ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: RWANDA

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ACRONYMS

APC	Advancing Partners & Communities
ASM	agent de santé maternelle
CBNP	Community Based Nutrition Program
CHS	community health system
CHW	community health worker
DHU	district health unit
FP	family planning
iCCM	integrated community case management
IUD	intrauterine device
MIYCN	maternal, infant, and young child nutrition
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
SISCom	système d'information sanitaire des communautés/CHW information system
TB	tuberculosis
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.

RWANDA COMMUNITY HEALTH OVERVIEW

The 1994 genocide in Rwanda resulted in an almost complete collapse of the health system. Following the end of the conflict, the Ministry of Health (MOH) embarked on an initiative to rebuild health services, which included establishing community health workers (CHWs) to provide services at the lowest levels of the health system—the *cell* and the *village*. The program began in 1995 with 12,000 CHWs who promoted healthy behaviors, conducted community mobilization, and provided basic services.

To ensure stronger management and more effective resource allocation, the MOH decentralized the health system. In 2004, the country designated the village as the lowest administrative level to encourage community ownership of development. This change shifted CHWs from the cell to the village level. The MOH also introduced an integrated community health services package, which transferred responsibility for selected maternal and child health services from health facility staff to CHWs. To meet community needs, the MOH increased the number of CHWs and scaled the program nationwide. Over the past decade, these efforts have contributed to health improvements, particularly in vaccination coverage rates and reduction in maternal and child mortality.

Table 1. Community Health Quick Stats

Main community health policies/ strategies	*Third Health Sector Strategic Plan (HSSP), July 2012 –June 2018*	*National Community Health Strategic Plan, July 2013– June 2018*	*Community Health Program Handbook*	*Health Sector Policy*	*National Community Health Policy*
Last updated	2012	2013	2015	2015	2015
Number of community health provider cadres	2 main cadres				
	Agents de santé maternelle (ASM)		Binomes		
Recommended number of community health providers	14,873 ASM[1]		29,746 binomes[2]		
Estimated number of community health providers	45,011 ASM and binomes combined[3]				
Recommended ratio of community health providers to beneficiaries	1 ASM : 1 village, or approximately 100-150 households		1 binome (pair of one male and one female CHW) : 1 village, or approximately 100-150 households		
Community-level data collection	Yes				
Levels of management of community-level service delivery	National, district, sector, cell, village				
Key community health program(s)	Community-based Nutrition Program (CBNP); Integrated Community Case Management (iCCM) Program; Community Maternal Newborn Health; Community- based Provision of Family Planning; Non-communicable Diseases and HIV/AIDS				

[1] Policy recommends one ASM per village. As of 2013, there were 14,873 villages, resulting in a recommended number of 14,873 ASM.
[2] Policy recommends 1 binome, or pair of CHWs, per village. As of 2013, there were 14,873 villages, resulting in a recommended number of 14,873 binomes, or 29,746 CHWs.
[3] As of 2013.

A number of policy and strategy documents guide Rwanda's health system. The 2015 *Health Sector Policy* provides a broad framework, sets priorities, and designates management and implementation roles. The *Third Health Sector Strategic Plan* guides implementation of the Health Sector Policy and includes annual targets. Other policies and strategies focus on specific health areas, including FP; nutrition; maternal, newborn, and child health (MNCH); and WASH.

Table 2. Key Health Indicators, Rwanda

Total population[1]	11.9 m
Rural population[1]	71%
Total expenditure on health per capita (current US$)[2]	$52
Total fertility rate[3]	4.2
Unmet need for contraception[3]	18.9%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	47.5%
Maternal mortality ratio[4]	210
Neonatal, infant, and under 5 mortality rates[3]	20 / 32 / 50
Percentage of births delivered by a skilled provider[3]	90.7%
Percentage of children under 5 years moderately or severely stunted[3]	37.9%
HIV prevalence rate[5]	3.0%

[1]PRB 2016; [2]World Bank 2016; [3]NISR, MOH, and ICF International 2015; [4]World Health Organization 2015; [5]UNAIDS 2015.

The *National Community Health Policy* guides community-level service provision and underscores how improving community health is critical for achieving Rwanda's overall health, economic, and development goals. Along with the *National Community Health Strategic Plan*, the policy outlines the community health system, including responsibilities of the management bodies at each level, implementation plans, monitoring and evaluation frameworks, and guidance for community performance-based financing. The *Community Health Program Handbook* further details the CHW scope of service as well as structures for recruitment, supervision, training, reporting, and incentives.

Two main cadres of volunteer community health providers operate in Rwanda: *agents de santé maternelle* (ASM), who deliver MNCH interventions, and *binomes*, who provide integrated community case management (iCCM) and general health services including FP. Each binome comprises a pair of community health providers, one male and one female. Policies refer to both ASM and binomes as CHWs. One binome and one ASM work in each village, and together the three CHWs conduct interventions and serve as the entry point to the health system.

Many types of community groups support Rwanda's community health system. CHW cooperatives comprise all the CHWs within each sector and are a platform for coordination and planning of health activities. Community hygiene clubs address issues in the village such as clean water, sanitation, and behavior change activities with support from CHWs. *Umugoroba w'Ababyeyi* (parents' evening forum) are support groups in each village, where parents discuss challenges across a variety of topics, including health. CHWs conduct community mobilization and health promotion during *Umugoroba w'Ababyeyi*.

Gender is central to many policies in Rwanda. The *National Gender Policy* provides guidelines and strategies for integrating gender into programs across multiple sectors, including health. The *National Community Health Strategic Plan* lays out strategies for combating sexual and gender-based violence at the community level. Health programs also focus on improving gender equity.

CHWs implement programs integrated at the community level, such as the Community-based Nutrition Program (CBNP), the iCCM program, the Community Maternal Newborn Health program, the Community-Based Provision of Family Planning program, and the Non-communicable Diseases and HIV/AIDS program. The MOH's Community Health Desk coordinates these programs, most of which operate nationwide. NGOs provide technical and financial support and assist with implementation in some districts. Most programs engage other sectors in implementation. For example, some programs collaborate with schools to provide health education, and the CBNP links with agriculture programs to improve community nutrition.

Rwanda's health policies are available and fairly comprehensive. The *Health Sector Policy* outlines plans to addresses current gaps, such as limited financial and geographic access to healthcare, poor service integration with other sectors, inadequate coordination between health facilities and the local government, and insufficient local human and financial resources to support a decentralized health system.

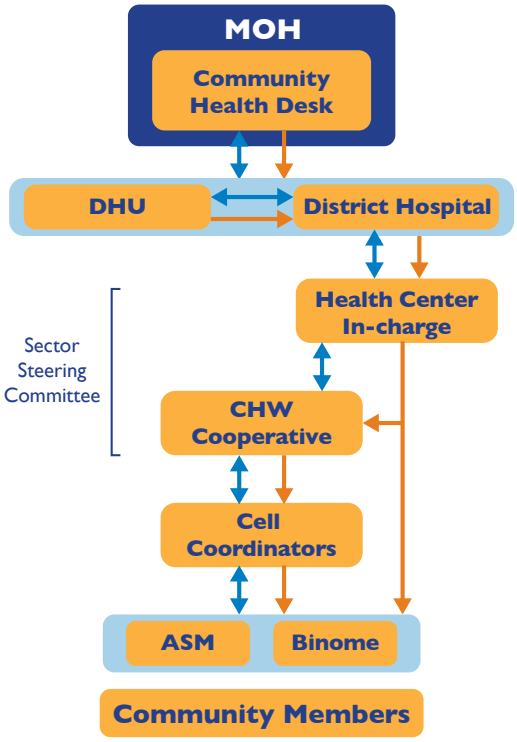
LEADERSHIP AND GOVERNANCE

Community-level service delivery in Rwanda is managed and coordinated across the national, district, sector, cell, and village levels. Each has a distinct role in supporting policy and program efforts.

- At the **national level**, the MOH provides broad oversight and develops guidelines, policies, and training manuals for community health programs; mobilizes resources; and coordinates stakeholders. The MOH's Community Health Desk oversees the coordination and management of community health programs, including planning, implementation, monitoring and evaluation, and general capacity-building. A national technical working group facilitates coordination between stakeholders, including other national bodies, civil society, and development partners.
- Under the decentralized system, the district health unit (DHU) oversees the implementation of community health policy at the **district level**. The DHU develops action plans, monitors progress, coordinates collaboration among implementing agencies and other sectors, and provides administrative support and technical oversight to district hospitals and health centers at the sector level. The district hospital directly oversees service implementation at the lower levels and manages disbursement of performance-based financing funds to CHW cooperatives, with oversight from the DHU.
- At the **sector level**, the Sector Steering Committee analyzes and approves monthly and quarterly reports from CHWs, approves performance-based financing payments to CHW cooperatives, and supports the CHW election process at the village level. It comprises community leaders, the health center in-charge, the health center accountant, the president of the CHW cooperative, and representatives from civil society. CHW cooperatives encourage and facilitate coordination of planning meetings for health interventions, and are overseen by the health center. The health center in-charge provides administrative oversight of CHWs, conducts trainings, oversees the referral system, and manages commodities and supplies.
- At the **cell level**, two CHWs (one binome member and one ASM) act as cell coordinators who oversee primary health services. The cell coordinators work with local leaders to plan health activities, conduct supportive supervision for all CHWs in the villages within that cell, and compile and submit CHW reports.
- Individual CHWs (ASM and binomes) deliver health services at the **village level**.

NGOs provide technical and administrative support at all levels of the health system and assist with implementation in some districts. Figure 1 summarizes Rwanda's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOH Community Health Desk TWG	Referral Hospital	
District	DHU District Hospital	District Hospital District Pharmacy	
Sector	Sector Steering Committee CHW Cooperative Health Center In-charge	Health Center	
Cell	Cell Coordinators		
Village	ASM Binome	ASM Binome	

*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

At the village level, one ASM and one binome pair operate as a team of three CHWs. The ASM provides mostly MNCH-focused services and links pregnant women to the health center for deliveries. The binome conducts iCCM, including malaria, diarrhea, pneumonia, and monitoring for malnutrition, as well as community-based provision of FP. Both cadres also conduct health promotion for hygiene, nutrition, breastfeeding, immunization, FP, and early care-seeking behavior; directly-observed therapy for tuberculosis (TB) patients; and screening for gender-based violence victims.

Rwanda uses a community performance-based financing system to incentivize high-impact service delivery by CHWs. CHWs are organized into collectives, which receive 70 percent of the payments to invest in income-generating activities, such as dairy farming and real estate development. Profits continue to motivate individual CHWs and help finance community health activities.

CHWs take part in a community performance-based financing system designed to incentivize high-impact health interventions to reach national targets. CHW performance measures are closely tracked by the CHW cooperative, and consolidated using a

reporting form, which the Sector Steering Committee reviews and approves. Payments are made to the CHW cooperative, and 30 percent is given directly to individual CHWs. The remaining 70 percent is invested into income-generating activities determined by each cooperative, such as poultry and dairy farming and real estate development. Profits from these activities are then divided amongst the individual CHWs, the cooperative to support operations, and a national reserve fund operated by the MOH to support and finance community health activities. This system has been credited with empowering CHWs to engage in income-generating activities and accelerating MNCH indicator improvements in communities.

Table 3 provides an overview of ASM and binomes.

Table 3. Community Health Provider Overview

	ASM	Binomes
Number in country	45,011 ASM and binomes combined[1]	
Target number	14,873[2]	29,746[3]
Coverage ratios and areas	1 ASM : 1 village, approximately 100–150 households Operate in urban, rural and peri-urban areas.	1 binome (pair of one male and one female CHW) : 1 village, approximately 100–150 households Operate in urban, rural and peri-urban areas.
Health system linkage	Volunteers who implement government health interventions, specifically MNCH, at the village level.	Volunteers who implement government health interventions, specifically iCCM and FP, at the village level.
Supervision	The health center in-charge provides administrative oversight to ASMs, while the cell coordinators provide technical supervision.	The health center in-charge provides administrative oversight to binomes, while the cell coordinators provide technical supervision.
Accessing clients	On foot Bicycle Public transport Clients travel to them	On foot Bicycle Public transport Clients travel to them
Selection criteria	Able to read, write, and calculate Completed at least primary level education 20–50 years old Willing to volunteer Lives in the village Honest, reliable, available, accessible, and trusted by the community Exemplary and a role model in the community in both health and social aspects Willing to maintain confidentiality Not a remunerated health worker at a health facility or a local leader	Able to read, write, and calculate Completed at least primary level education 20–50 years old Willing to volunteer Lives in the village Honest, reliable, available, accessible, and trusted by the community Exemplary and a role model in the community in both health and social aspects Willing to maintain confidentiality Not a remunerated health worker at a health facility or a local leader

Table 3. Community Health Provider Overview

	ASM	Binomes
Selection process	ASM are elected by the village. Elections typically take place during the *umuganda* (regularly organized community volunteer days), but may also take place in any other forum that convenes the village. Elections are supervised by health center staff and organized by the village executive committee. Candidates present their background and personal attributes and are elected by village members, who line up behind their chosen candidates.	One male and one female CHW are elected by the village to serve as the binome. Elections typically take place during the *umuganda* (regularly organized community volunteer days), but may also take place in any other forum that convenes the village. Elections are supervised by health center staff and organized by the village executive committee. Candidates present their background and personal attributes and are elected by village members, who line up behind their chosen candidates.
Training	ASM receive initial training from the health center staff on maternal, infant, and young child nutrition (MIYCN) (5 days); community information systems (3 days); and home-based maternal and newborn health care (6 days). On-the-job trainings are conducted as needed. The MOH organizes periodic refresher and additional trainings when a new program or policy is introduced.	Biomes receive initial training from the health center staff on MIYCN (5 days); community information systems (3 days); reproductive health and supply chain of commodities (4 days); ICCM (5 days); and community-based provision of FP services (10 days). Binomes also undergo training on adolescent sexual and reproductive rights, and gain practical experience conducting mentorship sessions with adolescent girls over the course of 10 months. On-the-job trainings are conducted as needed. The MOH organizes periodic refresher and additional trainings when a new program or policy is introduced.
Curriculum	ASM are trained using a variety of curricula, including: *Home-Based Maternal and Child Care: Training Module for Community Maternal Health Workers* (2010); *The Community Maternal, Infant and Young Child Nutrition Counselling Package* (2011); *User Training Manual, CHWs and Supervisors: Tracking 1,000 Days RapidSMS Rwanda* (2013); *National Postnatal Care Guideline for Mother and Newborn* (2015).	Binomes are trained using a variety of curricula, including: *The Community Maternal, Infant and Young Child Nutrition Counselling Package* (2011); *User Training Manual, CHWs and Supervisors: Tracking 1,000 Days RapidSMS Rwanda* (2013); *Trainer's Guide: Integrated Community Case Management of Childhood Illness* (2014); *Community Based Provision of Family Planning Trainer Guide* (2015).
Incentives and remuneration	ASM receive per diems and compensation through a community performance-based financing scheme for meeting pre-determined service delivery goals. ASM also receive a variety of non-financial incentives, including membership in the CHW cooperative; t-shirts; umbrellas; formal social recognition; mobile phones; boots; flashlights; identification badges; and participation in study tours.	Binomes receive per diems and compensation through a community performance-based financing scheme for meeting pre-determined service delivery goals. Binomes also receive a variety of non-financial incentives, including membership in the CHW cooperative; t-shirts; umbrellas; formal social recognition; mobile phones; boots; flashlights; identification badges; and participation in study tours.

[1] As of 2013.
[2] Policy recommends one ASM per village. As of 2013, there were 14,873 villages, resulting in a recommended number of 14,873 ASM.
[3] Policy recommends 1 binome, or a pair of CHWs, per village. As of 2013, there were 14,873 villages, resulting in a recommended number of 14,873 binomes, or 29,746 CHWs.

HEALTH INFORMATION SYSTEMS

The Rwanda health management information system collects data on service provision from health centers, district hospitals, and referrals. Parallel electronic information systems collect data from a CHW information system (SISCom), which tracks community-level service data; an integrated information system for human resource management data; and a logistics management information system for commodity tracking and supply. A national MOH dashboard consolidates data from each reporting system to allow integrated indicator tracking.

ASM and binomes collect data using home visit registers and stock cards. In the village, they consolidate their data into a monthly village paper-based reporting form and submit it to their cell coordinators. The CHW cooperative collects reports from the cell coordinators in their sector and submits them to the health center. Data are shared with the sector steering committee and sent to the district hospital, where they are entered into the electronic SISCom and transmitted to the MOH's Community Health Desk.

CHWs use mobile phones to report through a real-time RapidSMS text message reporting system. They report on specific indicators including pregnancies; child vaccinations; antenatal consultations; births; postnatal care visits; newborn care visits; iCCM; nutrition; life-threatening emergencies; maternal, newborn, and child deaths; and growth monitoring in children under five years of age.

Data collected at the cell and sector levels are interpreted locally and used to inform decisions. The Community Health Desk uses data for policy development and provides feedback to the decentralized levels.

The flow of data through Rwanda's health system is represented by blue arrows in Figure 1.

Table 4. Selected Medicines and Products Included in Rwanda's *National List of Essential Medicines for Adults, 6th Edition* (2015) and *National List of Essential Medicines for Paediatrics, First Edition* (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

HEALTH SUPPLY MANAGEMENT

CHWs are linked to the national supply chain, ensuring a reliable supply of community health commodities. ASM and binomes track commodity use with stock cards and request refills from their cell coordinators. The cell coordinators receive the required commodities and supplies from the health center during monthly coordination meetings and distribute them to CHWs. Policy does not specify where ASM and binomes should access back-up supplies in case of stockouts.

ASM and binomes collect medical waste in disposal boxes and bring them to the health center for proper disposal.

The full list of commodities that ASM and binomes provide is not available, but Table 4 shows selected medicines and products included in Rwanda's *National List of Essential Medicines for Adults, 6th Edition* and *National List of Essential Medicines for Paediatrics, First Edition*, both published in 2015.

SERVICE DELIVERY

ASM and binomes provide services according to their respective integrated packages. The ASM package includes MNCH services, while the binome package focuses on iCCM and FP. A general package for both cadres includes nutrition, health promotion, and TB services.

Table 5 summarizes the various channels that ASM and binomes use to mobilize communities, provide health education, and deliver clinical services.

ASM and binomes can refer patients to each other for services that fall within the other cadre's scope. When a patient requires more advanced care, both cadres refer patients to the health center or the district hospital. Health centers routinely counter-refer patients to both cadres for follow-up.

Using FP as an example, binomes can provide condoms, injectable contraceptives, oral contraceptive pills, and information on the Standard Days Method. ASM do not distribute FP commodities, but can provide information on the same range of methods and refer patients to binomes for the methods they provide. Both cadres refer patients to health centers for the same methods binomes can provide, as well as implants and permanent methods. They can also refer patients seeking implants or permanent methods to the district hospital.

Table 6 provides details about selected interventions delivered by ASM and binomes in the following health areas: FP, MNCH and nutrition, TB, HIV, malaria, and WASH.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	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
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
	Umuganda (community service events)

***Umuganda* are monthly community service events in which Rwandans between the ages of 18 and 65 years discuss community development issues and plans. During umuganda, CHWs mobilize communities to use health services.**

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	ASM, binome	Binome	ASM, binome	Binome
	CycleBeads®	ASM, binome	Binome	ASM, binome	Binome
	Emergency contraceptive pills	Unspecified	Unspecified	Unspecified	Unspecified
	Implants	No	No	ASM, binome	No
	Injectable contraceptives	ASM, binome	Binome[1]	ASM, binome	Binome
	IUDs	No	No	ASM, binome	No
	Lactational amenorrhea method	Unspecified		Unspecified	Unspecified
	Oral contraceptive pills	ASM, binome	Binome[1]	ASM, binome	Binome
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	No	No	ASM, binome	No
	Standard Days Method	ASM, binome		ASM, binome	Binome
Maternal health	Birth preparedness plan	ASM	Unspecified	Unspecified	ASM
	Iron/folate for pregnant women	ASM, binome	ASM, binome[2]	Unspecified	ASM, binome
	Nutrition/dietary practices during pregnancy	ASM		ASM	ASM
	Oxytocin or misoprostol for postpartum hemorrhage	ASM, binome	ASM, binome	ASM	ASM
	Recognition of danger signs during pregnancy	ASM	ASM	ASM	ASM
	Recognition of danger signs in mothers during postnatal period	ASM	ASM	ASM	ASM
Newborn care	Care seeking based on signs of illness	ASM, binome			ASM, binome
	Chlorhexidine use	Binome	Binome	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	ASM, binome		Unspecified	ASM, binome
	Nutrition/dietary practices during lactation	ASM, binome		Unspecified	ASM, binome
	Postnatal care	ASM	ASM	ASM	ASM
	Recognition of danger signs in newborns	ASM	ASM	ASM	ASM

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	ASM, binome	ASM, binome	ASM, binome	ASM, binome
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[3]	ASM, binome	ASM, binome	Unspecified	ASM, binome
	Exclusive breastfeeding for first 6 months	ASM, binome		Unspecified	ASM, binome
	Immunization of children[4]	ASM, binome	Unspecified	ASM, binome	ASM, binome
	Vitamin A supplementation for children 6–59 months	ASM, binome	Unspecified	ASM, binome	ASM, binome
HIV and TB	Community treatment adherence support, including directly observed therapy	ASM, binome	ASM, binome	ASM, binome	ASM, binome
	Contact tracing of people suspected of being exposed to TB	Unspecified	Unspecified	Unspecified	Unspecified
	HIV testing	ASM, binome	No	ASM, binome	Unspecified
	HIV treatment support	Unspecified	Unspecified	Unspecified	Unspecified
Malaria	Artemisinin combination therapy[5]	Binome	Binome	Binome	Binome
	Long-lasting insecticide-treated nets	ASM, binome	ASM, binome	ASM, binome	ASM, binome
	Rapid diagnostic testing for malaria	Binome	Binome	Binome	Binome
WASH	Community-led total sanitation	Unspecified	Unspecified		
	Hand washing with soap	ASM, binome			
	Household point-of-use water treatment	Unspecified			
	Oral rehydration salts	Binome	Binome	Unspecified	Binome

[1] Binomes can provide injectable contraceptives and oral contraceptive pills only to returning clients who have no history of complications. First-time users and clients with previous complications are referred to the health facility.
[2] ASM and binomes can also provide iron/folate to non-pregnant women and adolescent girls.
[3] ASM can also provide de-worming medication to the general population.
[4]ASMs and binomes monitor the immunization status of children and encourage parents to adhere to the immunization schedule. Policy does not specify which vaccinations they promote.
[5] Policy only states that binomes can provide artemisinin combination therapy to children as part of iCCM services.

KEY POLICIES AND STRATEGIES

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