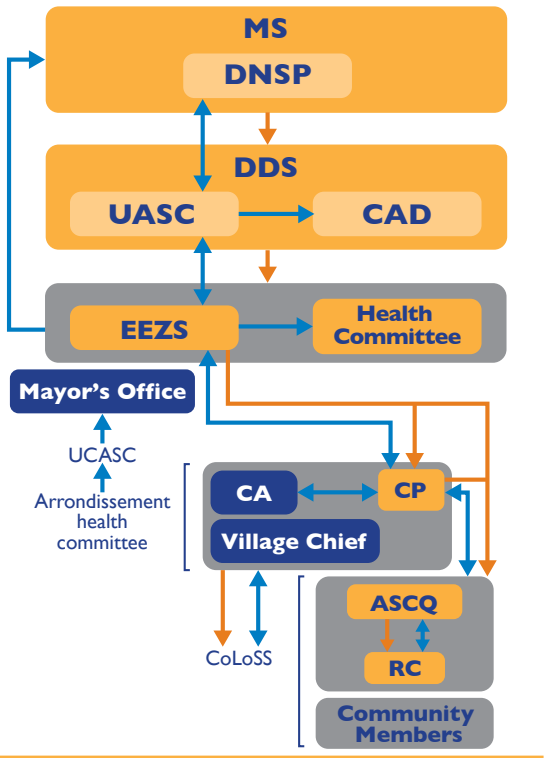
Administratively, Benin is organized into national, department, commune, arrondissement, and community levels. The country's health system is integrated into the administrative system but the levels of organization do not strictly align. Each department comprises 34 health zones. Each health zone contains several communes, which are subdivided into health areas. Each health area serves as the health center catchment and corresponds to approximately one arrondissement. Figure 1 summarizes the organization of this complex system, with the administrative actors in blue boxes and the health actors in orange boxes.

- The MS oversees the health sector at the **national level**. Within the MS, the DNSP is responsible for the PASCom, advocates for community health in other initiatives, and conveys information to lower levels of the health system. The MS and development partners, including international donors and NGOs, develop, disseminate, and update health strategies, curricula, and other planning materials; and ensure community health data collection, analysis, dissemination, and integration into the National Health Information and Management System (SNIGS).
- At the **department level**, the department health directorate (DDS) oversees health activities. Within the DDS, the departmental administrative conference (CAD) is the main coordinating body, and a community health support unit (UASC) provides technical support to the health zone management team (EEZS) related to the PASCom. Together, the UASC and the CAD train health workers and develop, update, and disseminate strategies, curricula, and other materials. The UASC shares information with the CAD and the DNSP.
- The chief decision-maker at the **health zone level** is the health committee. This committee and the EEZS provide technical support for PASCom implementation. The EEZS advocates for community health in other development sectors and conducts periodic supervision of the CoLoSS and health committees at lower levels. The EEZS shares information with the health committee and the DDS.
- A **commune** community health support unit (UCASC) is a multi-sectoral group of high-ranking commune officers that reports to the mayor's office. The UCASC has an operational function rather than technical. It executes decisions by the commune's council, which can include recruiting, establishing contracts with, and remunerating ASCQs and RCs; mobilizing resources; monitoring and sharing information; organizing ASCQ and RC training and refresher sessions and CoLoSS orientation; and replacing staff who perform poorly. The mayor's office quantifies, procures, and distributes community health equipment and materials with support from NGOs and donors.

- The **arrondissement level** generally aligns with each **health area**. The head of the arrondissement (CA), health center in-charge (CP), the village chiefs, and other local leaders serve on an arrondissement health committee, which supports community health coordination and supervision and reports to the UCASC. The CP supervises, mentors, monitors, and periodically retrains the CoLoSS, RCs, and ASCQs. He or she is linked to the arrondissement through a partnership agreement with the CA. Other health center staff and a health center management committee (CoGEC) help with community health provider recruitment, contracting, and remuneration.
- At the **community level**, the village council and the CoLoSS meet monthly to share information with the community and plan health activities. Under oversight of the village chief, the CoLoSS comprises local elected and traditional leaders; opinion leaders, representatives from health collectives and women's and men's groups, CoGEC members, RCs, and an ASCQ. The CoLoSS reports to the CA and the mayor's office. It determines local health priorities and supports ASCQ and RC resource management, including ensuring they receive payment. ASCQs supervise RCs.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point
National	MS DNSP	Hospital and University Center
Department	DDS CAD UASC	Departmental Hospital Center
Health Zone	EEZS Health Committee	Zonal Hospital
Commune	Mayor's Office UCASC	
Arrondissement/ Health Area	CA, CP, CoGEC, Arrondissement Health Committee	Arrondissement Health Center Health Center
Community	CoLoSS Village Chief	ASCQ RC



*NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

In 2015, the PASCOm established the ASCQ as a new community health provider cadre. ASCQs are salaried workers who have basic education as well as some previous health training. Once trained and deployed, they will be responsible for case management, promotion of UNICEF's 16 Key Family Practices; data collection, synthesis, validation, and submission; as well as training, supervising, and monitoring RCs. Policies include examples of ASCQ services (e.g., FP counseling, provision of oral and injectable contraceptives, and newborn care) but do not specify their full scope of service.

The scope of work for community health providers may vary across the country based on local needs, available resources, and NGO partner areas of focus. For instance, the MS has approved curricula to train ASCQs and RCs to administer injectable contraceptives in some areas.

RCs have provided preventive and curative services in Benin for many years. Their scope is derived from the PIHI and is outlined in guidance from 2010. It includes interventions related to family health, WASH, newborn health, young infant and child feeding, and C-IMCI. Under the PASCom, RCs are subdivided into two categories: those who provide preventive services only, and those who both preventive and curative services. Following deployment of ASCQs, the latter category will be gradually phased out so that RCs provide only preventive interventions.

ASCQs supervise and work closely with RCs. RCs support ASCQs in health promotion.

Table 3 provides an overview of these cadres.

Table 3. Community Health Provider Overview

	ASCQs	RCs
Number in country	The ASCQ cadre is not yet fully operational.	Between 13,000 and 15,000
Target number	*Information not available in policy*	*Information not available in policy*
Coverage ratios and areas	1 ASCQ: 1 village or neighborhood. This ratio may be adjusted in relation to accommodate the size of the population, geographical area of the village or hamlet, and sociolinguistic considerations. Operate in urban, rural and peri-urban areas.	1 RC: 30–50 households that are more than 5 kilometers from a health center or in a hard-to-reach area.
Health system linkage	ASCQs implement a government-led program in communities and are linked to a government health center.	RCs are linked with a government health center.
Supervision	The CP supervises ASCQs at least monthly and organizes a group supervision session with both ASCQs and RCs. The CA provides monthly administrative oversight to ASCQs. NGOs are partners in supervision.	ASCQs supervise an average of 3 RCs and conduct visits at least twice per month. The CP organizes a group supervision session with both ASCQs and RCs. NGOs are partners in supervision.
Accessing clients	On foot Motorbike	On foot
Selection criteria	Male or female 20 years of age or older Undergraduate study certificate or equivalent diploma Trained in basic nursing and obstetric care from an accredited school Recruited by the mayor's office	Male or female Volunteer From the community Chosen by the community Promotes health in his/her community Available
Selection process	The mayor's office recruits ASCQs.	RCs are chosen by the community, a process that village or neighborhood health groups, community-based organizations, and local NGOs may support. Further details are not provided.
Training	There is no guidance available about ASCQ training except that they will receive refresher trainings every 2 years.	Training is determined by the type of services required by the health zones in which they operate. If needed, RCs receive a 7-day training on C-IMCI, including rapid diagnostic testing, and a 4-day training on selected reproductive, maternal, newborn, and child health (RMNCH) and WASH interventions. RCs receive 5-day refresher trainings every 2 years.

Table 3. Community Health Provider Overview

	ASCQs	RCs
Curriculum	ASCQ training curricula have not been developed and/or are not yet available.	Policies do not state if a national RC training curriculum will be developed; rather, they insinuate that previous training modules will be adapted. In the past, RCs have been trained in C-IMCI using the *Integrated Case Management of Childhood Illness at the Community Level* (2011), which includes four modules: communication techniques; case management for fever, diarrhea, acute respiratory illness, and malnutrition in children under 5 years of age; follow-up of pregnant women, newborns, and new mothers; and management tools. Not all RCs in Benin are trained to conduct C-IMCI. RCs may be trained with other curricula as well, usually determined by the health zone and implementing partners that support specific programs.
Incentives and remuneration	ASCQs receive salaries and performance-based bonuses every trimester and financed by the MS, the mayor's office, and, in some locales, community funds. Policies note that ASCQs may also receive nonfinancial incentives but do not specify what they are.	RCs may receive performance-based bonuses every month of up to 20,000 West African CFA francs, financed by the MS, mayor's office, and in some locales, community funds. RCs may also receive free health care at the discretion of the medical coordinator in each health zone. Policies note that RCs may also receive other nonfinancial incentives but do not specify what they include.

HEALTH INFORMATION SYSTEMS

Guidance for data collection and community health information systems is spread across various policy documents and sometimes conflicts.

According to 2010 guidance, RCs document health data using stock forms, activity logs, case management registers, household registers, payment forms, and life event notebooks.[1] RCs then synthesize information and submit reports to their ASCQ supervisors during monthly meetings.

ASCQs review and compile data from the RCs and send reports to the CP. Local leaders, the CoLoSS, NGOs, and health collectives may help ASCQs with data analysis. The CP shares data with the CA and sends it to the health zone office. A health zone statistician reviews and inputs the data into a health management information system database specific to the PASCom. The Service for Information Management at the national level collects and manages information from this database. Community-level data is not currently integrated into the SNIGS, but there are plans to incorporate it in the future.

The role of departmental-level actors in data collection and review is unclear; some policies suggest that health data is shared at the department level, while others indicate that data moves directly from the health zone to the national level through an electronic system.

Policies do not explicitly state a mechanism for data sharing at the community level, though the CoLoSS has a role in assisting community health providers with reporting, prioritizing, planning, and decision-making.

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

Table 4. Selected Medicines and Products Included in Benin's list of *Generic Essential Drugs by Therapeutic Class and Corresponding Specialties* (2009)

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

HEALTH SUPPLY MANAGEMENT

ASCQs and RCs receive health supply starter kits after they complete training. Documents from 2010 indicate that RCs carry kits that include medicines for C-IMCI, condoms, oral contraceptive

1 Data collection and reporting tools are not detailed in 2015–2017 policies.

pills, spermicide, insecticide-treated nets, aquatabs, deworming medications, iron/folate, respiratory timers, and growth monitoring supplies. They also receive information, education, and communication materials including illustrated pamphlets and flipcharts.

Guidance does not specify the process for restocking commodities. However, as part of the activity planning process, the CoLoSS estimates the resources needed and communicates them to the mayor's office. The mayor's office, health zones, and/or local NGOs quantify, procure, and distribute materials. In some cases, NGOs and other technical and financial partners procure certain community health supplies.

Policies do not specify how community health providers access supplies in the event of a stockout, nor how they are expected to dispose of any medical waste.

Table 4 lists selected medicines and products included in Benin's *Generic Essential Drugs by Therapeutic Class and Corresponding Specialties* (2009).

SERVICE DELIVERY

The PIHI is Benin's main service delivery package and describes RMNCH interventions at the individual, household, and community levels. There is both a basic package and a complementary package, which comprises interventions that are implemented in selected areas and where resources are sufficient.

ASCQs and RCs refer clients to health centers for services they do not provide. Policy guidance does not indicate if RCs may refer to ASCQs. Staff at health centers are expected to counter-refer clients to community health providers for follow-up.

Table 5. Modes of Service Delivery

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

Using FP as an example, ASCQs and RCs may provide information on the lactational amenorrhea method and distribute condoms, oral contraceptive pills, and injectable contraceptives. They may refer clients to the health center for these methods as well as for implants, intrauterine devices (IUDs), and emergency contraceptive pills. Permanent methods are available at zonal hospitals, but the referral process is unspecified.

Table 6 provides details about selected interventions in FP, RMNCH, nutrition, tuberculosis (TB), HIV, malaria, and WASH that ASCQs and RCs may deliver. Because updated guidance and training manuals for both cadres are largely unavailable and/or yet to be developed, some of this information may be outdated or incomplete. Furthermore, because programs vary across different health zones, some interventions may only be implemented in parts of the country.

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	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
	CycleBeads®	Unspecified	Unspecified	Unspecified	Unspecified
	Emergency contraceptive pills	ASCQ, RC	Unspecified	ASCQ, RC	ASCQ, RC
	Implants	ASCQ, RC	No	ASCQ, RC	ASCQ, RC
	Injectable contraceptives	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
	IUDs	ASCQ, RC	No	ASCQ, RC	Unspecified
	Lactational amenorrhea method	ASCQ, RC		ASCQ, RC	ASCQ, RC
	Oral contraceptive pills	ASCQ, RC	ASCQ, RC[1]	ASCQ, RC	ASCQ, RC
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	ASCQ, RC	No	ASCQ, RC	Unspecified
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	Unspecified	Unspecified	Unspecified	Unspecified
	Iron/folate for pregnant women	RC	RC	RC	RC
	Nutrition/dietary practices during pregnancy	RC		RC	RC
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	Unspecified	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
	Recognition of danger signs in mothers during postnatal period	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
Newborn care	Care seeking based on signs of illness	ASCQ, RC			ASCQ, RC
	Chlorhexidine use	Unspecified	Unspecified	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	RC		RC	RC
	Nutrition/dietary practices during lactation	RC		RC	RC
	Postnatal care	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
	Recognition of danger signs in newborns	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC

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	ASCQ, RC	ASCQ, RC[3]	ASCQ, RC	ASCQ, RC
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years	RC	RC	RC	RC
	Exclusive breastfeeding for first 6 months	RC		RC	RC
	Immunization of children	RC	Unspecified	RC	RC
	Vitamin A supplementation for children 6–59 months[2]	RC	RC	RC	RC
HIV and TB	Community treatment adherence support, including directly observed therapy	Unspecified	Unspecified	Unspecified	Unspecified
	Contact tracing of people suspected of being exposed to TB	Unspecified	Unspecified	Unspecified	Unspecified
	HIV testing	Unspecified	Unspecified	Unspecified	Unspecified
	HIV treatment support	Unspecified	Unspecified	Unspecified	Unspecified
Malaria	Artemisinin combination therapy	ASCQ, RC	ASCQ, RC	ASCQ, RC	ASCQ, RC
	Long-lasting insecticide-treated nets	ASCQ, RC	ASCQ, RC[3]	ASCQ, RC	ASCQ, RC
	Rapid diagnostic testing for malaria	ASCQ, RC	ASCQ, RC[3]	ASCQ, RC	ASCQ, RC
WASH	Community-led total sanitation	Unspecified	Unspecified		
	Hand washing with soap	ASCQ, RC			
	Household point-of-use water treatment	RC			
	Oral rehydration salts[4]	ASCQ, RC	ASCQ, RC[3]	ASCQ, RC	ASCQ, RC

[1] Policies from 2015–2017 indicate that RCs may only provide refills for oral contraceptive pills.
[2] Guidance for RCs from 2010 indicates that they may administer this intervention; however, it is not included in more recent policies.
[3] After ASCQs are introduced, RCs will no longer provide this intervention.
[4] Guidance indicates that community health providers may administer these interventions to only children under 5 years of age.

KEY POLICIES AND STRATEGIES

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