



# Country Report for Bhutan

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Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

**Date:** January 2022

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**Commissioned by UNICEF Regional Office for South Asia**

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**Special thanks to:**

The participants in Bhutan who took part in the study, and the  
Bhutan Ministry of Health and UNICEF Country Office staff who  
supported the study.

# Content

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Executive summary	5
Introduction and background	10
Country context	10
Object of the evaluation	11
Purpose and objectives of the evaluation	14
Scope of the Evaluation	
Methodology	17
1. Data collection	17
2. Data analysis	17
3. Gender Analysis Frameworks	20
4. Frameworks used to inform data collection and analysis	20
5. Ethical standards	21
6. Limitations and mitigation measures taken by evaluation team	21
Findings	22
1. Current CHW profiles, roles and responsibilities, policies and systems support	22
2. Policy and system support improvements to optimize the VHW programme in Bhutan	32
3. Prioritised measures to strengthen health policy and system support to optimize the contribution of VHWs to PHC	34
Conclusions and Recommendations	37
Annexes	38
Annex 1: Generic KII topic guide	38
Annex 2: KII topic guide for gender	41
Annex 3: References	43
Annex 4: Ethical approval letter	45
Figures	
Figure 1: Illustrative theory of change for CHW programme	12
Figure 2: Conceptual framework for gender analysis	19
Figure 3: Gender responsive assessment scale	20
Figure 4: Roles and responsibilities of VHWs in Bhutan	25
Figure 5: Selection, education and training pathway for VHW	27
Figure 6: Gender assessment of CHW programme	33
Tables	
Table 1: Indicative evaluation matrix	16
Table 2: Analysis plan	18
Table 3: Number of VHWs in Bhutan	22
Table 4: Training and supervision of VHW in Bhutan	27

# Acronyms

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<b>ANC</b>	Antenatal Care
<b>BCC</b>	Behaviour Change Communication
<b>BHTF</b>	Bhutan Health Trust Fund
<b>BHU I</b>	Basic Health Unit
<b>BHU II</b>	Basic Health Units II
<b>CHW</b>	Community Health Worker
<b>CMNH</b>	Centre for Maternal and Newborn Health
<b>CPD</b>	Continuing Professional Development
<b>DHO</b>	District Health Officer
<b>DV</b>	Domestic Violence
<b>GBV</b>	Gender Based Violence
<b>GNH</b>	Gross National Happiness
<b>GNHC</b>	Gross National Happiness Commission
<b>HA</b>	Health Assistant
<b>IPC</b>	Interpersonal Communication
<b>KI</b>	Key Informant
<b>KII</b>	Key Informant Interview
<b>LSTM</b>	Liverpool School of Tropical Medicine
<b>MMR</b>	Maternal Mortality Ratio
<b>MOH</b>	Ministry of Health
<b>NCDs</b>	Non-Communicable Diseases
<b>NGO</b>	Non-Governmental Organization
<b>ORC</b>	Outreach Clinic
<b>PHC</b>	Primary Health Care
<b>PNC</b>	Post Natal Care
<b>RGOB</b>	Royal Government of Bhutan
<b>RMNCAH</b>	Reproductive, maternal, newborn, child and adolescent health
<b>ROSA</b>	Regional Office for South Asia
<b>SDG</b>	Sustainable Development Goals
<b>SOW</b>	Scope of Work
<b>UHC</b>	Universal health coverage
<b>UNEG</b>	United Nations Evaluation Group
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization
<b>VHW</b>	Village Health Worker



## Executive summary

### Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of primary health care (PHC) in achieving universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs). Community Health Workers (CHW) are the backbone of PHC and evidence highlights their effectiveness in delivering a range of preventive, promotive and curative services. In the South Asian context of ongoing demographic and epidemiologic changes, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to address any gaps, a formative evaluation CHW policies and systems support in South Asian countries was conducted. The evaluation also assessed the readiness of CHW programmes to expand or change roles and responsibilities within the post-Astana national health care strengthening plans.

For Bhutan, the evaluation team, in consultation with UNICEF ROSA, the UNICEF Bhutan office and the Ministry of Health

confirmed that there was one CHW cadre active in the country, known as the Village Health Workers (VHW). This cadre falls within the WHO's CHW definition and it was agreed that they would be covered by this evaluation. VHWs act as a link between the health system and the communities at the grassroots level to provide first aid, treatment of minor ailments, create awareness and mobilize community for health promotion and improving sanitation.

### Objective, methodology and intended use of the evaluation

The overall objective of the evaluation is to understand the congruence between the current profiles, policy framework and system support for CHWs, especially those involved in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) programmes, and the profiles, policy framework and system support required to better serve RMNCAH, and to respond to PHC reform and strengthening in seven countries of South Asia, including Bhutan.

The findings will inform national government plans and enhance UNICEF's and partner's advocacy and technical guidance to local governments who are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

The evaluation responds to the following three key evaluation questions (KEQ):

1. What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?
2. What policy and system support improvements are needed to realistically optimize the profiles, roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening.
3. What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?

Bhutan achieved Millennium Development Goals (MDG) 4 and 5. There is a high coverage in RMNCAH services which has translated into a drastic reduction of maternal and child morbidities with concomitant reduction in mortality due to preventable causes. However, Bhutan currently strives to address the triple burden of disease. There are disparities in infant mortality related to wealth, and despite free health care, there are disparities in access to health care due to remoteness and out of pocket expenditure related to transport and medicines. Non-communicable diseases (NCD) are gaining prominence. Shortage of human resources, especially doctors and specialists, is the major challenge faced by the Ministry of Health.

## Methodology

The evaluation used a mixed methods approach for this evaluation that combined a desk review and key informant interviews. The review examined available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local non-governmental organizations, evaluation reports, training guidelines, and CHW databases. In addition, qualitative data was collected through 12 interviews with 12 national level key informants (KIs) involved in the CHW programmes.

A semi-structured topic guide and a gender-specific guide, informed by the evaluation framework and analysis plan was used to collect data. Analysis was conducted using NVivo Version 11 based on the following: the World Health Organization (WHO) Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018), the WHO Gender Responsive Assessment Scale (WHO, 2011), and the Steege et al (2018) conceptual framework.

## Gender analysis

In addition, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

## Findings

### 1. Current CHW profiles, roles and responsibilities, policies and systems support

The findings below relate to KEQ 1.

**Current CHW profiles and roles and responsibilities**  
There is only one CHW cadre in Bhutan, called the VHW, who are the link between the formal health system and the communities. They are expected to provide first aid and treatment for minor ailments, create awareness and mobilize the community for health promotion (particularly in reproductive, maternal and child health) and improving sanitation. There are a total of 1150 VHWs as of 2018, and a majority (77 per cent) of them are men. VHWs are voluntary workers and each VHW covers approximately 20-30 households. There is no VHW or any other CHW cadre in urban areas.

### Key policies and the policy environment for CHWs

Health is recognized as one of the nine domains of the Gross National Happiness (GNH) policy and Bhutan's 2008 Constitution mandates universal access to health as part of the government's commitment to GNH. The VHW programme is seen as key to PHC and achieving UHC in Bhutan. The programme was conceptualised as volunteer-led care provided by community members to community members, as set out in the 2013 Village Health Worker Programme Policy and Strategic Plan 2013 to 2018. The government has a policy of community participation in health, and VHWs function as a bridge between the community and the various programmes of the formal health system under the Ministry of Health (MOH).

A VHW Programme Officer, based in Thimphu in the Non-Communicable Diseases Division (NCDD) of the MOH is responsible for maintaining the VHW database which includes the numbers and the distribution of VHWs across the country. Health administration and management has been devolved to districts.

Challenges related to the VHW programme identified include a lack of guidance documents on VHW and MoH engagement, lack of prioritization for the VHW programme in resource provision, and dissonance between policy at the central level and local implementation by local government.

### CHW roles and responsibilities and focus on RMNCAH

VHWs provide services in the community and act as the link between health services and the community, facilitating access to quality services. VHWs are not expected to provide clinical care but rather, to promote healthy practices and care seeking behaviours in the community.



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The VHW's scope of work (SOW) is defined in the 2013-2018 Village Health Worker Programme: Policy and Strategic Plan. Their roles and responsibilities include RMNCAH health promotion activities including safe motherhood interventions, nutrition in pregnancy, exclusive breastfeeding, newborn care, and prevention of teenage pregnancy, support for TB DOTS therapy, health communication on malaria, HIV, alcohol and tobacco use, distribution of medicines like iron folate, anti-helminthics and oral contraceptives, and community engagement activities. Although the SOW includes preventive and promotive services related to adolescent health, with a focus on teenage pregnancy, it is unclear what services VHWs currently provide for adolescents. Pregnancies below the age of 18, whether within marriage or outside, are criminalized, and entail punishment for the male partner. Thus, VHWs are often reluctant to report such pregnancies, resulting in a lack of access to appropriate care and support for these adolescents.

VHWs are estimated to work around 40–50 hours per month. However, their original scope of work has expanded to include a wider range of services, including community-based postnatal care, newborn care and NCD screening.

### Selection, education and certification

VHWs are selected in consultation with the community and they must be literate with at least eight years education, permanent resident in the community, and acceptable to the community. They could be of either sex, but majority are men. Once selected, they undergo a seven-day initial training, followed by a three-day refresher training annually. Training is provided by the Health Assistant and District Health Officer who have been trained as trainers. VHWs are certified after a post-training assessment. Challenges identified in the VHW selection and training include a high rate of illiteracy among VHWs affecting their performance, lack of training material in local language, high turnover and attrition of VHWs, and gender imbalance among VHWs.

### Management and supervision

VHWs are a non-salaried and voluntary cadre. The high attrition of VHWs has been attributed to the lack of remuneration and fair compensation for travel and participation in training. Career progression for VHWs is limited.

Health Assistants (HAs) based in the health facility are responsible for the training and supervision of the VHWs and are expected to review the VHWs' work and performance on a monthly basis. The community has a role in monitoring and evaluating the activity of the VHW through *chiwog tshogpa*. Supervision is generally perceived to be poor and there are no standard operating procedures or clear guidance for how supervision at BHU and district level is expected to be carried out.

### Integration of VHWs into the health system and community

VHWs are expected to work closely with staff in the BHU. In addition, the community is expected to play an active role in providing feedback, solving problems, and helping to establish VHW as leaders in the community.

VHWs keep simple records of their activities and submit specific information through monthly reports to the HA who oversees their work. They are provided with an Extension Kit; however, these may not be consistently available.

### Financing of CHW programme

Within the Royal Government of Bhutan (RGOB), financial commitment to the VHW programme has not been a priority. Government funding has been proportionately higher for curative care than for the preventive and promotive care offered through the VHW programme.

### Private sector involvement in CHW programmes

There is little private sector involvement in health in Bhutan

and there is no private sector involvement or contribution to CHW programmes.

## 2. Policy improvements to optimize CHW programmes to respond to post-Astana requirements and PHC strengthening, including gender responsive policies

The findings below relate to KEQ 2.

### Improved financing and integration of the VHW programme within the health system and MOH programmes

Funding for the VHW programme is mostly opportunistic. The VHW programme would better serve its objectives if integrated within the overall health system, the national strategic plan, and in all the health programmes across the country, which will enhance its sustainability, its effectiveness and its performance management.

### Advocacy for health as a priority on the district development agenda

Improving the understanding and capacity of Dzongkhag and Gewog leadership of the importance of health in development, and the role VHWs can play in this, will ensure that adequate funding is available for PHC and community-based services at sub-national level.

### Strengthening the VHW programme

Including the VHW workforce in national and district HR plans and budgets and recognizing these cadres as an important subset of the PHC workforce will also enhance their integration and help to ensure they get the policy and system support they require.

### Involving other programmes in health promotion activities

Non-formal educators based in every gewog could be potentially trained to provide health messages and mobilize the community, taking on the VHW role and/or working in collaboration with existing VHWs, and supporting them with health education and promotion.

### Strengthening PHC in urban settings

Establishing a cadre like the VHW for urban health could ensure the provision and effective coverage of services in urban settings.

### Mainstreaming and provisioning for gender in policies

Under the Twelfth Five-Year Plan (2018-2023), gender should be mainstreamed into all government policies and plans and all project proposals, policies and projects should be screened using the gender screening tool developed by the Gross National Happiness Commission. However, in

practice, many policies are found not to be very strong in their gender components, raising questions about the strength of the tool to pick up gender sensitivity. Resource allocation also needs to follow RGOB efforts to improve the gender responsiveness and transformative aspects of its policies, to ensure meaningful change follows the introduction and implementation of its gender policies. While gender equality and equity are being considered at a macro level in the formulation of a gender equality policy and a gender action plan, they also need to be addressed in operational and implementation plans across all sectors at all levels. All health programmes should be also be periodically reviewed with a gender, social inclusion and disability lens.

## 3. System support improvements to optimize CHW cadres to respond to post-Astana requirements and PHC strengthening

The findings below relate to the third question

### Improving VHW recruitment practices

In the short term, to address literacy gaps in VHWs, more visual educational materials and job aids translated into Dzongkha may help those who have low level of literacy. Targeting and supporting VHWs, especially women who are interested, to achieve a functional level of literacy would enhance their performance, would help attract and retain more female VHWs, as well as contribute to their empowerment. Efforts could be made to attract candidates with higher level of prior learning for more specialized and expanded VHW roles, especially for the provision of community based RMNCAH and NCD services.

### Regular training and supportive supervision

The initial and continuing training of VHW should be systematic and provided on a regular and consistent basis. The training content and approaches should be appropriate for the level of education of current VHWs. The capacity and competencies of trainers and supervisors should also be continuously updated.

Valuing the contribution of VHWs within the health system It is critical to acknowledge and continue to support the important role VHWs play in PHC and address the motivational factors and sources of job dissatisfaction, including lack of remuneration and career pathways.

### Remuneration and compensation

The current compensation policy needs to be reviewed and the range and types of incentives provided to VHWs improved to address the motivation and retention of VHWs. VHWs could also be compensated for specific activities.

### Expanding the role of VHWs

If the numbers and gender mix of VHWs are improved, and the cadre is appropriately skilled and competent, they could better support the formal health system and overburdened facility-based health workers in disseminating updated

health promotion and prevention messages and in disease surveillance. Investment in the frequency and quality of their training and greater involvement of local leaders in the supervision and monitoring of VHWs will help towards this.

### Address gender imbalances in VHWs and in leadership positions

The gender imbalance in the VHW workforce, with currently over three fourths of the CHWs being men, could potentially impact the utilization and uptake of health services by women and adolescent females. Achieving increased female participation in this role will require addressing cultural, social and gender barriers, as well as improving the conditions of employment. Leadership may also be affected by gender imbalances and this situation may influence and skew the VHW selection process towards men, as well as overall attitudes towards the participation of women in the VHW programme.

## Recommendations

**Recommendation 1a:** While **gender equality and equity are being considered at a macro level** in the formulation of a gender equality policy and a gender action plan, **they also need to be addressed in operational and implementation plans** across all sectors at all levels. Adequate resources should be mobilized and allocated to effectively implement such policies and achieve planned and transformative change.

**Recommendation 1b:** All health programmes should be also be periodically reviewed with a gender, social inclusion and disability lens.

**Recommendation 2:** **Local leaders should be motivated to provide support for VHWs**, with the Dzongkhag authority and/or District Health Officer (DHO) **ensuring VHWs receive regular training and orientation and supportive supervision** on the technical and operational aspects of their work.

**Recommendation 3a:** Efforts should be made to **target and support VHWs, especially women who are interested, to achieve a functional level of literacy**. This would enhance their performance, would help attract and retain more female VHWs, as well as contribute to their empowerment.

**Recommendation 3b:** In addition, efforts should be made to **attract candidates with higher level of prior learning for more specialized and expanded VHW roles**, especially for the provision of community based RMNCAH and NCD services. However, remuneration and fair and predictable compensation would need to be considered to attract and retain these more educated VHWs.

**Recommendation 3c:** Additionally, **a formal career pathway could be offered** as an incentive to attract more

educated women into the post. If school graduates are recruited and trained as VHWs, they could, after a minimum period of service, meet the basic entry requirements for nursing and other health related professions such as Health Assistants, and thus have a career pathway into paid employment in the future.

**Recommendation 4a:** At a minimum, VHWs should **be provided with the required kit and supplies and be reimbursed for travel and other expenses** incurred during the course of their work.

**Recommendation 4b:** The evaluation recommends **proactively recruiting more women as VHWs to improve the uptake and acceptability of services for women and girls**. The RGOB should also consider involving the non-formal educators, who are mostly women, and training this group to support VHWs in undertaking their responsibilities and/or to undertake more specific and specialised VHW roles and responsibilities that require a higher level of education and literacy.

**Recommendation 5:** The MOH should **ensure that the VHW training is adequately financed, so that it can be delivered in a systematic way that meets VHWs' learning needs**. The VHW Programme Officer should liaise with other programmes within the MOH to ensure that **an integrated training package for VHWs is developed and delivered**. This training should satisfactorily cover all the key messages, including RMNCAH, ensuring that training is aligned with the priority health needs in the country.

**Recommendation 6:** Efforts should be made to **create a link between the urban population and the PHC services and facilities in urban settings**. Such a link could be a cadre like the VHW. With the high population density in urban settings, the geographic area that each worker would have to cover would be more manageable, which might suit female VHWs. Access related issues will be minimal, if any and the chances of recruitment of better educated female candidates would be higher.



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## Introduction and background

### Country context

The Kingdom of Bhutan is a constitutional monarchy with a parliamentary form of government, situated in the eastern Himalayas, bordered by China and India. It has an area of 38,394 sq. km and had a population of 734,934 in 2018. Administratively, the country is divided into 20 Dzhongkhags (districts) composed of 205 gewogs (a block or group of villages), and four thromdes (municipalities) (Thinley, et al, 2017). The average age of the population is 26.9 years. The overall population density is 19.1 persons per sq. km. Thimphu, the national capital is the biggest city in Bhutan and has 15 per cent of the population. The few other towns are significantly smaller. Most of the population live in rural settings. The remote and difficult terrain makes health service delivery difficult. (National Statistics Bureau, Oct 2019).

The first hospital in Bhutan was established in 1956. In 1961 with the first five-year development plan (1961-1966), there

were two hospitals with two doctors and two nurses. Since then, significant progress has been made in health (Dorji, 2016). The health sector has an administrative system similar to that of the governance system, with increasing decentralization of responsibilities. Currently, there are three referral hospitals, 28 district hospitals, 23 Basic Health Units I (BHU I), 184 Basic Health Units II (BHU II), 28 sub-posts and 562 outreach clinics (ORC) (Thinley, et al, 2017). To align the ministry's efforts to strengthen the PHC approach, the nomenclature of certain health facilities was changed in early 2020, for example the Basic Health Unit II are now known as Primary Health Centres.

Bhutan achieved Millennium Development Goals (MDG) 4 and 5. Polio was eradicated but other diseases such as HIV, dengue and multidrug resistant tuberculosis (MDR TB) have appeared. Deaths from malaria have been significantly reduced.

Bhutan has made impressive progress in many of the targets within the sustainable development goals (SDG) for health and well-being. Almost all pregnant women attended at least one antenatal care visit and over 54 per cent attended more

than eight antenatal care visits in 2019. Institutional delivery coverage has increased to over 94 per cent in 2019. Postnatal care coverage stands at over 74 per cent and is set to increase to 90 per cent by the end of 12th FYP10. The high coverage in the RMNCAH services has “translated into a drastic reduction of maternal and child morbidities with concomitant reduction in mortality due to preventable causes” (MoH, 2020).

Despite the steady progress in health outcomes, the country still faces challenges to achieve the 2030 SDG targets. Childhood immunization rates have been sustained at over 95 per cent since 2010 (Thinley, et al, 2017). While stunting in children has fallen, there are regional disparities. Stunting is more pervasive in rural areas, and ‘malnutrition remains persistently a major public health issue.’ (MoH, 2020). While the exclusive breast-feeding rate is 51.4 per cent, only 11.7 per cent of children in Bhutan consume the minimum acceptable diet. Iron deficiency anaemia is prevalent in 55 per cent of women and 80 per cent of children. Reducing neonatal mortality, which constitutes about 56 per cent of under-five deaths remains one of the key challenges. The majority of the newborn deaths were due to preterm births, neonatal sepsis, and birth asphyxia which are largely preventable in nature (MoH, 2020).

There are disparities in infant mortality related to wealth, and preferences, among some groups, for local healers instead of the modern health system. Despite free health care, there are disparities in access to health care due to remoteness and out of pocket expenditure related to transport and medicines. Non communicable diseases (NCD) are gaining prominence with change in lifestyle, dietary habits, global marketing of unhealthy products, ageing population and consumption of alcohol and tobacco. In 2019, conditions such as hypertension, cardiovascular diseases (CVDs), cancers, and diabetes accounted for 71 per cent of the reported deaths in the country (MoH, 2020).

NCDs account for 71 per cent of all deaths. Social determinants that have negatively influenced health include increasingly sedentary lifestyle related to urbanization and changing nutritional habits, social insecurity as migration to urban settings increases and alcohol abuse. Mental health issues are on the increase and a national suicide prevention plan has been in place since 2015. With urban migration of young people, agricultural lands are being left fallow and contribute to food shortages in some areas. Bhutan currently strives to address the triple burden of disease (Thinley et al ,2017).

Shortages of human resources, especially doctors, and specialists is the major challenge faced by the MOH. The Khesar Gyalpo University of Medical Sciences in Bhutan (KGUMSB) was established to accelerate the development of human resources for the health sector. Many students are also being trained in Bangladesh, India and Sri Lanka. The MOH and the Royal Civil Services Commission will need to plan how to absorb this exponential supply of trained health workers (Dorji, 2016).

Bhutan recognizes health as one of the nine domains of Gross National Happiness (GNH) and implements the right to health through GNH policy reforms (Meier & Chakrabarti, 2016). The 2011 National Health Policy frames the health system in accordance to the human right to health, seeking to make health progressively available, accessible, acceptable, and of sufficient quality. Through its PHC approach and its disease prevention and health promotion programmes, it is

acknowledged that the government has achieved significant public health advancements; the first national GNH survey found the greatest expressions of citizen happiness in the health domain (Meier BM & Chakrabarti A, 2016).

Two of the nine Gross National Happiness (GNH) domains are directly related to health and mental wellbeing, while other domains have indirect links to health. Traditional Bhutanese medicine is also offered through the holistic approach towards health and wellbeing. Public expectations for quality health care and more sophisticated health care have been rising because of increased literacy, use of internet and overseas experiences. The above context and status of SDGs affect the implementation of CHWs and their subsequent performance.

Specific Linkage to the SDGs: The SDGs call for an accelerated return to principles of a more holistic PHC approach. This evaluation is more directly related to SDG 3:(Ensure healthy lives and promote well-being at all ages), and SDG 5 (Achieve gender equality and empower all women and girls). The WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes, which was the key framework for the study also notes that “policy and investment decisions on health workers have broader implications on several other targets of the SDGs, including job creation, economic growth, gender empowerment and education”.

## Object of the evaluation

In 2018, the Astana Declaration reaffirmed PHC as the most inclusive, effective and efficient approach to enhance people’s health and set PHC as the route to UHC and the health-related SDGs. In this context, Community Health Workers (CHWs) play an important role in advancing health protection and promotion and timely care seeking at the PHC level. Part of this declaration focuses on strengthening the PHC health workforce and thereby CHW programmes.

The Astana Declaration envisioned :

1. Governments and societies that prioritize, promote and protect people’s health and well-being, at both population and individual levels, through strong health systems;
2. PHC and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;
3. Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being; and
4. Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

## Relevant Theory of Change

While the evaluation is not theory based, the WHO Guideline on Health Policy and System Support to optimize Community Health Worker Programmes, which was the key framework

### Relevant Theory of Change

While the evaluation is not theory based, the WHO Guideline on Health Policy and System Support to Optimize CHW Programmes, which was the key framework for the study, organizes the contribution of CHWs to PHCs around three broad areas: 1) selection, education and certification of CHWs; 2) management and supervision of CHWs; and 3) integration into and support by health systems and communities. The assumption is that with the necessary policy and system support related to these broad areas (i.e., supportive policies, investment, quality education, supervision and management systems and improved integration of community health into formal health systems), there will be improved contribution of CHW programmes to PHC strengthening. Governance, investment (financing), and monitoring and evaluation are also key to ensure that these investments lead to expected improvements in PHC service provision and health outcomes.

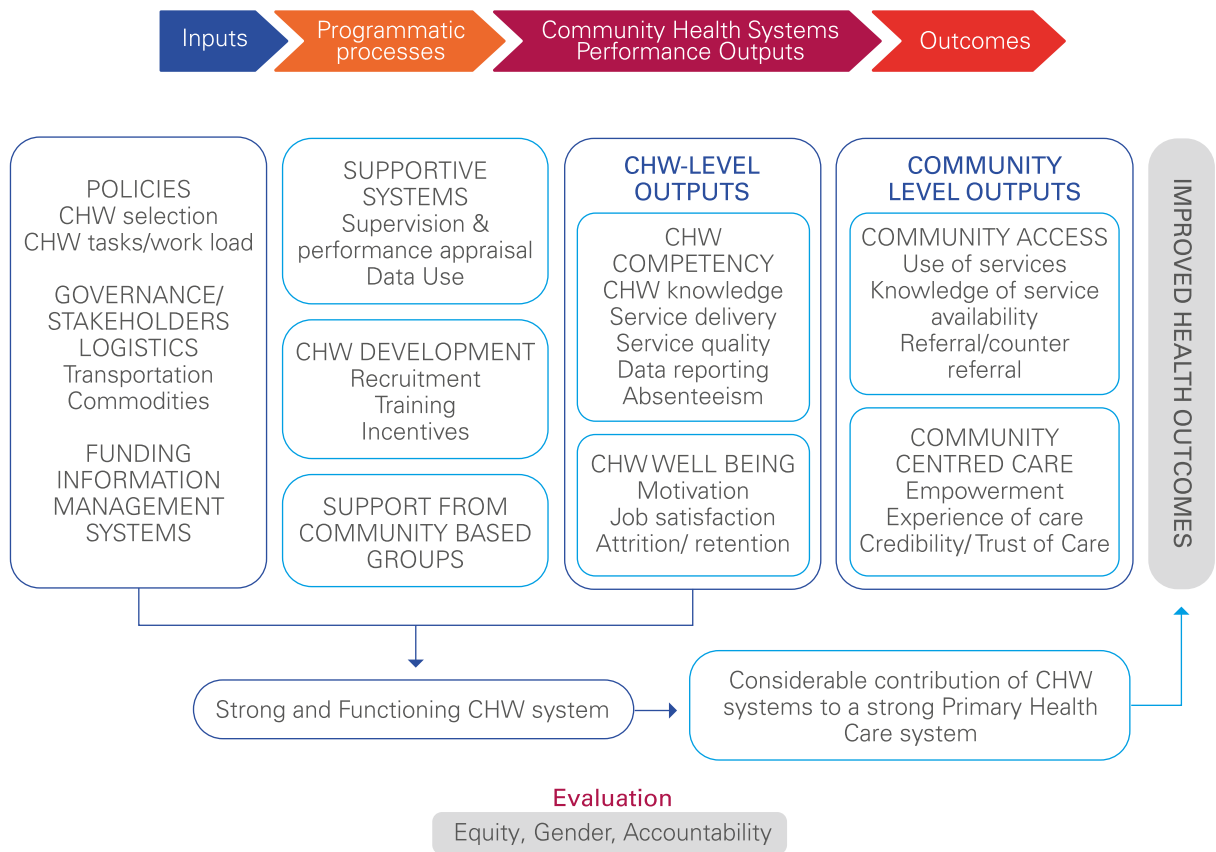
There is a need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments. It is therefore important to understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to help existing CHW cadres' transition

into effective contributors to RMNCAH and to the PHC of the future in South Asian countries, including Bhutan...

To contribute to knowledge generation in this area, the Centre for Maternal and Newborn Health (CMNH) at the Liverpool School of Tropical Medicine (LSTM) was commissioned by the UNICEF Regional Office for South Asia (ROSA) to conduct a formative evaluation of CHW policies and systems support in South Asia, and their readiness for expanding or changing roles and responsibilities within the Post-Astana national health care strengthening plans. This regional evaluation covers seven of the eight South Asian countries that fall under the remit of UNICEF ROSA: namely, Afghanistan, Bangladesh, Bhutan, the Maldives, Nepal, Pakistan and Sri Lanka, and assesses CHW policies and system support at national level only.

One of the initial activities of the evaluation was a desk review, for which the LSTM evaluation team reviewed peer-reviewed publications and policy documentation, relevant to CHWs programmes, with a focus on the provision of Reproductive Maternal, Newborn and Child Health (RMNCAH) services. A key output of the desk review was the mapping of the available CHW cadres in each of the seven countries, information which was then shared with and validated by stakeholders in each country, including the UNICEF country offices.

Figure 1: Illustrative Theory of Change for CHW Programme



Adapted from Agarwal et al.<sup>1</sup>

[1] Agarwal et al., A conceptual framework for measuring community health workforce performance within primary health care systems, Resources for Health (2019) 17:86

## Right holders and duty bearers

The LSTM evaluation team adopted the WHO definition of a CHW: “Health workers based in communities (i.e., conducting outreach beyond primary health care facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours.” (WHO 2018).

For Bhutan, the LSTM team, in consultation with UNICEF ROSA, the UNICEF Bhutan office and the Ministry of Health confirmed that there was one CHW cadre active in the country, known as the Village Health Worker (VHW). This cadre falls within the WHO CHW definition and it was agreed that they would be covered by this evaluation. The VHW could be either men or women but are predominantly men.

The VHW programme was piloted in 1978 in the Wangdue Phodrang and Trashigang dzongkhags (districts) before being rolled out nationwide in the mid 1980’s (Thinley, et al, 2017). Respondents indicated that previously, in the “early 1980s” there were “birth attendants” but reportedly this programme was “not that effective.” One part time volunteer VHW covers more than one village if the villages are small and close by (approximately 20-30 households) (UNICEF, 2004).

Village Health Workers (VHWs), the Basic Health Units (BHUs) (primary health care facilities in Bhutan), and Outreach Clinics (ORCs) linked to these BHUs, provide the ‘principal level of primary health care,’ supporting the government to provide “access to free basic public health services in both modern and traditional medicines” to its largely rural population (Meier & Chakrabarti, 2016).

VHWs are the link between the formal health system and the communities and are expected to provide first aid and treatment for minor ailments, create awareness and mobilize the community for health promotion (particularly in reproductive, maternal and child health) and improving sanitation (Thinley, et al, 2017).

The number of VHWs has varied over the years. At the peak of the programme, there were 4,000 VHWs. However, by 2018, there were only 1,150 VHWs working across the country. Of these, 884 (77 per cent) were male and 266 were female.

The reduction in numbers, in part, reflects improvements in the health system and in transportation infrastructure, which made many villages ineligible to have a VHW due to the criterion that they must be at least an hour’s walk from the nearest primary care facility (Thinley, et al, 2017; WHO CCS 2010; MOH 2012a). Reportedly 98 per cent of the population have accessible health care (Meier & Chakrabarti, 2016). In rural areas, 25 per cent of the population can access a health unit within 30 minutes, while nearly 40 per cent can do so within thirty to sixty minutes (MOH 2012b). The corresponding figures for urban areas were 83 per cent and 16 per cent respectively.

## Key stakeholders, their needs and roles

Countries in South Asia have large numbers of CHWs whose training, duties and retention schemes form a rich and confusing tapestry. Across South Asia, CHWs play a substantial role in PHC: through individual counselling; in community education and engagement; in the establishment of trust-based bridges between communities and health service planners and providers; and, in the facilitation of evidence generation and use at the micro-community level. Most are female CHW cadres developed to support promotion of desirable family planning, maternal and child health, immunization, nutrition, sanitation and hygiene practices. Due to insufficient funding, village-based volunteers were replaced by volunteers or minimally remunerated CHWs with assigned catchment areas covering multiple villages. Neither they nor the health centres they were affiliated with provide the range of services nor the quality of care that is acceptable for the PHC reforms underway. CHWs work with diverse partners, the Ministry of Health being a critical partner.

Beneficiaries of CHW’s services are socio economically depressed communities who are disproportionately affected by a wider range of illnesses and their health needs remain largely unaddressed. The Astana Declaration therefore reiterated the need for promotive, preventative, curative, rehabilitative services and palliative care to be made accessible to all. Too many vulnerable individuals, families and communities fall into deep poverty due to health conditions that are largely either preventable or more likely to have better outcomes if diagnosed and treated early. The global health community therefore reaffirmed the need to accord higher priority to community-based health promotion and disease prevention, and early diagnosis and care at the PHC level. They also decried the system-wide inefficiencies and the poor accountability of service providers that maintain the levels of out-of-pocket health expenditure highest among those who can least afford them, in exchange for what is strikingly fragmented, poor quality care.

Severe shortages and markedly uneven distribution of health workers are a major impediment to the attainment of the ambitions stated in the Astana Declaration, especially at the PHC level and in areas where communities are socio-economically depressed. The following comprises the general list of stakeholders

- Ministry of Health department and programmes at national and sub-national levels;
- Other government agencies – including local government, etc.;
- Professional Councils;
- Training institutions;
- Development partners;
- Donors and multilateral agencies;
- Formal/facility-based health workers;
- Not-for-profit organizations and community groups; and
- Civil society/Communities.

As a key partner in the Community Health Road Map – a global collaboration to accelerate investment in community health – UNICEF works with governments and other development organizations to elevate community health in national agendas. UNICEF’s approach integrates service delivery across sectors



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– including health; nutrition; early childhood development; social protection; education; and water, sanitation and hygiene. UNICEF strengthens community health systems and provides promotive and preventative care to remote communities around the world. UNICEF also supports and trains community health workers to provide essential services, prevent the spread of diseases and respond to humanitarian crises.

## Purpose and objectives of the evaluation

The overall objectives of the evaluation are to understand the congruence between:

- the current profiles, policy framework and system support for CHWs, especially those involved in RMNCAH programmes and
- the profiles, policy framework and system support required to better serve RMNCAH, and to respond to PHC reforms and strengthening in seven South Asia countries, including Bhutan.

The specific objectives of the evaluation are presented below:

- Evaluate current existing policy and system support in terms of the 15 areas of the WHO Guideline, including a gap analysis, to develop country-specific, prioritized recommendations for action. This should provide insight on how governments and partners can redesign and/or strengthen CHW programmes while ensuring that the quality of RMNCAH service delivery is protected and enhanced.
- Identify and prioritize ways in which the WHO recommendations can be translated from vision to action in a manner that creates functional integrated CHW teams within functioning support systems, in decentralized and non-decentralized national political and administrative systems that are aligned with the

objectives, context and architecture of the national health system in each country.

- Consider how the process of strengthening CHW policies and system support can be made dynamic, responsive to context-specific evidence, linked to social accountability systems, and promote local, area specific, and national learning and innovation.
- Evaluate the extent to which the content of proposed national PHC and CHW related policy adjustments currently articulate effective transition management, to enable CHW cadres to be effectively reoriented into integrated and functional teams that are expected to cover expanding sets of community health services for the Post-Astana vision of community health systems strengthening for UHC.

In addition, the evaluation included a comprehensive gender analysis that sought to determine the extent to which GESI considerations are incorporated into CHW programmes and policies. See specific details below and in the attached gender analysis report

### Intended Utilization and Users

The findings of this evaluation are expected to influence community health systems strengthening plans. Evaluation findings will be used for UNICEF's community health agenda and priorities and its partnership building and leveraging of technical and financial resources to strengthen national CHW programmes in Bhutan to accelerate the strengthened community health systems within ongoing or planned PHC reforms. The findings will also inform national government plans and enhance UNICEF and partner's advocacy and technical guidance to local governments who, in many of these South Asia countries, are instrumental in PHC priority setting, resource mobilization and allocation and the recruitment of the PHC workforce, including CHWs under national decentralization policies.

The evaluation will be used to support the identification of priorities and sequencing of long to medium term health systems strengthening initiatives to ensure that system support functions, such as training, management, and supervision to enable CHW programmes to function effectively. This will also support their integration and support from health systems and communities to enable CHWs to contribute within PHC teams, as well as be effective members of their communities, helping to address the social determinants including gender, that affect the health and well-being of the communities they serve. In addition to UNICEF, RGOB, other users will include implementing partners and other stakeholders who support programmes aided by CHWs.

## Scope of the Evaluation

### 1. Subject of the evaluation

The evaluation adopts the definition of a CHW used in the WHO guideline (WHO, 2018) and focuses on the identified CHW cadre in Bhutan VHW and the policies and system support that enable and guide their work. Other health workers to whom CHWs relate are described for context where necessary, and to the extent that they form part of the support structure for CHWs, but they are not covered by this evaluation.

### 2. Geographical scope

The evaluation in Bhutan assessed CHW policies and system support at national level only. The evaluation team conducted interviews with key informants at this level to elicit their views and explore their perspectives on CHW policies, system support and on any planned or ongoing PHC reforms in the country.

### 3. Temporal scope

The evaluation is primarily focussed on existing policies or policies under design and therefore covers the period from early 2018 onwards, with reference to historical CHWs policies, where necessary.

### 4. Key Evaluation Questions

The evaluation responds to the following three key evaluation questions (KEQ):

- **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?  
This is a descriptive KEQ. The key framework used to address this evaluation question was WHO Guideline as described below. All the data collected and analysed to address this question adopted a gender lens.
- **KEQ 2:** What policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening?  
This evaluation question entailed assessing actual or prospective country level commitments driven by

the Astana Declaration and/or planned or ongoing PHC reforms, and the implications for existing CHWs policies and system support. A gender lens was also adopted in responding to the KEQ to ensure gender-responsive efforts/strategies can be identified.

- **KEQ 3:** What prioritized measures can be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre is able to make to PHC?  
This evaluation question entailed synthesising the key findings from KEQ 1 and KEQ2, and assessing what possible reforms, including gender-informed reforms are necessary and should be implemented, to enhance the contribution of CHW programmes to PHC, and to ensure gender equality, equity and responsiveness, given the individual country contexts.

The evaluation was informed by the indicative evaluation matrix below. The matrix was developed – before data collection. However, some aspects were not achieved and/or addressed by the evaluation for various reasons. For example, although the original intention was to identify and analyse gaps in existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans, unfortunately there was little or no information available (from secondary or primary sources) on these areas. At the time of the evaluation, few countries had articulated or developed stand-alone post-Astana commitments or PHC plans that covered community health systems.

Table 1: Indicative Evaluation matrix

Evaluation questions	Primary Data Sources	Secondary Data Sources	Data Analysis & evidence generation	Outputs
<p><b>KEQ 1:</b> What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?</p>	<p>Key Informant interviews with UNICEF Country Office staff Key informant interviews with national level stakeholders including representatives from Ministry of Health, Ministry of Gender, Ministry of Women’s Affairs, and other relevant line ministries; health policy makers, health planners and RMCAH programme managers; professional associations and regulatory bodies; international NGOs; international service providers (ISPs), local NGO; development partners; and funders</p>	<p>These data will be extracted and analyzed as part of a desk review, but also revisited and expanded once the desk review is completed and the second phase of the evaluation is being carried out to triangulate findings wherever possible.</p> <p>Sources include:</p> <ul style="list-style-type: none"> <li>• National Policies</li> <li>• National plans and strategies</li> <li>• National Reports</li> <li>• Peer reviewed literature</li> <li>• Donor reports</li> <li>• Evaluation reports</li> <li>• Training guidelines</li> <li>• CHW databases</li> </ul>	<p>Narrative synthesis of findings from key peer-reviewed and grey literature from across the eight countries produced from desk <b>review</b></p> <p>Synthesis structured around the 15 components of the WHO CHW guideline, gaps identified and options for improvement as well as further study in the second phase of the evaluation proposed.</p> <p>A framework (informed by the 15 components within the WHO Guideline; selected health systems strengthening/ building blocks (leadership and governance; service delivery; and financing); as well as factors related to gender and equity, engagement with the private sector; alliance-building; and resource mobilization) and on-going or planned post-Astana reforms or PHC strengthening plans were developed during inception phase to guide the data collected and analyzed from the <b>key informant interviews</b></p>	<p>Map of CHW cadres to be assessed in each country, validated and finalized with countries</p> <p>Map of policies related to community health worker programmes to be assessed for each country validated and finalized</p> <p>Map of available information for each country against the 15 core components in the WHO Guideline, key health systems building blocks and other factors including private sector involvement, alliance building, and resource mobilization created and validated</p> <p>Framework for analysis constructed informed by WHO Guideline, key health systems building blocks and other factors and identified gaps.</p>
<p><b>KEQ 2:</b> What policy and system support improvement are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the-post-Astana or PHC reforms and strengthening.</p>	<p>(Same as KEQ 1)</p>	<p>(Same as KEQ 1)</p>	<p>Throughout, key challenges and areas for adaptation and strengthening will be identified by participants. Data will then be synthesised by cadre, across cadres within a country, and across countries to generate top-level findings at the regional, national, and cadre levels. . The analysis will involve transcript familiarization, coding and synthesis of relationships between themes</p>	<p>Map of post-Astana commitments for each country where available</p> <p>Map of ongoing and planned PHC reforms and PHC systems strengthening plans</p> <p>Gap analysis of existing CHWs policies and system support against PHC reform agenda, post-Astana commitments or PHC system strengthening plans.</p>
<p><b>KEQ 3:</b> What prioritized measures can be taken by government and partners to strengthen health policy and system support to optimize the contribution that each CHW cadre is able to make to PHC</p>	<p>Data sources as per KEQs 1 and 2</p>	<p>Data sources as per KEQs 1 and 2</p>	<p>Synthesis of analysed data from KEQs 1 and 2</p>	<p>Recommendations and reform options to enhance the contribution of CHW programmes to PHC systems strengthening within the country context using relevant levers in the WHO and UNICEF Operational Framework Set of feasibility and prioritization criteria to support countries in developing an action plan aimed to optimize the contribution that each CHW cadre is able to make to PHC. All recommendations and options adopt a gender lens and are gender responsive</p>

[2] Primary health care: transforming vision into action. OPERATIONAL FRAMEWORK. Draft for consultation A World Health Organization and the United Nations Children’s Fund (UNICEF), 2018

## Methodology

The LSTM team used a mixed methods approach for this evaluation. This formative evaluation is intended to help with the on-going strengthening and evolution of the PHC components of national health systems. It is not an impact evaluation that seeks to measure the impact of CHWs, CHW programs or the health system. This distinction has guided the selection of the methods to be used for this Evaluation.

To further involve duty bearers and stakeholders, the draft report was shared with relevant government entities and feedback was received and incorporated in the final report.

### 1. Data collection

#### 1.1. Desk review

The LSTM team undertook a desk review of available national policies, plans and strategies, country reports, peer reviewed publications, reports from donors/development partners, international and local NGOs, evaluation reports, training guidelines, and CHW databases. The review focused particularly on CHW programmes and CHW cadres involved in RMNCAH service delivery. Data extracted and analysed as part of the desk review were revisited and expanded on during the implementation phase of the evaluation to triangulate findings wherever possible.

Specifically, the desk review mapped out and validated available CHW cadres, their roles and responsibilities and system support across eight South Asian countries and identified any post-Astana or PHC strengthening plans. It reviewed international literature, and regional and national CHW policies, strategies and programmes against the WHO 15 policy options and recommendations, health system building blocks and highlighted gaps. A key aspect of the desk review was the analysis of the extent to which CHW programmes are gender responsive. It also generated a list of key international and national references and resources that were used to guide the overall evaluation process, which was circulated to all the country offices to enable them to identify any additional secondary data sources that the team should examine.

#### 1.2. Key informant interviews (KIIs)

The desk review was complemented by qualitative data, collected through interviews with national level key informants (KIs) involved in the CHW programmes. LSTM worked with the UNICEF Country Office to draw up the list of key informants (KI) to be interviewed, which comprised national level representatives from government, United Nations agencies, and local NGOs. To save on resources and manage the time available for the evaluation, key informants were sampled purposively to generate a diverse sample of participants, to ensure that data derived from KIIs were as rich as possible, and to ensure the inclusion of a gender-balanced range of organizations, cadres, and stakeholders.

A semi-structured topic guide and a gender-specific guide, informed by the evaluation framework and analysis plan (shown below), were used by the LSTM evaluator to collect data to respond to the three key evaluation questions, and to validate and triangulate the desk review findings, and to collect any information not availed through the desk review. Using these guides, the LSTM evaluator sought to elicit and

explore KIs' views and perspectives on a range of topics including the national VHW programmes, cadres and health system support; the policy environment; the role of gender in the design and implementation of the VHW programmes, financing and resource mobilization, and the contribution of the private sector to VHW programmes.

A gender-specific topic guide was used with four key informants selected for their specialist knowledge of or work remit for gender and VHWs, to enable a more in-depth exploration of the gender issues and constraints that impact the effectiveness of the VHW program, and the identification of efforts to address these constraints to improve the functioning of VHWs and strengthen PHC.

A member of the LSTM evaluation team conducted a total of 12 KIIs with 12 key informants in Bhutan between January 23 and 27, 2020. Discussions with the UNICEF country office in the planning of the evaluation, had ascertained and determined that because many of the key informant would be policy makers at the national level, they would be proficient in English and would not need a translator. Therefore, all interviews were conducted in English and digitally recorded with the participants' consent. Interviews were transcribed verbatim soon after collection, anonymised and all identifying information removed.

#### Participation of key stakeholders and duty bearers:

Stakeholders and duty bearers participated in different capacities. UNICEF personnel participated in the selection of key informants. The LSTM evaluation team provided guidance for the UNICEF country offices on a range of potential national level KIs for inclusion in the study, comprising policy makers and programme managers from the Ministry of Health, and other line ministries, including Ministry of Gender, Ministry of Women's Affairs and representatives from professional councils, associations and regulatory bodies, training and academic institutions, international and local NGO; United Nations agencies, development partners and funders and the private sector. A list of KIs for each country was then drawn up, validated and finalized. Selected persons participated in the key informant interviews.

Three members of the LSTM evaluation team also participated in the UNICEF Regional Management Team (RMT) meeting in Nepal in April 2019. They presented an overview of the evaluation and preliminary findings from the desk review, facilitated a question and answer session, and elicited feedback and inputs from participants on the study. During the UNICEF RMT, the LSTM evaluation team also conducted KIIs with UNICEF country office representatives. Another level of participation was the review and validation of country reports. Both UNICEF and the relevant stakeholders provided feedback to the reports before being finalized.

### 2. Data analysis

The transcribed KIIs material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. A data analysis plan, shown below, was formulated identifying topics for analysis drawn from the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (WHO, 2018), the health system building blocks (WHO, 2007), PHC levers (WHO/UNICEF, 2018) the WHO Gender Responsive Assessment Scale (WHO,

2011), and the Steege et al (2018) conceptual framework. Other topics, such as PHC reforms and the contribution of the private sector were also included in the analysis to help address and respond to the research questions. Additional documents were identified by KIs during the KIs, and these were reviewed by the LSTM team. (A full list of

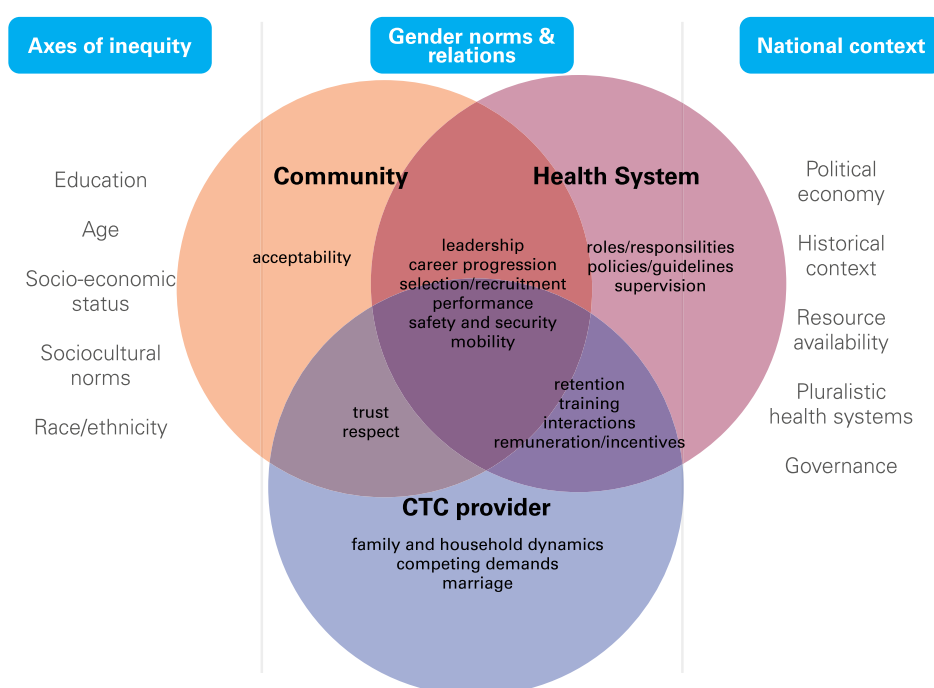
references is included in Annex 3). Findings and results from the analysis of the 12 KIs, and the additional secondary data are presented in the findings section. In all cases respondents' comments and insights are quoted verbatim. However, some have been shortened and where it has been deemed necessary, explanations are also included to improve clarity.

Table 2: Analysis Plan

Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
CHW programmes and cadres	Health Workforce	PHC workforce	Availability of gender-sensitive, responsive and transformative CHW policies and programmes; implementation and evaluation of such policies; maintenance of sex disaggregated CHW workforce data and use for design of CHW programmes	KEQ 1
CHW roles and responsibilities	Health Workforce; Service delivery	PHC workforce; Service delivery	Gender norms and constraints in delivering particular services; household roles/responsibilities	KEQ 1
Selection, education, certification	Health Workforce	PHC workforce	Requirements for selection for training/education; recognition and certification of knowledge and skills	KEQ 1 & 2
Management and supervision, including remuneration, contracting and career ladders	Information; Health Workforce	PHC workforce; monitoring and evaluation	Family and household dynamics and impact of responsibilities/obligations/demands of male and female CHWs on employment needs and preferences; accommodations in employment contracts and work environments to support needs and preferences of women CHWs, including mobility, family responsibilities and relocation after marriage; women's access to supervisory positions; support from supervisor with gender related issues for male and female CHWs; support with maternity leave and during mensuration; fair remuneration and compensation including financial and non-financial incentives; participation in community/health facility leadership roles; cultural and gender barriers to remaining in the CHW role; career progression opportunities; provision of safe and secure workplaces, including GBV, and basic amenities and necessities for male and female CHWs; strategies used by CHWs to remain safe; CHW accountability and responsibility for performance and delivery of services/tasks.	KEQ 1 & 2
Integration with health system and communities, including target pop size, data collection and use, types of CHWs, community engagement, and availability of supplies	Health Workforce; Medical Products	Engagement of community; Appropriate medicines and products	Acceptance, trust, respect for female and male, married/unmarried CHWs by the community and the formal health system; relationship with facility-based providers; access to and take up of RMNCAH services from male and female CHWs by community members; representation of female CHWs on community and health facility leadership/management committees; impact of expanding target population size on ability of females to undertake CHW role.	KEQ 1 & 2
RMNCAH focus	Service delivery	PHC workforce	Acceptability of RMNCAH services provided by male and female CHWs; access to and take up of RMNCAH services from male and female CHWs by community members;	KEQ 2

Topic	HS Building Block	PHC Levers	Gender Analysis	Research questions
Leadership and Governance	Leadership and governance	Political commitment and leadership; Governance and policy frameworks	Efforts/progress towards gender-sensitive, responsive and transformative CHW policies and programmes; gender-power relations and access to resources	KEQ 1, 2 & 3
PHC reforms	Service delivery; Health Workforce	PHC workforce; Adequate funding and equitable allocation of resource; Political commitment and leadership; Governance and policy frameworks	Formulation of gender-sensitive, responsive and transformative CHW policies, programmes and practices that consider and address gender inequalities; resources and action to transform unequal and harmful gender inequalities; design appropriate indicators to measure impact of reforms on gender equity; participation of CHWs and community members in design, implementation and evaluation of gender policies; and implementation of gender-sensitive system support; CHW participation and representation in leadership and decision making; disaggregated CHW data by factors such as sex, age, location; consider gender composition of the CHW/PHC workforce; conduct assessments with participation of CHWs and community members	KEQ 2
Financing and Resource mobilisation	Financing; Medical products; Service delivery	Adequate funding and equitable allocation of resource	Remuneration/compensation of CHWs; gender-sensitive planning and budgeting for CHWs and community health systems in processes; gender-sensitive budgeting for PHC and community-based health programmes	KEQ 2 & 3
Private sector	Service delivery; Health Workforce; Medical Products	Engagement with private sector providers	Private sector employers' gender policies and practices	KEQ 2 & 3

Figure 2: Conceptual Framework



Source: Steege et al., 2018

Figure 3: Gender Responsive Assessment Scale



### 3. Gender Analysis Frameworks

The gender analysis draws on the Steege et al. (2018) conceptual framework (Figure 2), which focuses on gender relations and factors affecting the working lives of community health service providers at the individual level (family and household dynamics, decision making competing demands), the community level (social and cultural norms, acceptability, trust respect) and the health system level (gender policies and gendered system support, roles and responsibilities, and integration). At the individual level, family influence and household dynamics are important factors affecting CHWs; at the community level, safety and the ability to move around are aspects considered; while at the health systems level, gender relations and norms affecting training and supportive supervision, remuneration and career progression are important factors considered. (Steege et al., 2018).

The analysis also draws on the WHO Gender Responsive Assessment Scale (WHO, 2011) (Figure 3) to determine the extent to which GESI considerations are incorporated into CHW programmes and policies.

The scale includes five stages of GESI responsiveness within policy and programming as follows:

- **Gender-Unequal:** perpetuates gender and other forms of inequality by reinforcing unbalanced norms, roles and relations.
- **Gender-Blind:** Ignores gender and other forms of inequality.
- **Gender-sensitive:** considers gender and other forms of inequality but takes no remedial action to address it.
- **Gender-Specific:** considers gender and other forms of inequality and takes remedial action to address it but does not change underlying power relations.
- **Gender-Transformative:** addresses the causes of gender-based and other forms of inequality by transforming harmful norms, roles and relations through the inclusion of strategies to foster progressive changes in power relationships.

### 4. Frameworks used to inform data collection and analysis

The evaluation uses the WHO Guideline on Health Policy and System Support to Optimize Community Health

Worker Programmes (WHO, 2018) and the policy and system enablers it identifies, and in particular, the 15 policy recommendations. It presents, as a benchmarking framework to map and assess CHWs policies and system support, and identify gaps and areas for optimizing CHW programmes.

The Guideline's 15 policy recommendations are organized around three broad areas:

1. Selection, education and certification (selection, duration of pre-service training, competencies in pre-service training curriculum, pre-service training modalities and competency-based certification)
2. Management and supervision (supportive supervision, remuneration, contracting agreements, and career ladder)
3. Integration into and support by health systems and communities (target population size, collection and use of data, types of CHWs, community engagement, mobilization of community resources, and availability of supplies).

For the purposes of the evaluation, health system support is defined as the support that the health system needs to provide to optimize CHW programmes, including the education, training, management, supervision, remuneration and compensation of CHWs, the provision of commodities and supplies, clear definition of roles and responsibilities, and expectations, as well as adequate financing and the integration of such programmes into the health system and the community.

The evaluation framework is also informed by the WHO six health system building blocks (WHO, 2007), , leadership and governance; service delivery; health system financing; the health workforce; medical products, vaccines, and technologies; and health information systems. In addition, the governance, policy, and finance and operational levers presented in the WHO and UNICEF Operational Framework (WHO/UNICEF 2018) provides useful benchmarks levers for assessing progress on PHC strengthening.

The LSTM team adopted a gender lens in the review of secondary data, the design of the data collection tools, and the analysis of the data. A gender-specific topic guide was designed to target key informants with specialist knowledge of, or responsibility for gender and CHWs, to enable a more in-depth exploration of the gender issues and constraints that impact the effectiveness of CHW programmes, and

[3] WHO (2018) Guideline on health policy and system support to optimize community health worker programs. <https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1>

the identification of efforts to address these constraints to improve the functioning of CHW programmes and cadres and strengthen PHC. The gender component of the evaluation drew on the Steege et al (2018) conceptual framework of gender norms and relations across the levels of the individual provider, the community and the health system.

The team also assessed CHW programmes and policies using the WHO Gender Responsive Assessment Scale (WHO, 2011) that presents findings along the five levels of the scale including, 1) gender-unequal, 2) gender-blind, 3) gender-sensitive, 4) gender-specific, and 5) gender-transformative. Citations (and in some cases, links) to the frameworks are included in the reference (Annex 3) for further review.

### **Application of a rights-based approach, and Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Gender Equality and the Empowerment of Women**

As reflected in the frameworks applied, this evaluation uses a gender-responsive evaluation methodology, and data analysis techniques. Because women comprise a substantial number of CHWs in many SA countries, the evaluation also looks at aspects of inequality, examining how existing policies and systems may unequally affect women in the selection, training and promotion in the different CHW cadres.

At the core of this evaluation is an assessment of Gender Equality and the Empowerment of Women (GEEW). Both the WHO Gender-responsive Assessment Scale and the framework proposed by Steege et al, which are used in this evaluation, focus on gender equality and empowerment. The ability of existing systems to reach all persons including those who are marginalized is also explored

## **5. Ethical standards**

The proposal for the evaluation was submitted to the Institutional Ethics Review Committee of LSTM and full ethical clearance for the study was granted by LSTM (REC 19- 037). LSTM ensured, in line with its internal policies and code of conduct, that the research associated with the evaluation follows the ethical principles and considerations outlined in the United Nations Evaluation Group (UNEG) Ethical Guidelines for Evaluation and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (CF/PD/DRP/2015-001). In addition, the UNEG norms and standards were observed.

Written informed consent was obtained from all key informants (KIs) in this evaluation using the LSTM Research Ethics Committee (REC) consent template, adapted for this evaluation. The template consists of an information sheet and certificate of consent. LSTM's stringent procedures for obtaining consent adhered to the Helsinki Declaration on the rights of subjects. These rights included autonomy (ability to participate or withdraw from the study at their own free will), beneficence (that the benefits of participation to the respondent outweigh the possible harms) and justice. Written consent included the participants' consent to participate in the interview and for the interview to be digitally recorded to aid in the transcription.

The participant information sheet, which explained the purpose of the study and all the possible benefits and harms, was

provided to respondents in advance of the interviews and also reviewed with the participant, if required, before the start of the interview. The participant was provided with the opportunity to ask questions and responses were provided to the queries and issues raised. Participation was on a voluntary basis and all participants were assured that they had the right to withdraw from the interview at any stage without needing to offer any explanation. Participants were also encouraged not to disclose any information they are not comfortable with sharing and to decline responding to any statement they considered sensitive.

Every effort was made to ensure that the confidentiality and privacy of participants was protected at all stages of data collection and processing. Confidentiality and anonymity were ensured and assured to the participants explicitly in writing and verbally at all stages of the study to ensure that no data or responses/statements could not be traced to the participant.

All members of the LSTM evaluation team involved in conducting the KIIs received training in good interviewing skills and principles of data confidentiality. Participants were informed about the study in advance (written communication and telephone calls for key informants) and prior to data collection to ensure that participants understand the purpose of the study and their rights to participate (voluntarily) or not and to withdraw from the study at any time without prejudice.

All interviews were conducted in English and were transcribed verbatim soon after collection, anonymised and all identifying information removed. The transcribed KII material was cleaned and then underwent a framework analysis by the LSTM team using NVivo Version 11. Recordings of interviews were stored on password-protected data devices.

## **6. Limitations and mitigation measures taken by evaluation team**

- Availability and quality of secondary data related to VHWs
  - ◊ **Mitigation measure:** To ensure maximum responsiveness of stakeholders and access to relevant and quality data, the LSTM evaluation team sought the support and guidance from UNICEF country offices in approaching and following up with relevant partners to obtain the necessary information. Processes for the quality assurance of secondary data put in place for the desk review were applied and where possible, triangulation of data collected through KII was used to validate findings.
- Limitations of the qualitative research methods used such as participant and interviewer bias during the key informant interviews (KII)
  - ◊ **Mitigation:** The LSTM evaluation team used topic guides with open-ended questions to minimize interviewer/facilitator bias and probe with follow-up questions to clarify intent and meaning. Independent coding of qualitative data was performed by the LSTM team to minimize the risks of bias.
- Limited generalizability of the evaluation findings due to the limited availability of stakeholders for interviews during the field visit.
  - ◊ **Mitigation:** By using qualitative research methods

Table 3: Number of VHWs in Bhutan

Type of CHW	Number	Sex	Employment Status
Village Health Worker (VHW)	1150 (2018)	Men & women; 884(77%) men in 2018	Unpaid voluntary part-time cadre; working 40–50 hours per month

such as KIs, the evaluation team sought to get in-depth information to answer evaluation questions. Generalisability was not the main goal of qualitative research. The LSTM evaluation team used purposive sampling carefully targeting “information-rich” participants to represent (not statistically) the broad types of informants relevant to our evaluation.

- All interviews conducted in English affecting the ability of participants to fully articulate views and insights
  - ◊ **Mitigation:** Probes were used to ensure that respondents understood the questions. There was careful review of KI guide to ensure that the level of English used was most appropriate for the respondents.

## Findings

The following findings are based on a review of available secondary data and an analysis of the qualitative data collected through 12 key informant interviews with MoH policy makers and programme managers, NGOs, and representatives from United Nations agencies. Four of the interviews were conducted with gender informed participants using the gender focused topic guide.

### 1. Current CHW profiles, roles and responsibilities, policies and systems support

This section responds to **KEQ 1** and provides an overview of the current profiles, roles and responsibilities of the identified CHW cadres in Bhutan involved in the provision of RMNCAH. It also reviews and assesses the policies and support these cadres receive from the health system.

- **KEQ 1:** What are the current profiles, roles and responsibilities, policies and system support in relation to each CHW cadre?

#### 1.1. CHW programs and cadres in Bhutan

Village Health Workers (VHWs), the Basic Health Units (BHUs) (primary health care facilities in Bhutan), and Outreach Clinics (ORCs) linked to these BHUs, provide the ‘principal level of primary health care’, supporting the government to provide “access to free basic public health services in both modern and traditional medicines” to its largely rural population (Meier & Chakrabarti, 2016). The following table gives the number of VHWs in Bhutan, their employment status and sex disaggregation.

Respondents and the literature indicated that there are various groups and committees at the district and community levels for health promotion and disease prevention. These include the elected Gewog/Block administration, headed by the village leader (the Gup), and comprising three staff, who also take part in community health services. According to one respondent, ideally these should be the key people to communicate health messages from the central and district health authorities and the health facilities but communication and collaboration between local government and health facilities is often weak and is not encouraged or supported through policy. It was felt that because these people are elected and “empowered by the government”, they may have more influence than the VHWs, who because they are from the village, “don’t have the teeth to bite”.

As there is no VHW or any other CHW cadre in urban areas, it is acknowledged that urban populations are actually underserved in relation to PHC in Bhutan (MOH 2013a). However one respondent indicated that civil society committees and multisectoral task forces have been formed in urban areas, comprising shopkeepers, and representative from other areas of business, that help in “awareness creation and information dissemination for the health system”.

A VHW Programme Officer, based in Thimphu in the Non-Communicable Diseases Division (NCDD) of the MOH is responsible for maintaining the VHW database which includes the numbers and the distribution of VHWs across the country.

According to a key informant, this database, which is updated on an annual basis, provides information on “the total number of VHWs in the country by district”, and “the dropout”, disaggregated by sex and location. As the designated officer had recently retired, details about the VHW database were obtained through interviews with other key informants in the MOH.

One key informant had concerns about the comprehensiveness of the Health Management Information System (HMIS) in general, and the completeness and maintenance of health workforce data, including the VHWs, in particular, and noted that “when it comes to data, this is one of the weaknesses of the country” According to this informant, health data, including data on the health workforce, which is between “6000 to 7000 health professionals”, are not “up to date”, “though small, we are still grappling with it.” The districts are responsible for collecting and collating the data in each district and the programs use these data to monitor and report on their activities. VHWs submit data to the health facility which is uploaded onto the HMIS.



## 1.2. Key policies and policy environment

Although the Kingdom of Bhutan has not ratified many of the international treaties that codify a right to health, health is recognized as one of the nine domains of the Gross National Happiness (GNH) policy (Meier & Chakrabarti, 2016). As Bhutan's 2008 Constitution mandates universal access to health as part of the government's commitment to GNH, the 2011 National Health Policy, aims to *build a healthy and happy nation through a dynamic professional health system; and to make health available, accessible, acceptable, and of sufficient quality.* (Meier & Chakrabarti, 2016).

Beyond health care, the new Bhutanese Constitution also seeks to "ensure a safe and healthy environment," and the MOH has reportedly made significant progress in achieving health outcomes in eliminating leprosy, reducing the prevalence of vector-borne diseases and water-borne illness, and near-universal childhood immunization, through disease prevention and health promotion programs. The country's PHC approach and impact on public health are widely recognized and the first national GNH surveys found a close link between citizen happiness and the health domain (Meier & Chakrabarti, 2016).

The VHW program is seen as key to PHC and achieving UHC in Bhutan. The program was conceptualised as volunteer-led care provided by community members to community members, as set out in the 2013 Village Health Worker Program Policy and Strategic Plan 2013 to 2018 (MoH 2013b). VHWs are expected to provide first aid and treat minor ailments, create awareness and mobilize the community for health promotion particularly in reproductive, maternal and child health, and sanitation (Thinley, et al, 2017). Communities are informed about prevention of disease and promotion of good health through immunization, care during and following pregnancy and childbirth, and advice on nutrition, water and sanitation, alcohol and smoking.

The government has a policy of community participation in health, and VHWs function as a bridge between the community and the various programs of the formal health system under the MOH. VHWs are expected to help bring health services to the community by participating in outreach activities, and also through participation in development activities (MOH 2012a). The health system in Bhutan emphasizes the importance of community health to "ensure quality and equality and quality health services with equity to the public. As one respondent put it, community health

ensures, "the coverage of the healthcare services to all the nooks and corners of the country." All the health programs are expected to support the VHW, as what they do is "for the benefit of the community." The VHW is perceived to be key to the "participation" and "involvement" of the community.

Critically, however, there is a lack of detailed guiding policy documents that direct the VHWs and clearly outline their engagement within the MOH more broadly (MOH 2013a). The Village Health Worker Program; Policy and Strategic Plan developed for the period 2013 to 2018 has not been revised or updated.

Some aspects of the government's policies may be considered gender transformative. The use of a tool by the Gross National Happiness Commission (GNHC) to screen all government policies for gender sensitivity and the development of a gender equality policy and a gender action plan provide evidence of efforts towards being more gender transformative. The National Commission on Women and Children is working on a gender equality policy and a gender action plan, which is expected to include LGBTQI issues and to mainstream gender in all policies and programs.

However, in practice, many policies are found not to be very strong in their gender components, raising questions about the strength of the tool to pick up gender sensitivity. Often, policy makers are not convinced about the need to address gender issues without strong data to support this. There is no mention reportedly of other genders in the draft gender policy of the Gross National Happiness Commission.

Efforts made by the government to enhance health care workers' knowledge to address GBV is an example of a gender responsive practice. One respondent felt that VHW policies could be described as "mostly gender neutral or gender-sensitive."

## 1.3. Governance and Leadership

The MoH is responsible for policy formulation and implementation, planning, monitoring and supervision of services, provision of technical guidance to the district health management and assuring the provision of medical and non-medical supplies and human resources. The MOH also plays leadership role working in collaboration with development partners to strengthen health care and public health programs (Meier & Chakrabarti, 2016).

Although Bhutan has adopted and invested in PHC as the official approach for health development, increasingly, PHC service levels are being bypassed for secondary and tertiary health care in urban areas, mainly due to population's preference for services at higher levels health facilities and the absence of a "formal gatekeeping mechanism" (Thinley, et al, 2017). In 2017, the national referral hospital in the capital was catering to 40 per cent of all outpatient services in the country, which not only has implications for quality and maintaining a continuum of care but also for the PHC strengthening efforts and investments in community health systems.

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Health administration and management has been devolved to districts and district-level health service planning and management are decentralized to district health management teams (DHMTs) that function within the framework of the local government (Thinley, et al, 2017). Under the decentralized structure of government, MOH provides technical support to local government including the District Health Management Team (DHMT) on planning, budgeting and implementation. The DHMT is responsible for delivery of health services and responding to local needs through multi-stakeholder engagement and community participation (Thinley et al, 2017). The district health office is also responsible for deploying the health workforce in the district, while the district health authority has direct responsibility for the management of the district hospital and BHUs.

At the village level, the Dzongkhag Tshogdu (District Council) and the Gewog (Block) Tshogde are responsible for enforcing rules on public health and safety and tasked with encouraging economic development. Gewog governments also formulate five-year development plans, run their own budgets, and raise their own labor for public projects.

BHUs provide services at PHC level including basic medical care, maternal and childcare services, and prevention interventions, and conduct the ORCs for more remote communities. They refer cases when necessary to the district hospitals (located in each of the country's 20 districts), the regional referral hospitals in Mongar (east Bhutan) and Gelephu (south Bhutan), and the Jigme Dorji Wangchuk National Referral Hospital in Thimphu (Meier & Chakrabarti, 2016). Although the VHWs are not paid government employees, they are a valuable resource to support health system activities at the PHC level.

Various reports suggest that over the years the VHW program has not been prioritized. While the contribution of VHW is recognized and there is a designated officer responsible for the program within the MOH, the program has not been allocated adequate resources, and the overall perception was

that it is not well integrated into the health system. This has resulted in inadequate capacity building, low motivation of VHWs, and consequently, a high attrition rate among this cadre (MoH 2013b; MoH 2018).

Some respondents reported that the VHW program does not get the policy attention and financial support it requires.

*'because right now the village health worker program is not really being you know sort of taken care of. Both in terms of funding and both in terms of concrete strategy, policy directions...'* (KI6 MOH)

Other respondents felt that the lack of leadership and support may be linked to the decentralization of decision-making authority. While there are "guiding principles" for the management of the VHW program developed at the central level, for example related to their selection and training, their roles and responsibilities, and catchment population, the application of these principles and standards is at the discretion of the local government.

It was perceived that centrally formulated policies may be difficult to enforce and may cause problems at the local level, and that the implementation and translation of policy were best left to the local authorities. For example, traditionally all families in a community are required to contribute to activities such as building an irrigation channel or a road for the community- "the Compulsory Labour Contribution," as one respondent referred to it, equal to a month's contribution of labour per year. While the usual practice has been to exempt families of VHWs from these compulsory "community services," this exemption may be difficult to implement, especially in less populated communities, where there are lots of people volunteering in different areas and "there may not be enough people to contribute to the work within their community."

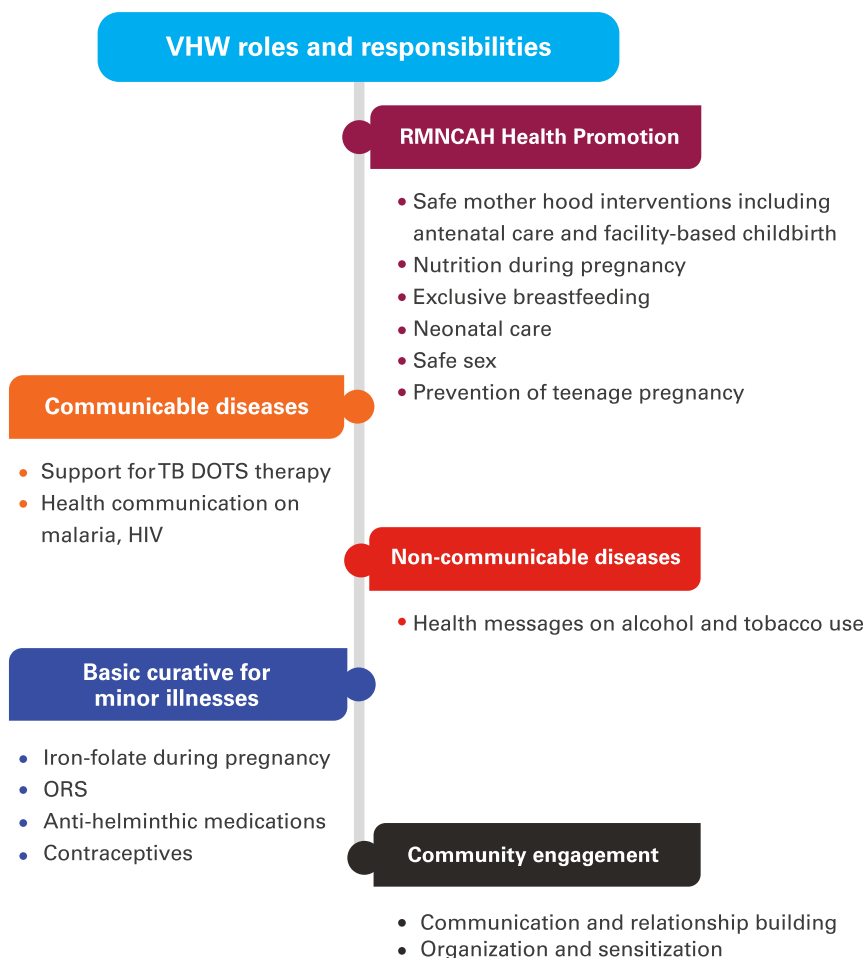
Leadership may also be affected by gender imbalances. Almost all leadership roles in the health sector, except perhaps in the nursing department, are held by men. These include the different departments of the MOH, at district level, and in hospitals. This situation may influence and skew the VHW selection process towards men, as well as overall attitudes towards the participation of women in the VHW program.

#### 1.4. VHW roles and responsibilities and focus on RMNCAH

Clinical services are provided by the MOH through a network of hospitals and health centres mostly in urban and semi-urban settings, and ORCs in remote rural settings. VHWs provide services in the community and act as the link between health services and the community, facilitating access to quality services. VHWs are not expected to provide clinical care but rather, to promote healthy practices and care seeking behaviours in the community.

The VHW's scope of work (SOW) is defined in the 2013-2018 Village Health Worker Program: Policy and Strategic Plan. The SOW comprises preventive and promotive services for RMNCAH, NCDs, communicable and vector borne diseases, and sanitation; and curative services, which include the management of minor ailments. It also proposes a leadership

Figure 4: Roles and responsibilities of VHWs in Bhutan



role for the VHW within the community, with responsibility for activities such as communication and relationship building; organizing and sensitizing communities; social mobilization and community participation. Additional duties proposed in the SOW include supporting ORCs, creating awareness of domestic violence (DV) and maintaining records and submitting reports to the health facility (MOH, 2013a).

A similar set of VHW roles and responsibilities, as well as a Code of Conduct are set out in a bulleted list in the revised 2015 MOH Handbook for Village Health Workers. According to the Handbook, the primary role of the VHW is to *“function as an effective catalyst for health promotion and disease prevention in the communities, and not just as a mere advocate of health information”* (MOH, 2015 Handbook).

Respondents affirmed that many of the roles and responsibilities set out in these official documents were being undertaken by the VHW cadre. Reportedly, RMNCAH has been a priority for the VHW program from the time of its initiation, with VHWs focusing on promoting safe motherhood (inclusive of antenatal care), neonatal care, adolescent care with an emphasis on teenage pregnancy, nutrition during pregnancy, exclusive breastfeeding, family planning and birth spacing (especially through the provision of oral contraceptive pills), and promoting safe sex (MOH 2012a, MOH 2012b; MOH 2013a).

As outlined by respondents, as part of their RMNCAH roles and responsibilities, VHWs are expected to identify, prepare a list, and keep records of all the pregnant women in their communities, they *“have to know the numbers of women pregnant in their village”*. They should encourage and motivate women to attend outreach clinics, *“to go to the health centre for early booking”* and to seek facility-based care during and following pregnancy and childbirth. They are also expected to provide information on family planning. In some cases, the VHW will *“accompany the pregnant mother, if there is a need”*. In addition, they are responsible for promoting breast feeding and immunization and disseminate health information in their communities during immunization campaigns. In cases of obstetric or paediatric emergencies, VHWs encourage families to seek referral care and to access services from the nearest health centre.

VHWs work closely with the facility-based Health Assistant to collect information and report on key MNCH indicators, such as *“PNC coverage, ANC coverage, neonatal death and all these institutional deliveries”*.

VHWs are involved in the distribution of iron and folic acid supplements during pregnancy, medicines for minor ailments, oral rehydration solutions, anti-helminthic medicines and contraceptives, *“guided by the health worker”*, especially in *“far off places where outreach clinics are not possible”*. They are prohibited from prescribing any other medicines by the medical health council.

In addition to RMNCAH, VHWs also play an important role in communicating health policies and key messages “*shared by the basic health unit and the hospital*,” to community members, which includes “*knowledge on the do’s and don’ts, and especially focusing on the awareness of healthcare services*” (Thinley, et al, 2017). During home visits, VHWs provide health education and promote the uptake of facility-based services. They also liaise and link people in need of different care to the appropriate facility and health care provider and assist healthcare workers in their outreach activities (MOH 2013a). VHW support the implementation of the TB-Direct Observation of Therapy short-course (DOTS) program in their communities; they “*have knowledge on the signs and symptoms of TB, tuberculosis, so that they are able to identify and then refer to the nearest basic health centre*.” However, the extent of their involvement in this area varies depending on their proximity to TB patients. They also provide health messages about other communicable diseases, such as malaria and HIV, and help to identify and refer potentially infected people for further tests and treatment. For reasons of confidentiality, stigma and discrimination, VHWs are not involved in the care of people living with HIV. VHWs also assist with the collection of information on polio surveillance and the reporting of disease outbreaks in the community to the HA in the facility.

With regards to non-communicable diseases (NCDs), VHWs provide health messages about alcohol and tobacco abuse, promoting ‘*alcohol harm reduction*’ and the importance of physical activity for health.

Although the SOW includes preventive and promotive services related to adolescent health, with a focus on teenage pregnancy, it is unclear what services VHWs currently provide for adolescents. A key challenge for the VHW in the provision of adolescent health services is in the area of teenage pregnancies. Pregnancies below the age of 18, whether within marriage or outside, are criminalized, and entail punishment for the male partner. Thus, VHWs are often reluctant to report such pregnancies, resulting in a lack of access to appropriate care and support for these adolescents.

VHWs are estimated to work around 40–50 hours per month, though this may be less in smaller communities (MOH, 2012a). Respondents suggested that this cadre has now been inundated with too many activities, and their original SOW has expanded to include a wider range of services, including community based PNC, NBC and NCD screening. Many of the stakeholders, including VHWs, who participated in a review of the VHW program in 2012, suggested that there was a high demand for the services of the VHWs across all sections of the health departments and that the workload needed to be reduced (MOH 2012a). Some perceived that the VHWs have become an unpaid extension of the Health Department.

## 1.5. Selection, education, and certification

### 1.5.1. Selection

There is a range of criteria guiding the selection of VHWs. VHWs should be literate in either Dzonghka or English “*they only want somebody who can read and write*” and have completed at least eight years of education. However, in reality, many of the more senior VHWs are illiterate. The literature suggests that the high rate of illiteracy has been linked to poor performance on counselling on complex issues like danger

signs during and following pregnancy and childbirth. However, training materials and job aides are often in English, not in Dzonghka, and there is inadequate visual content for those who are illiterate or have low literacy levels, and supplies of such materials are insufficient, contributing to ineffective retention and application of learning (MOH and UNICEF, 2018).

*‘The training is given in English; the materials are developed in English. So when we did the impact assessment of the training, we found out that the IPC materials were in English and then people were not able to communicate.’ (KI5-United Nations)*

Selected persons must be permanently resident in the community that they will serve and be trusted and acceptable to the community. They must be willing to attend training and to commit to the role for a minimum of one year. Typically, people selected are those in their 30s, who are married, and who are willing and able (MOH, 2012a). It was reported that the health assistant and district health officer, in consultation with “*community leaders*” and “*the head of the people*” “*select as per the criteria*.”

High turnover and attrition of VHWs, both male and female, mostly related to the lack of recognition and inadequate remuneration and compensation for VHWs, has also resulted in a relaxation of many of the stipulations around age, marital status, and level of education, and selection criteria set at the national level are not always strictly adhered to at the community level. A suggestion in the 2012 review of the VHW program was that the central level should focus on the “*commitment and residential criteria, leaving the rest to the community to ponder*.” This was reaffirmed by one of the respondents, who suggested that while the criteria could be set at the “*central level*,” the application of the selection criteria will depend on the local context, as “*the community may not find exactly those persons with those criteria*.”

While the numbers of female VHWs had improved in recent years and despite the findings in the literature that the preference among many stakeholder was for educated youth, especially female “*school dropouts*” (MOH, 2012a), according to the VHW data provided to the team, in 2018 only 23 per cent of VHWs were female. An earlier cadre of Auxiliary Nurse Midwife, now abolished, was almost exclusively women. This cadre was replaced by the Health Assistant (HA) and the VHW, who could be men or women, which has resulted in there being more men in these positions, which could have implications for the take up of the services these cadres provide by women.

Various reasons have been cited for this gender imbalance such as lack of mobility, the need to navigate difficult terrain, as well as lower female literacy rates (Thinley, et al, 2017). Certain literacy criteria for selection may disadvantage women. While girls predominate in education up to the 12th Standard, and especially in urban areas, men predominate in higher education, especially in the science, technology, engineering and mathematics (STEM) related areas. Whether these criteria are indeed necessary for the roles and responsibilities the VHW is expected to fulfil was questioned by at least one key informant. Other respondents pointed out that training and communication materials are often in English requiring a functional literacy level.

Table 4: Training and supervision of VHW in Bhutan

Type of CHW	Training	Supervision
Village Health Worker (VHW)	14 days initial training and 7 days refresher	Health Assistant – mostly men

Figure 5: Selection, education and training pathway for VHW



Most leadership positions in the community are held by men, which could influence communities' preferences in selecting men as VHWs. While women's participation in electoral politics is increasing, very few win elections, however, so men predominantly continue to occupy leadership positions.

Some key informants felt that there was no gender-based discrimination in the selection of VHWs as they were all volunteers. Men would be more likely to take up the volunteer VHW roles, as the cultural norm is that the woman's role is in the home. As one respondent remarked, *"in the Asian culture, the female might have to play an active role in the house, or they never used to go out and do something different."* Another suggested that as most of those working in the village are labourers, who are men, *"it is always the woman who stays back"*.

Respondents reported that women shoulder the major share of domestic responsibilities, including childcare and elderly care and *"it is difficult for women to participate because of the responsibilities at home."* Women also make a significant contribution to the work on the family farm. This acts as a barrier to them taking on work outside the home, especially VHW work that requires a lot of time and travel outside the

home. The unsalaried nature of the post is also a barrier for women to take up these positions while they have competing demands at home. Respondents confirmed that the higher numbers of men volunteering was related to woman's household and childcare responsibilities, which would take precedence, *"they have to look after their own children," "they have parents behind who they have to look after, they have more work to do at home, and that the "female coming, volunteering as the VHW, is an issue"*.

Gender norms within the family are reported to be changing with time. An example is the increased participation of women in local electoral politics.

While road connectivity has improved over the years, the distances that VHWs must travel and the lack of paved roads are still problematic. Houses are also "scattered", and it can sometimes take the VHW three to four hours to reach one household by foot. Some respondents reported that while the selection criteria do not actively discriminate against women, the educational requirement and the travel involved for the work - *"they have to move around in the community, because their main role is to pass the message, to refer, to make references, and so that means it requires lot of movement"*,

and the unpaid nature of the work, “they do not get any compensation for the time they’ve spent,” all act as barriers to their participation in the VHW program.

However, reportedly, relaxing selection criteria to allow women who have not completed their education and who may not be literate to take up VHW roles, has created problems with the performance and quality of some of their activities, such as the maintenance of registers and reporting, as well as the management of appropriate referrals (MOH 2012a).

One respondent reported that the gender imbalance in the VHW workforce may also be due to the nature of the VHW work. As the VHW role involves mainly health promotion and prevention activities, requiring limited physical contact with clients. “they don’t have to touch the patients,” it may therefore be more acceptable to have mostly men as VHWs.

Some respondents perceived that men command better trust from the community, and that the community may be more accepting of health information if it is communicated by a male VHW, with one respondent indicating that “acceptance of messaging seems to be better when men are messaging.” It was suggested that along with the “general acceptance that the head of family should be a man, there is a misconception that women cannot look after the community.”

Others provided examples of gender issues in the country, including acceptance of gender-based violence, the concentration of women in low paying jobs, and the under representation of women in leadership positions “at the executive level” within the government civil service. The absence of overall gender disaggregated data was also raised as a constraint to addressing some of these issues.

*‘There is a lot of gender issues related to urbanization. Data shows that 67 per cent of them [women] accept it is okay for men to hit them. If you go to any of the hotels they have recruited lots of girls, but their payments are very low. Girls, you know by nature, they are put into housekeeping, receptionist. So these jobs are seen as girl’s work. And everything starts on there.’ (KI5- United Nations)*

The gender imbalance in the VHW workforce could potentially impact the utilization and uptake of health services by women and adolescent females. Women, it was felt by almost all key informants, would be more comfortable receiving information on sexual and reproductive health (SRH) issues from women VHWs, rather than from those who are men, “they would certainly prefer a female talking to them rather than a male.” Similarly, adolescent girls are uncomfortable receiving SRH related information from men. There is a high level of school absenteeism during menstruation and it was felt that women VHWs would be more acceptable to girls to provide information on menstrual hygiene. This is already acknowledged as a problem in the provision of facility-based services where women often prefer to be seen by female healthcare workers and will not go to the health facility to seek care “if it is a male health service provider.”

Some key respondents expressed concerns about the safety and security of female VHWs if their participation in the VHW program was expanded. While there are no data on safety issues faced by women VHWs, crimes against women were

reported to be increasing in society, “rising issues of women being raped, women being molested,” leading to women being fearful about traveling long distances in remote areas. Also, wildlife attacks are a danger for both men and women VHWs when traveling in such areas.

The government is trying to ensure that the VHW program is more gender-specific and gender-sensitive. Efforts are ongoing to ensure female health care providers are deployed in health facilities “the minister has been trying to put female health workers in every health facility.” Improving the availability of women VHWs to address women’s sexual and reproductive health concerns will improve acceptability and confidence of by women and girl to utilize these services

Despite these efforts to address gender issues in the country, most health programs were seen as being gender-neutral. The only gender related intervention, according to one respondent, was to reach an equal numbers of boys, girls, men and women.

Gender is a key result area in the Twelfth Five-Year Plan (2018-2023). Under this plan, gender should be mainstreamed into all government policies and plans and all project proposals, policies and projects should be screened using the gender screening tool developed by the Gross National Happiness Commission. The United Nations agencies and the government have a prevention of domestic violence program of which the Queen is a goodwill ambassador.

### 1.5.2. Education and Training

It was expected that VHWs would receive 14 days initial training with a seven-day refresher training course provided annually. However, this was reduced in 2012 to a seven-day initial training and a three-day refresher training, with 10–30 participants (Thinley, et al, 2017, MOH 2012a), with no apparent change in the range of topics to be covered through the training. The overall perception is that the duration, delivery and quality are variable and often dependent on the availability of funding. One respondent indicated that because of the large number of VHWs it is difficult to reach all VHWs with refresher training during the year, and instead they “prioritize and support, according to the needs of the districts for the VHW refresher training.”

A revised version of the Trainers’ Manual for Training Village Health Workers was developed in 2013, with the companion Handbook for VHWs developed as a ‘quick reference for VHWs in 2015. The Handbook was expected to assist the VHW in “executing health promotional activities” and to ensure that VHWs provide correct health advice and information to the community. The Handbook is also held up as a symbol of the appreciation the MOH accords to the VHWs “for their selfless and dedicated service for the betterment of community health.”

The Handbook covers a range of topics around sanitation and hygiene, pregnancy and childbirth (antenatal and postnatal care attendance, skilled care at birth, and exclusive breastfeeding), child health, family planning, nutrition and cervical cancer, sexually-transmitted infections and HIV/AIDS, malaria, TB and leprosy, NCDs, mental health and alcohol, epidemics and outbreaks, climate change and disaster management, and

record-keeping. According to the literature, VHWs are given a pre- and post-training test to assess their knowledge at the start and conclusion of the initial training (UNICEF 2004; Thinley, et al, 2017; MOH 2013b). At the conclusion of the training, the VHWs are certified (MOH 2013a).

As there are no differences in roles and responsibilities between male and female VHWs, both male and female VHWs are trained in all components of the training program. However, with the limited resources available for the VHW programme in general, and for training in particular, the shorter duration of the initial and the infrequent refresher training it would be challenging to deliver and address all these topics satisfactorily.

In 2016, the MoH, with the support of UNICEF developed a training program and manual on Interpersonal Communication (IPC), and training was delivered to 501 VHWs across 12 districts. The objective of the training was to improve VHWs IPC skills to “impart messages and initiate community dialogue” on MNCH, nutrition, and hygiene and sanitation (MOH & UNICEF 2018). According to one respondent the training involved skills on “impart messages and initiate community dialogue” on MNCH, nutrition, and hygiene and sanitation (MOH & UNICEF 2018). According to one respondent the training involved training the VHWs how to “communicate with the communities,” “how to impart messages,” “talk nicely to people,” “in a way that encourages women to go for antenatal and PNC check-ups.”

A 2017-18 study on health sector responses to GBV found that about 60 per cent of health workers, including VHWs did not know how to address GBV. According to respondents, GBV has now been included as part of the training for health care providers.

The HAs in the local BHU, and the District Health Officer (DHO), undergo training as trainers; a course which is reportedly well-conducted, is participatory and utilises technology appropriately. They then deliver the training to VHWs, primarily in the local health facility, using the VHW Trainers' Manual. The HAs, and DHO are also expected to provide on-the-job training and continuing education for the VHWs (Thinley, et al, 2017; MOH 2012a).

## 1.6. Management and Supervision

### 1.6.1 Remuneration

VHWs are a non-salaried and voluntary cadre. They receive a per diem (Nu 500) for attending training. Respondents indicated that if “they come outside their jurisdiction [to provide services], they are compensated” but only partially, “they have to make do what is there.. They also receive “porter charges” for carrying vaccines during immunisation campaigns. Beside these allowances, VHW do not receive any other monetary incentives (MOH 2012a), which respondents felt was a “challenge.” There were plans to compensate VHWs for the loss of paid employment, but this is not happening currently (MOH 2013a).

There is an annual monetary award (Nu 5000) in each Dzongkhag (district) for the “best performing” VHW to motivate and “promote healthy competition” among VHWs (Thinley, et al, 2017). In the past, as a reward for good performance, some VHWs were sent on “study tours” to

other districts and neighbouring countries. However, both of these practices have been waning in recent years due to central level funding constraints.

### 1.6.2. Attraction and retention of VHWs

Multiple respondents made the link between the high attrition of VHWs, which has been an ongoing challenge, and the lack of remuneration, and fair compensation for travel and participation in training (MoH/UNICEF 2018). One respondent observed that the “very high transition rate of village health workers is because they are not paid, simply because they are not paid”, while another highlighted how difficult it is “for people to work for free right because it is going to compromise their farm work.”

One respondent claimed that because of the lack of remuneration, “nobody wants to be Village Health Worker.” However, the community recognizes the importance of the VHW services and “households “take turns” to take on the VHW role. Instead of volunteering for the role, one respondent observed that “it’s thrust upon them.” Because of the economic consequences and income and ‘opportunities lost’ by being a VHW, in more affluent communities, “entrepreneurs” will “get someone who is unable to be an entrepreneur like them, to be the Village Health Worker, in place of them.” One respondent reported that these people are “appreciative of the work that the VHWs are doing, just because they don’t want their turn to come to them.”

Stakeholders such as BHU and district staff, made the link between lack of remuneration and the poor accountability of VHWs (MOH, 2012c).

One respondent suggested that a key factor influencing the attraction and retention of VHWs is the exemption they receive from the Compulsory Labour Contribution scheme, which involves one month a year of compulsory labour, however this is not available to all VHWs. Others highlighted the spiritual and religious influences, such as Buddhist belief that while they do not receive anything for their VHW service now, this will improve their “karma” for the next life. There is also a general attitude in Bhutan that responsibility delegated has to be fulfilled. However, these beliefs and norms are changing and may be less of an influence on people choices to take up or continue in the VHW role nowadays.

In addition to remuneration, other factors associated with VHW dissatisfaction and intent to leave the role highlighted in the literature, included VHWs’ perceived inability to satisfy the needs of the local community, as well as community expectations that the VHW would be available “round the clock” to meet their needs (MOH, 2012c). This 2012 review also found that VHWs believed that their lack of representation on the Gewog Yargay Tshogdug (GYT)/Block Development Committee, and participation in these meetings, affected their standing in the community: they felt their “image’ in the community was “poor” as they had “no voice” in GYT was also identified in the literature as a key cause of dissatisfaction. Facility based health workers and district level staff also felt that “low esteem” among VHWs was one of the reasons for dissatisfaction and attrition among this cadre.

In the 2012 review of the VHW programme, VHWs indicated that they wanted more recognition, in terms of ID cards, uniform and kits, as well as refresher training and monetary incentives ‘to compensate’ for days worked (MOH, 2012c). At that time, fixed payment as well as performance-based incentives (PBI) were raised as options to compensating VHWs, but there was no consensus on this. PBI had not worked well in the past, and there was a perceived risk of “conflict of interest” at the BHU level and that it could lead to demands for compensation from other “village workers”. It was also felt that such a scheme could also disadvantage VHWs in more remote areas where the terrain made access to households difficult.

Respondents in this study pointed out that there are now more opportunities for paid work, especially for more educated VHWs, who tend to leave when more attractive jobs and careers are available (MOH 2013b). Family pressures and the difficulty of the job were also highlighted as potential causes of attrition in an earlier 2004 study (UNICEF 2004). Although age disaggregated data for the VHW workforce were not available for the evaluation team to review, the 2012 review identified that some senior VHWs felt that they were being forced to continue despite their age (MOH, 2012c).

### 1.6.3. Career advancement

Although the 2013-2018 VHW Program Policy and Strategic Plan states that “VHWs who fulfil criteria (qualification) to join [the] institute for allied health sciences and who have completed three years of dedicated and distinguished service shall be given extra weight in the selection process with recommendation from the Dzongkhag Health Authority”, in practice most VHWs lack the minimum educational qualifications required to take up or be considered for such courses. As one respondent observed, a lot of VHWs are “minimally qualified”, and “they cannot become nurses”

Career progression is therefore limited and depends on the opportunities available and the individual’s interest, “capability” and motivation. Some VHWs reportedly perceived the job as a step towards “getting higher level community and block leadership” positions.

### 1.6.4. Supervision

HAs, based in the health facility are the VHWs first point of contact with the formal health system. All BHU-II should have two to three HAs, but there are challenges attracting and retaining these cadres, especially in rural and semi-urban areas. In 2015, the majority of HAs were male and of the 207 BHUs across the country, 74 did not have a female HA (Thinley, et al, 2017).

HAs are responsible for the training and supervision of the VHWs. The HA is expected to review the VHWs work and performance on a monthly basis. VHWs meet with the HA supervisor monthly at the BHU or the ORC, during which time the HA and the VHW are expected to review the previous month’s performance, plan activities for the next month and review any clinical or health promotion topics or issues.

According to the VHW Policy, the community have a role in monitoring and evaluating the activity of the VHW through *chiwog tshogpa*, once every year or more frequently if required, and members of the GYTor Block Development Committee also monitor the VHWs’ activities in their catchment area. The DHO is expected to compile relevant information provided by VHW every quarter for evaluation and supportive supervision.

However, although supervision is a critical element in the VHW program, supervision is generally perceived to be poor. While some respondents were aware of the HAs’ role in the supervision and monitoring of the VHW, they indicated that there are no standard operating procedures (SOPs) or clear guidance for how supervision at BHU and district level is expected to be carried out. HAs also identified the lack of SOPs and guidelines as a challenge to the effective supervision of VHWs; without such guidance supervision tended to be confined to checking the maintenance of registers and correcting mistakes (MOH 2012a; MOH 2013a).

When asked about the quality of supervision, one respondent reported that the HAs “follow up”, mainly to check that the VHW has done “what was expected”.

## 1.7. Integration of VHWs into the health system and community

VHWs are expected to work closely with staff in the BHU. The HA based at the BHU supervises the VHW, facilitates training and provides them with supplies and kits. In turn the VHW supports facility-based staff with ORCs in the community, provides up-to-date health information on community members, including pregnant women, and refers and mobilizes clients to take up facility-based services. Health system stakeholders, including HAs, recognize the contribution of VHWs to improve health outcomes and acknowledge the important role they play in community mobilization for promotive and preventive programs and in reaching remote households and marginalized populations (MOH 2012c; Many of those involved in the 2012 review were in favour of continuing and strengthening the program.

VHWs live within the community they provide services for. Typically, there are 17 VHWs per 10,000 people, or one for every “sub-block” in the country, or about 20–30 households (30–50 if they are close together) to help provide basic services at the primary care level (Thinley, et al, 2017, 2017; Meier & Chakrabarti, 2016; MOH 2012a). Across the country, 55 per cent of households in areas with VHWs reported meeting a VHW at least once for health reasons in the previous year (MOH 2012b).

As described above, community members must endorse the selection of the VHWs in their locality. The community is also expected to “play an active role in providing feedback, solving problems, and helping to establish VHW as leaders in the community” (MoH, 2013 Policy). Further, the community can monitor the activities of the VHWs through the *chewog tshogpa* (village health committee) and is involved in identifying good performers and rewarding them if they feel this is warranted (MOH 2012a).

Community members perceive the work of the VHW to be important in their respective communities, and most were familiar with the activities carried out by this cadre, as reported in various documents and reports (MoH 2013; MoH 2018). Community acceptance and support is an important motivating factor for the VHW and was one of the factors that would help them to improve their effectiveness (MOH/UNICEF 2018). A perceived lack of community cooperation was linked to dissatisfaction among some VHWs. One respondent suggested that to improve levels of community cooperation, “the village health workers should be someone who the communities looked up to”.

Many VHWs are happy to volunteer their time to serve the community in line with Buddhist traditions (MOH 2012a). VHWs sometimes receive informal token of thanks from community members and some are exempted from having compulsory community labour. The community acceptance and trust that comes with the VHW role can also present opportunities for the VHW to assume a leadership position in the community, as one respondent describes. One respondent described a case of an VHW who was “illiterate” and “became the head of that block’s government”, which he attributed to the “people’s confidence” in this particular individual.

VHWs use existing community structures to provide health education, through “community dialogue sessions” that piggyback on existing community meetings. Continued support from local leaders in hosting these sessions is important (MOH, 2012a).

At the individual level, CHWs are uniquely positioned to both influence and be influenced by gender norms and expectations. They can challenge the causes and consequences of discrimination, exclusion, prejudice, stigma and other barriers to accessing health services. However, the work, behaviour and attitudes of these CHW cadres are also affected by the prevailing gender and social norms in the community. The CHW is part of society and may have to face harmful gender norms for example SGBV, within his/her own family; the internalized gender norms and stereotyping beliefs, held by some CHWs may act as a barrier to reaching marginalised and vulnerable populations with services.

CHWs may need support to maintain self-awareness around own beliefs, biases, emotional responses and values and embrace cultural diversity and individual differences. In some settings, gender approaches are promoted in direct opposition to the belief of individuals or national policies, presenting challenges for CHWs who must reconcile the competing demands of donors, national legislators and their own values systems. For other details on gender findings, please refer to the attached “gender analysis report”.

## 1.8. Data collection and use

VHWs receive training on how to collect data and how to keep information private and confidential (MOH 2013b, MOH 2015). They keep simple records of their activities and submit specific information, for example, information on pregnant women and on the general population served in their catchment area through monthly reports to the HA who oversees their work. VHWs also contribute to quarterly reporting of births and deaths in their community.

Information from VHWs and HAs is then collated at the district level and verified by the DHO in consultation with technical officers, before submission to the VHW Program Officer at national level. The national VHW Program Officer uses these data to monitor and plan VHW activities.

## 1.9. Availability of appropriate supplies, medicines and products

VHWs are provided with an ‘Extension Kit’ which includes gumboots, hand towel, raincoat, torch, soap and a badge. Extension kits are provided once every three years and boots or shoes every year (Thinley, et al, 2017). VHWs also receive a mobile phone. However, in recent years these may not be consistently available. The predictability and availability of some supplies may depend on the resources available at the district level.

In the 2012 review of the VHW programme, service users suggested that the government should ensure VHW have the supplies needed to treat common ailments and other conditions such as asthma, dental care, and child development (MOH, 2012c).

## 1.10. Private sector contribution to CHW programs

There is little private sector involvement in health in Bhutan. Although the government encouraged the establishment of specialist hospitals providing services currently not available in the country, these have not been implemented. Currently there are privately run pharmacies and diagnostics laboratories, and a few private medical consultation rooms. There are concerns that expanding the role of the private sector in health in Bhutan may create competition and cause the internal migration of the already scarce public health workforce as well as impact adversely on the principle of equity in access (Thinley, et al, 2017 et al).

Key informants reported that there is no private sector involvement or contribution to CHW programs. As a means of ensuring the sustainability of the VHW program, the MOH partners with UNICEF for program support and funding and mobilizes additional funding and partnerships from the WHO, local non-governmental and community-based organizations, religious institutions, and larger development partners more broadly (MOH 2013a).

## 1.11. Financing and resource mobilization

The overall health budget envelope for the five-year planning period has a 70:30 resource allocation between central and local governments. The resource allocation to local government is further allocated in a 60:40 ratio between the district and its blocks (a sub-unit of the district). Weightage is given for population, multi-dimensional poverty, area and transportation cost index (Thinley, et al, 2017).

Although budgetary allocations for health in terms of absolute figures have increased, the total health expenditure as a percentage of GDP has declined from 6.9 per cent in 2000 to 3.6 per cent in 2014 (Thinley, et al, 2017). It is unclear how free health care to citizens, visitors and foreigners who reside in the country can be sustained (Dorji, 2016). India is the largest external contributor to the health sector in Bhutan.



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Although the 2013-2018 Village Health Worker Program Policy and Strategic Plan states that “every health program shall provide budget outlay in funding activities for VHWs depending upon the activities of the VHWs the program intends out of them,” within the Royal Government of Bhutan (RGOB), financial commitment to the program has not been a priority. At the national level, there is a designated program officer within the NCDD who is responsible for the program. The incumbent has recently retired. While government funding had generally increased over time, the increase has been proportionately higher for curative care than for the preventive and promotive care offered through the VHW program. Additionally, with the decentralization of government, resources are now allocated to the districts. Government strategy documents have highlighted the need to secure funding to sustain the program in the future and there were plans to allocate additional funding for the VHW program in the Twelfth Five Year Plan (2018-2023) (Thinley, et al, 2017). MOH respondents acknowledged the support it receives from UNICEF to implement the VHW program. UNICEF has supported the development of aids for health promotion and prevention, and as described above, has supported the MOH with the delivery of IPC skills training for VHVs in 12 districts. While the MOH support the salary of the VHW program office and may contribute funding for various aspects of VHW training, “sometimes logistics, sometimes the working lunch, sometimes the per diem,” the overall perception was that the RGOB’s financial support for the program is minimal.

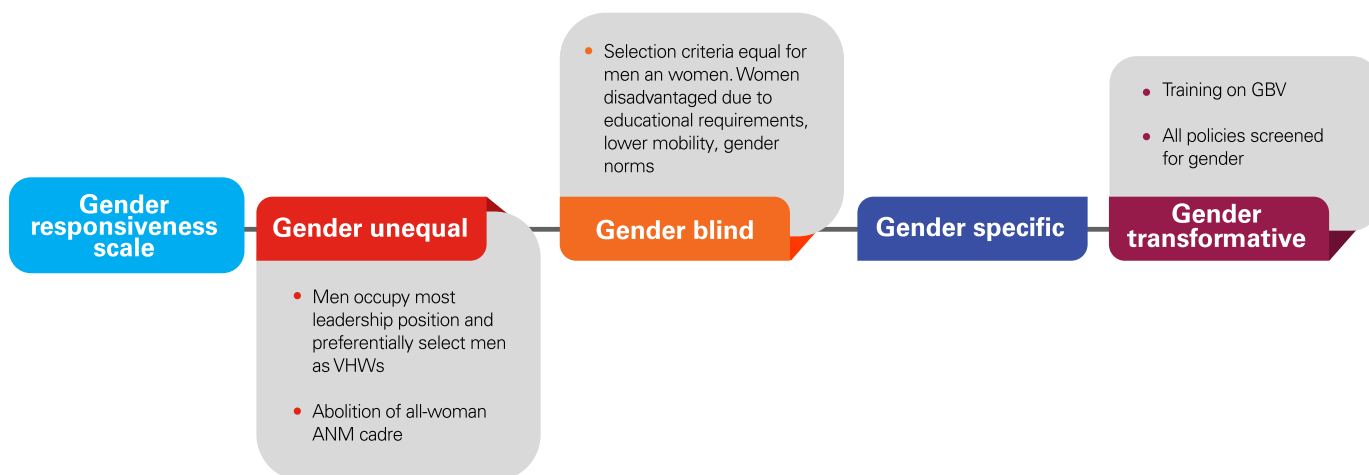
Key informants indicated that the district health officer provides financial support for refresher training for the VHVs but this may only cover the “small and essential training to the VHW and community” and may only be enough to “call them once and give a sensitization”.

The level of funding received for implementation depends on the leadership and resourcefulness of district health officers, “how they budget and the amount of budget they get from their own district share depends on how they are planning, how they are convincing about getting their money.” Respondents indicated that local governments can allocate the funding they receive through block grants to fund identified local priorities and therefore it would be important to sensitise all district administrators on the key links between health and development and the need to allocate adequate resources for health.

## 2. Policy and system support improvements to optimize the VHW program in Bhutan

The **KEQ 2** sought to understand what policy and system support improvements are needed to realistically optimize the CHW profiles and roles and responsibilities of CHWs to better serve maternal and newborn health and to respond to the post-Astana or PHC reforms and strengthening. Key informants made a number of suggestions to improve policy and health system support for the VHW program, including ensuring better financial support and greater integration of the VHW program within the health system and the MOH to enhance its effectiveness and sustainability. It was also suggested that advocacy on the prioritization of health, especially promotive and preventive health services, on the district development agenda was needed. In addition, respondents identified the need for the recruitment of more educated women into the VHW workforce; and the provision of financial compensation and incentives for VHVs.

Figure 6: Gender assessment of CHW programme



## 2.1. Improved financing and integration of the VHW program within the health system and MOH programs

While the MOH has a designated post for a VHW Program Officer, funding for the VHW program is mostly opportunistic. Currently, additional funding is dependent on the priorities of other MOH programs and the availability of resources within these programs. Respondents suggested that the VHW program should not be “a stand-alone program and should be better integrated within the overall health system, the “national strategic plan”, and in all the health programs across the country, which will enhance its sustainability.

## 2.2. Advocacy for health as a priority on the district development agenda

Under decentralization, local governments have greater roles and responsibilities in the prioritisation and allocation of resources to respond to the needs of their districts. Health is only one among the many competing priorities, and is perceived to be difficult to prioritize because, “it costs money to get people, even to create awareness.”

Some suggested that “people have stopped talking about health” and that health workers, including VHWs should participate in local “planning and budgeting meetings” and “convey to the people that health is one of the development agendas”. They need to sensitize local leaders on the importance of health, and to advocate for sufficient funding to be allocated for PHC, especially for promotive and preventive services.

## 2.3. Improving the gender responsiveness and transformative aspects of VHW policies and programs

Assessing the findings against the WHO’s gender responsiveness scale showed that some aspects of the current VHW program were gender unequal. The fact that most leadership positions at the different levels of the health system and the community are held by men has created a situation where there is preferential selection of men for the

posts of VHWs and has engendered greater trust in men’s performance. Women VHWs were seen as essential to improve the uptake and acceptability of SRH services amongst girls and women. The abolition of the all-woman Auxiliary Nurse Midwife cadre and its replacement with a supposedly gender neutral VHW cadre is another example of gender unequal programming.

Some aspects of the current policies and system support are gender blind. Although both men and women were supposed to be equally eligible for the post of VHW, the education requirements for selection, the language medium used in training materials, as well as the fact that the position requires travelling long distances in remote areas, disadvantages women. The prevailing cultural norms that hold the women primarily responsible for domestic chores also ensure that women are disadvantaged in the selection process. Similarly, even though women VHWs had a possible career pathway to nursing, in reality, this was not possible because they did not possess the educational requirements for admission.

## 2.4. Recruitment of more female VHWs

Increasing the number of women VHWs will enhance the take up and acceptability of the services they provide, including RMNCAH and SRH services for women and adolescent girls. Low educational levels among women have reportedly affected the selection and recruitment of females into VHW roles. Low levels of education also affect VHW performance and limit their opportunities for career progression. Achieving increased recruitment and female participation in this role will require addressing the cultural, social and gender barriers described above, as well as improving the conditions of employment. The challenges in recruiting more educated women who often have more employment options has also been noted.

As has been suggested in the literature, one informant shared that girls who drop out from school continue to stay in villages and that these could be targeted and recruited into VHW roles, if they were provided with basic training and some incentives. Furthermore, the additional training and experience they acquire from the VHW role could also provide them with opportunities for further professional and career advancement.

VHWs have played a vital role in sensitizing and following up women in the pilot cervical cancer screening program in the country. Their local knowledge of the community has helped with the identification of women for screening and follow up. This needs to be upscaled with the use of women VHWs.

## 2.5. Remuneration and compensation

VHWs are not remunerated beyond the reimbursement of minor expenses. While incentives such as study tours are perceived to improve VHW motivation, some key informants felt that as long as the VHW role remains unpaid, attracting greater numbers and more educated candidates into the role would be difficult, with one observing that *“as long as they’re not getting anything from the government, they won’t be interested to work.”*

Some suggested that it was now time to review the current compensation policy and the range and types of incentives provided to VHWs to improve the motivation and retention of VHW. Others suggested that VHWs could be compensated for specific activities such as when they *‘accompany patients to health centres’* or are involved in *‘outreach clinics in their villages along with formal health workers. The need to’* incentivize the VHW program” has been a key recommendation of the various program assessments and reviews that have been conducted.

## 3. Prioritized measures to strengthen health policy and system support to optimize the contribution of VHWs to PHC

The findings in this section respond to KEQ 3 and provide a synthesis of the key findings from KEQ 1 and KEQ2, and an assessment of the possible reforms, including gender - informed reforms, required to enhance the contribution of the VHW program to PHC, and to ensure gender equity and responsiveness, given the country context.

### 3.1. Strengthening health policies

#### 3.1.1. Strengthening community health policy frameworks

Respondents spoke about the RGOB’s commitment to PHC, community health and UHC, evidenced by the existing strategy and plan, with some suggesting a renewed focus on community health in the new health policy. One respondent observed that the current government is “really pushing towards community health”, with the Prime Minister advocating for “doorstep” health services. Some suggested that the HA, currently based in the BHU, could also be more involved in the provision of community-based services.

*‘So maybe this government will completely change the policy with more focus on the community health.’ (KI2 MOH)*

#### 3.1.2. Strengthening the VHW program

The overall perception is that the VHW program needs to be strengthened as VHWs play a very important role in providing doorstep services and reaching households as well as supporting RGOB efforts to achieve UHC. The 2013-2018 Village Health Worker Program Policy and Strategic Plan

directive that VHWs must be reflected in the National Human Resource for Health plan and included in the health strategic planning process should be acted on; VHWs are not included in the health workforce data presented in the Annual Health Bulletin (MoH, 2020, Table 6.2 pp. 126-127).

While local leaders and community groups have a responsibility for the dissemination of health information, it was felt that VHWs are key for reinforcing these messages, for *“community mobilization”* and for strengthening existing PHC systems.

Home and community-based services are often neglected by the formal health system because of health care worker shortages, and the heavy workloads and time constraints of facility-based health care workers. But VHWs *“know their household and neighbours”, they can provide services “at the doorstep of the people “and support the RGOB’s ambition of achieving “people centered care.”*

*‘I think village health workers play an important role because our (paid) health workers spend most of the time in the health facility, they have no time to go into the communities and impart our health messages. But to make sure that each and every one is reached; I think we should make the best use of village health workers.’*

Strengthening the VHW program would potentially contribute to the overall strengthening of community based PHC services, with VHWs well placed to reach households, especially the unreached and most vulnerable and marginalised in the community who are not accessing services, supporting RGOB efforts to achieve UHC.

#### 3.1.3. Mobilizing and allocating adequate resources for the VHW program

As noted earlier, over the years the VHW program has suffered as a result of the limited resources committed and allocated to it from the RGOB. It is acknowledged at national, Dzongkhag and Gewog levels and by community members that VHWs are essential non-formal health worker cadres who play a crucial role in delivering preventive and promotive services across many programs. VHWs, especially those working in remote areas with unreached populations, have the potential to support the formal health system achieving its aspiration of making health services available and accessible at the ‘doorstep’.

Local leaders need to be sensitized about health needs and ensure adequate and predictable funding is allocated for VHWs training, supervision and remuneration.

Additionally, another potential funding stream are the programs that use the services of VHWs; such programs should make a regular financial contribution to the VHW program to help cover the cost of such activities.

*‘...there may be policy changes like, taking the services to the doorstep, that is good to have if we have enough resources. Do we have enough resources?’ (KI4 MOH)*

Healthcare financing from the Bhutan Health Trust Fund (BHTF) has increased from 0.042 per cent in 2010 to 5.14 per cent in 2014 and is expected to increase in the coming years with the gradual phasing out of the traditional donors. (MoH, 2020). This

funding source could also be tapped to support overall PHC strengthening and the VHW program.

Resource allocation also needs to follow RGOB efforts to improve the gender responsiveness and transformative aspects of its policies to ensure meaningful change follows the introduction and implementation of its gender policies

### 3.1.4. Involving other programs in health promotion activities

Bhutan currently has non-formal education centers and non-formal educators, based in every 'gewog' whose role is to improve literacy in the population. These educators are mostly educated women, are based in the community and "work really closely with the local leaders and local women." Though non-formal educators are not currently involved in health-related activities, respondents suggested that they could be potentially trained to provide health messages and mobilize the community, taking on the VHW role and/or working in collaboration with existing VHWs, and supporting them with health education and promotion, while undertaking their routine work. This is an area that the MOH could consider exploring further.

### 3.1.5. Strengthening primary health care in urban settings

Increasing urban migration has created challenges to the provision of PHC in urban settings. While the government has created a new city health officer post, PHC in these settings is neglected. Establishing a cadre like the VHW for urban health could help to support the "city health officer and ensure the provision and effective coverage of services across the whole area.

## 3.2. Strengthening health system support

### 3.2.1. Improving VHW recruitment practices

As reported by many key informants, women and girls prefer to receive health care and services from female providers, however, only a quarter of all VHWs in Bhutan are female and many of the HAs in the more remote BHUs are men. Recruitment criteria related to minimum literacy requirement, perceptions around male VHWs enhanced mobility, and the social and cultural norms around women's family and household responsibilities were some of the reasons attributed to this gender disparity.

However, one respondent suggested that this gender balance could be addressed by adopting different selection practices and proposed that one solution would be to recruit young women who had dropped out of school, and were in the community, into the VHW role. These young women traditionally remain in the community, and with the provision of incentives could be easier to attract and retain.

*'So, we retain the girls, because boys usually if they drop out, they don't stay in the communities. We noticed that a lot of girls stay back and this could be a good opportunity for the girls to become Village health workers provided they get some incentives.'* (KI5 United Nations)

### 3.2.2. Regular training and supportive supervision

The initial and continuing training of VHW should be systematic and provided on a regular and consistent basis. An integrated and comprehensive training package for VHWs should be developed and delivered is developed that satisfactorily covers all the key topics.

Such a program should also focus on strengthening the communication skills of these workers to disseminate this information. The training content and approaches should be appropriate for the level of education of current VHWs, many of who are illiterate or have completed primary education only. However, efforts should be made to ensure that VHWs with lower literacy levels are supported to achieve a functional literacy level.

The capacity and competencies of trainers and supervisors, such as the DHO, HAs and other facility-based staff, should also be continuously updated, to enable them employ a range of instructional modalities to deliver effective on the job competency-based training and mentoring and to provide post-training follow-up to ensure VHWs can competently and confidently apply their knowledge and skills to communicate and provide quality services to all population groups.

Regular training, mentoring and supportive supervision will enable VHWs to retain, refresh and confidently apply knowledge, skills and competencies. Appropriate job aids and visual educational materials, preferably in local languages should also be made available to all VHWs.

### 3.2.3. Valuing the contribution of VHWs within the health system

In the past VHWs were "expected to provide a service to the community," and many continue to do so on a voluntary basis. As informants reported, over recent years the VHW program has been neglected due to "competing priorities" and resource constraints, yet "the society found relevance in them" and VHWs continue to provide valuable services that meet the needs of their communities. It would therefore be critical to acknowledge and continue to support the important role VHWs play in PHC and address the motivational factors and sources of job dissatisfaction described above.

Providing some form of compensation will help VHWs to secure their livelihoods and contribute to their empowerment, as well as enhancing their motivation and effectiveness in the provision of services, including RMNCAH services, and as agents of change. Formally recognizing and rewarding both male and female VHWs may also contribute to the economic development of the country. Mother's income has led to improved child health outcomes. Ensuring compliance with the guidelines and selection criteria will help to mitigate any unintended consequences, such as the men only receiving the compensation or incentives, which would only serve to reinforce gender power relations.

### 3.2.4. Expanding the role of VHWs

VHWs are primarily responsible for health education, promotion and prevention related to RMNCAH, nutrition, water and sanitation, and communicable diseases and NCDs. While there is ongoing epidemiological transition from communicable to

non-communicable diseases, there are also new infections emerging. The formal health system may not be able to cope with the increasing scope of health promotion and prevention messages to address these changing epidemiological patterns. If the numbers and gender mix of VHWs are improved, and the cadre is appropriately skilled and competent, they could better support the formal health system and overburdened facility-based health workers in disseminating updated health promotion and prevention messages and in disease surveillance.

Respondents highlighted the need to invest in and improve the frequency and quality of VHW training. Key recommendations of the 2018 rapid impact assessment of the IPC training on MNCHN for VHWs for improving the overall effectiveness of the program included the need for more regular training for VHWs to improve their knowledge and skills, with particular emphasis on immunisation and nutrition, and confidence in communicating with and providing services to the community. Other recommendations included the provision of sufficient job aids in local languages and greater involvement of local leaders in the supervision and monitoring of VHWs.

## Conclusions and Recommendations

The Kingdom of Bhutan has made tremendous progress in health and wellbeing in recent decades. Even with the challenges of a sparsely distributed population spread over a difficult mountainous terrain, the country successfully achieved MDGs 4 and 5. The country is going through an epidemiological transition from predominantly communicable diseases to non-communicable diseases. Health and wellbeing are key domains in the country's Gross National Happiness plans and the RGOB is committed to PHC and achieving UHC.

The VHW program has been in existence for over four decades. VHWs provide the link between the formal health system and the communities. Our study confirms that these community-based health workers have and continue to play a key role in the provision of community based PHC services in Bhutan.

While the role of VHWs has been mainly to convey health messages (mostly RMNCAH, nutrition and sanitation related), it is time to review their roles and responsibilities in the post-Astana agenda, and to consider what policy and systems support should be in place moving forward. Following recommendations were derived by the evaluation team based on all findings, including responses from respondents on evaluation question three. This question solicited information on prioritized measures that could be taken by government and partners to strengthen health policy and system supports to optimize the contribution that each CHW cadre can make to PHC. Respondents' responses on this question were interpreted considering the other information from all data sources including the desk review. Moreover, the report including recommendations was reviewed by the relevant stakeholders, including the UNICEF staff in the country and region.

Given the system-building nature of the recommendations, all must be spearheaded by the RGoB. Relevant development partners in the country should advocate as well as provide the technical support for implementing the recommendations according to their capacity. The evaluation team presents below a key list of recommendations that have already been narrowed based on the findings. Prioritizing the

recommendations further is difficult given that most of the recommendations are required to improve and enhance the policies and system to address the needs of the PHC and CHWs in the country.

### Health policies to support the integration and resourcing of the VHW program and community health systems to provide quality RMNCAH services

VHWs are a vital link between the formal health system and communities and can make a valuable contribution to PHC and UHC. The VHW program and community health systems need adequate government investment and support to improve the provision and take up of quality RMNCAH services, especially among unreached and marginalised populations, in both rural and urban areas.

**Recommendation 1a: While gender equality and equity are being considered at a macro level in the formulation of a gender equality policy and a gender action plan, they also need to be addressed in operational and implementation plans across all sectors at all levels. Adequate resources should be mobilized and allocated to effectively implement such policies and achieve planned and transformative change.**

**Recommendation 1b: All health programs should be also be periodically reviewed with a gender, social inclusion and disability lens.** (Actor: Royal Government of Bhutan)

### Better integration of VHWs into the health system and recognition of their contribution

It is important to ensure that VHWs feel that they are valued as important members of the health system. While some VHWs may be satisfied to continue to work under the current conditions and get satisfaction from serving the community in line with Buddhist traditions, many are demoralized and demotivated, affecting their performance and retention. Ensuring adequate compensation, providing regular training and effective supportive supervision, as well as community and the government recognition of their contributions will help to encourage and motivate this cadre, and ultimately lead to improved performance, and uptake of the services they provide. Including the VHW workforce in national and district HR plans and budgets and recognizing these cadres as an important subset of the PHC workforce will also enhance their integration and help to ensure they get the policy and system support they require.

**Recommendation 2: Improving the understanding and capacity of Dzongkhag and Gewog leadership of the importance of health in development and the role VHWs can play in this, will ensure that adequate funding is available for PHC and community-based services at sub-national level. Local leaders should be motivated to provide support for VHWs, with the Dzongkhag authority and/or DHO ensuring VHWs receive regular training and orientation and supportive supervision on the technical and operational aspects of their work.** Actors: Royal Government of Bhutan, development partners)

## Raise educational requirements for VHWs

Many VHWs are illiterate and are often unable to make the best use of training materials and/or deliver the correct health messages. In the short term, more visual educational materials and job aids translated into Dzongkha may help those who have low or some level of literacy.

**Recommendation 3a:** Efforts should be made to **target and support VHWs, especially women who are interested, to achieve a functional level of literacy.** This would enhance their performance, would help attract and retain more female VHWs, as well as contribute to their empowerment.

**Recommendation 3b:** In addition, efforts should be made **to attract candidates with higher level of prior learning for more specialized and expanded VHW roles,** especially for the provision of community based RMNCAH and NCD services. However, remuneration and fair and predictable compensation would need to be considered to attract and retain these more educated VHWs.

**Recommendation 3c:** Additionally, a **formal career pathway could be offered as an incentive to attract more educated women into the post.** If school graduates are recruited and trained as VHWs, they could, after a minimum period of service, meet the basic entry requirements for nursing and other health related professions such as Health Assistants, and thus have a career pathway into paid employment in the future. (Actor: Royal Government of Bhutan)

## Proactively recruit more women as VHWs

Female literacy rates are significantly higher than ever before. Improvements in infrastructure in Bhutan have reduced travel time due to motorable roads in most communities. With the increasing number of men migrating to urban settings, women in rural populations are more likely to be available to work as VHWs, and could be attracted and retained in the role, if the right package of financial and non-financial incentives and systems support are in place.

**Recommendation 4a:** At a minimum, **VHWs should be provided with the required kit and supplies and be reimbursed for travel** and other expenses incurred during the course of their work.

**Recommendation 4b:** The evaluation recommends **proactively recruiting more women as VHWs to improve the uptake and acceptability of services for women and girls.** The RGOB should also consider involving the non-formal educators, who are mostly women, and training this group to support VHWs in undertaking their responsibilities and/or to undertake more specific and specialised VHW roles and responsibilities that require a higher level of education and literacy. (Actor: Royal Government of Bhutan)

## Regular training and supportive supervision

Training has been opportunistic and hence irregular and inconsistent.

**Recommendation 5:** The MOH **should ensure that the VHW training is adequately financed,** so that it can be delivered in a systematic way that meets VHWs' learning needs. The VHW Program Officer should liaise with other programs within the MOH to ensure that an **integrated training package for VHWs is developed and delivered** that satisfactorily covers all the key messages, including RMNCAH, and is aligned with the priority health needs in the country.

Improving VHW knowledge, skills and competencies will also enhance their status in the community and engender community confidence in and uptake of the services they provide. The VHW Program Officer should also work with DHOs to ensure that VHWs in their districts receive regular supportive supervision. (Actor: Royal Government of Bhutan)

## Create a cadre of Urban Health Worker

The disease burden linked to urbanisation is on the increase. Currently, most people in urban settings seek care in larger hospitals and not in primary care centres, overburdening facilities at the secondary and tertiary levels.

**Recommendation 6:** The evaluation recommends to create **a link between the urban population and the PHC services and facilities in urban settings.** Such a link could be a cadre like the VHW. With the high population density in urban settings, the geographic area that each worker would have to cover would be more manageable, which might suit female VHWs. Access related issues will be minimal, if any and the chances of recruitment of better educated female candidates would be higher. (Actor: Royal Government of Bhutan)

## Annex 1 Key informant interview guide for national level informants (Generic)

**Potential informants:** policy makers and national opinion leaders; officials from Ministry of Health and from other relevant community health, gender, women's' affairs line ministry officials; representatives from local government and civil service; professional association and regulatory bodies; development partners and donors/funders; representatives from international and local NGOs, private sector, and training providers.

### Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders of policies and systems support for CHW programmes in the country in order to enhance the effectiveness of the health care system and strengthen health outcomes in the country.
- Ensure each participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

### Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheets, consent forms, country specific CHW map, CHW definition; definition of support system; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration; figure of WHO HS Framework; and country-specific desk review findings.

**Please include the following details and participant profiles as part of the recording:**

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organization
- Number of months/years working in this position

*For example: 'This is a key informant interview in the Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'.*

### A. National CHW programmes and cadres

1. What is your role in CHW programmes in this country?
2. Are the following key CHWs, (*name cadre(s)*) identified for (name the country), correct? (*Provide agreed study CHW definition, if required*)
  - a. If not, which cadres should be omitted or added? (For those added, probe for their roles in Q3 below)
3. Which of these CHW cadres or programmes are you most involved with or knowledgeable about and would be comfortable discussing today?
4. Could you please describe the key roles and responsibilities of these cadres with respect to the provision of maternal, newborn, reproductive, and child health services?
  - a. How would you describe the effectiveness of these CHWs currently in fulfilling their RMNCAH roles and responsibilities?

Probe for:

- i. any other roles and responsibilities these RMNCAH CHWs might have: immunization/ polio, nutrition &/ECD, disease surveillance, WASH and/or disaster response, etc.
- ii. to determine if RMNCAH roles and responsibilities are spread across a number of cadres and how these cadres are coordinated.

- b. What factors facilitate and what factors constrain their effectiveness in fulfilling their RMNCAH roles and responsibilities?

Probe for:

- i. What facilitating factors should be retained
- ii. Factors related to the individual CHW, the community and the health systems
- iii. Any gender related constraints to CHW effectiveness
- iv. Any other equity related constraints such as caste
- v. Any constraints related to competences and availability of supervisors
- vi. Recommendations to overcome these constraints.

Thoughts on how the RMNCAH roles and responsibilities of these CHWs might change in the next 10 years.

During our desk review we identified the following key findings related to health system support (explain/provide definition) for these CHW cadres. Do you agree with these?

Discuss any country specific issues identified through the desk review related to:

- i. Selection, education & certification
- ii. Management and supervision, including remuneration, contracting and career ladders
- iii. Integration with health system and communities, including target pop size, data collection and use, community engagement, and availability of supplies
- iv. Gender
- v. Leadership and Governance

Probe for key strengths and weaknesses of the system support for these CHWs when discussing these findings.

5. What system support improvements do you think are needed to optimise the roles and responsibilities of these CHWs to better serve maternal and newborn health?
  - a. How would you prioritise these?

6. What system support improvements do you think are needed to optimize the roles and responsibilities of these CHWs to better serve maternal and newborn health?

Provide a summary and discuss key information gaps identified through the desk review (see country snapshot summaries)

7. Is there a database/HR information system in place and maintained for CHWs in (name the country)?

Probe for:

- i. for which cadre are data collected
- ii. the type of information collected (e.g. name, sex, age, location, cadre, training, funding source)
- iii. how the information is used
- iv. ownership and maintenance of database

8. Could you recommend any sources of information to address these information gaps?

## B. Policy environment for CHW programmes

1. From the list of policy documents that we have, are there any other key policies or strategic frameworks that guide CHW programmes in (name the country)?
2. How well do the policies support the implementation of programmes related to these CHWs and the achievement of results? What are the policy gaps? Probe for any challenges to effectively translate policies into results.

3. Are there any plans to strengthen or reform programmes related to these CHWs in (name the country)? (Please describe)

Probe for:

- i. changing roles in RMNCAH
- ii. changing roles in primary health care
- iii. competing roles with non-communicable diseases
- iv. improved information systems
- v. changing nature of demographics/community structures that is likely to influence any changes in the CHW roles and responsibilities (i.e. due to patterns of regional or national migration/outmigration, security concerns, labour market demands etc.)

4. Are there any plans to strengthen or reform primary health care services in (name the country)? (Please describe). Draw on any country specific information from desk review findings.

Probe for:

- i. the impact of reforms on the roles and responsibilities of these CHWs
- ii. any ongoing or planned reforms related to Astana or Universal Health Coverage

5. What policy improvements are needed to optimize the roles and responsibilities of these CHWs to:
  - a. provide RMNACH services
  - b. respond to Post Astana or PHC reforms?
  - c. How would you prioritise these?

6. In your opinion, what do you think are the key challenges to strengthening or reforming programmes related to these CHW in (name the country)?

Probe for the following:

- i. systems support issues
- ii. unclear roles and responsibilities
- iii. lack of policies
- iv. governance and leadership
- v. financing/resources
- vi. technical capacity
- vii. Lack of coordination

## C. Gender

1. What role does gender play in the design and implementation of programmes related to these CHW in (name the country)? (Contextualise the probes based on desk review findings)
  - i. Female and male CHW roles in the provision of services and take up of services by communities

- ii. CHW selection criteria for different CHW roles- RMNCAH, immunization/polio, nutrition, &/or ECD 0-3, other disease surveillance, WASH and disaster response
  - iii. Community acceptability
  - iv. Effectiveness of CHWs in carrying out their roles and responsibilities
  - v. Access to training
  - vi. Discrepancies between prescribed coverage area/target population and what happens in practice due to HR/CHW shortages
  - vii. Work environment and safety
  - viii. Remuneration
  - ix. Senior/leadership roles
  - x. Career progression opportunities/criteria and constraints
  - xi. Overcoming potentially prohibitive cultural norms
  - xii. How other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs
2. Of the gender issues related to these CHWs that you have identified, how are these being addressed?

Probe for policies and specific system support

#### D. Financing and resource mobilization

1. How are programmes related to these CHWs currently financed and/or resourced?

Probe for information on the following funding streams and proportion of funding from each:

- i. Government financing
- ii. Donor projects/programmes (off budget)
- iii. Direct budget support from donors
- iv. Community resources
- v. Support from NGO and private not-for profit organizations
- vi. Support from private-for-profit organizations

Request any documentation to support responses

2. Are there any changes planned to financing strategies for programmes related to these CHWs and/or to improve system support?

Probe for the following:

- i. increased domestic or external funding;
- ii. private sector support/involvement
- iii. new mechanisms for health financing (user fees, health insurance,...),

Probe for availability of financing for CHW system support including:

- i. drugs and medical supplies,
- ii. remuneration
- iii. job aids
- iv. transport and logistics support

- v. IT equipment for data collection
- vi. supervision and mentoring
- vii. refresher training

#### E. Private Sector Contribution to CHWs

1. What is the private sector's contribution to the production, use and management of these CHWs in this country?

Probe for:

- i. Participation of contribution of not-for-profit and for-profit private sector organizations
- ii. participation of private training institutions in training these CHWs
- iii. participation of health professional societies in training these CHWs

2. How could the contribution from the private sector be enhanced?

##### **Additional information:**

- Which key stakeholders would you recommend we meet while we are in the country?
- Are there any key documents that we should review for this study?

##### **Closure**

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

## Annex 2 Key informant interview guide on GENDER for national level stakeholders

**Potential informants:** Informants with a special knowledge/work area of gender and CHWs – including UNICEF CO gender focal person, any gender focal persons with different ministries involved with CHWs, gender focal persons from development partners, representatives from NGOs working on gender and health.

### Introduction

- Introduce yourself. Explain that the purpose of the interview is to collect the views and perspectives of stakeholders on gender issues in policies and programmes related to CHWs.
- Ensure participant has a copy of the information sheet. Obtain informed consent.
- Ensure key aspects from the information sheet are well-understood, primarily: (1) that the discussion will last a maximum of 45- 60 minutes; (2) that the content of the interview will remain confidential; (3) that the participant's name will not be used when reporting the findings; (4) that quotations will be anonymised; and (5) a voice recorder will be used, only to ensure that all the information from the interview is captured, and only if they agree to being recorded.

### Materials

KII guide, KII log, notepad, pens, voice recorders, batteries, information sheet, consent form, note on country-specific gender issues identified from desk review; front cover and weblink for WHO CHW Guideline, WHO/UNICEF Operational Framework, and Astana Declaration

**Please include the following details and participant profiles as part of the recording:**

- Country of data collection
- Date of interview
- Post title of the participant
- Employer of the interviewee
- Sex
- Department/Unit/Organization
- Number of months/years working in this position

*For example: 'This is an key informant interview in Maldives, it's the second of October 2019, the interview is with the Director of the Sexual and Reproductive Health Division, of the Ministry of Health'*

1. Please describe briefly your current position and your work, current and previous, related to gender and CHWs.

2. In your experience, in this country (name the country), how do you think gender impacts on the work of the CHW cadres we have identified in this country (name the cadres or provide list of the cadres we are referring to)?

Probe for:

- I. Gender issues faced by these CHWs
  - i. at family/household level
  - ii. in the community
  - iii. within the health system
- II. Challenges faced by these CHWs in their work due to these issues

3. You spoke about how gender impacts the work of CHWs. How do other dimensions like caste, religion, ethnicity interact with gender in the work of these CHWs?

4. At the policy level how does gender play a role in policies related to these CHWs in this country (name the country)?

Probe for:

- I. Selection of CHWs for training
- II. Division of roles/services between male and female CHWs
- III. Remuneration
- IV. Career progression
- V. Work environment and safety
- VI. any focus in CHW/PHC policy on gender issues related to other genders (apart from male/female, eg. transgender) and any suggestions on how these can be included

5. At the programme level how does gender play a role in in the design and implementation of programmes related to these CHW cadres in this country (name the country)?

Probe for:

- I. Female and male CHW roles in the provision of RMNCHAH services by the health system and take up of services by communities
- II. CHW selection criteria
- III. Access to training
- IV. Work environment and safety
- V. Mobility
- VI. Remuneration
- VII. Senior/leadership/supervisory roles
- VIII. Career progression
- IX. Overcoming potentially prohibitive cultural norms

6. Have any specific policy measures been put in place to ensure that policies and programmes related to these CHWs are gender responsive/address issues related to gender?

If necessary, explain that gender responsiveness involves considering gender norms, roles and inequalities, and measures to actively address them.

Refer back to issues raised as part of previous questions. Probe for answers from Q2 i, ii, iii, and Q3 if any solutions were given).

Probe for:

- I. What are the key successes of these measures in addressing gender concerns in the CHW policies/programmes?
- II. What are the key challenges of these measures in addressing gender concerns in the CHW policies/programmes?
- III. Can you cite any specific examples of CHW programmes in the country where policies or programmes have been/have made efforts to be gender transformative?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

7. If programmes related to these CHW in this country (name the country) were to be made truly gender transformative, what would you suggest should happen to achieve this?

If there are any issues identified in the desk review around gender for this specific country, refer to these and ask if anything has been done to address them.

Probe for:

- I. Anticipated barriers, challenges and suggested solutions in implementing these suggestions
- II. Equal pay
- III. Equal access to training
- IV. Equal access to promotion opportunities
- V. Overcoming cultural norms/barriers

8. With regards to community health and/or PHC reforms being planned in this country (name the country), what are the measures being put in place to make programmes related to these CHWs responsive to gender concerns?

- I. What would be your suggestions to make them more gender responsive?
- II. Anticipated barriers, challenges and suggested solutions in implementing these suggestions

**Additional information:**

- Which key gender informed stakeholders would you recommend we meet while we are in the country (name the country)?
- Are there any key gender related documents that we should review for this study?

**Closure**

- Ask if the participant would like to add further comments
- Bring the meeting to a close by summarising the main points
- Thank the participant for his/her time and active participation

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## Annex 4: Ethics Approval letter

Margaret Caffrey  
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 Liverpool  
 L3 5QA



Friday, 30 August 2019

Dear Ms Caffrey,

**Re. Research Protocol (19-037) *Evaluation of South Asia's current Community Health Workers policies and system supports, and their readiness for Community Health Workers' expanding roles and responsibilities within Post-Astana national health care strengthening Plans***

Thank you for your letter providing the necessary in-country approvals for this project. I can confirm that the protocol now has formal ethical approval from the LSTM Research Ethics Committee.

The approval is for a fixed period of three years and will therefore expire on 30<sup>th</sup> August 2022. The Committee may suspend or withdraw ethical approval at any time if appropriate.

Approval is conditional upon:

- Continued adherence to all in-country ethical requirements.
- Notification of all amendments to the protocol for approval before implementation.
- Notification of when the project actually starts.
- Provision of an annual update to the Committee.  
 Failure to do so could result in suspension of the study without further notice.
- Reporting of new information relevant to patient safety to the Committee
- Provision of Data Monitoring Committee reports (if applicable) to the Committee

Failure to comply with these requirements is a breach of the LSTM Research Code of Conduct and will result in withdrawal of approval and may lead to disciplinary action. The Committee would also like to receive copies of the final report once the study is completed. Please quote your Ethics Reference number with all correspondence.

Yours sincerely

**Dr Jamie Rylance**  
 Co Chair  
 LSTM Research Ethics Committee

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RECTEM010 v1.0  
 Release date: 14/07/2017 Issued by: RGEO





# Country Report for Bhutan

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UNICEF Regional Office  
for South Asia (ROSA)