



Policy brief for Bhutan

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

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Acronyms

BHUs	Basic Health Units
DHO	District health office
DHMT	District Health Management Team
GNH	Gross National Happiness
GYT	Gewog Yargay Gewog Tshogde
HAs	Health Assistants
MOH	Ministry of Health
NCD	Non-communicable diseases
NCDD	Non-Communicable Diseases Division
ORCs	Outreach Clinics
PHC	Primary Health Care
RGOB	Royal Government of Bhutan
RMNCAH	Reproductive maternal, newborn, child and adolescent health
SOW	Scope of work
SDGs	Sustainable Development Goals
VHW	Village Health Worker



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Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) towards achieving Universal Health Coverage and the health-related Sustainable Development Goals (SDGs). It reiterated the urgent need to build sustainable PHC systems that are people-centred, responsive to community needs, holistic in scope, and able to engender socio-cultural changes among communities and providers to promote and preserve good health and well-being.

Community Health Workers (CHW) are the backbone of Primary Health Care systems. Evidence highlights the effectiveness of CHWs in delivering a range of preventive, promotive and curative services related to reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and neglected tropical diseases. However, CHW programmes often face several challenges including lack of clarity in roles, inadequate pre and in-service training, lack of clear career pathways, poor supervision mechanisms, and poor linkages with both the health system and communities.

We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.

Astana Declaration 2018

South Asia has a rich history of vibrant CHW programmes and CHWs in the region continue to play a substantive role in Primary Health Care and act as bridges between the community and the health system. Simultaneously, countries in the region are witnessing demographic and epidemiologic transitions with increasingly ageing and urbanized populations and a rising burden of non-communicable diseases.

In such a scenario, 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.

CHWs are health workers based in communities (i.e. conducting outreach beyond PHC 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.
World Health Organization

- Formative evaluation in seven countries – Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka
- Objectives
 - To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
 - to determine the key policy adjustments and interventions needed to address any gaps
 - To assess the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans
- Desk review and key informant interviews at the national level in seven countries
- Analysis frameworks
 - WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
 - WHO health systems building blocks
 - Operational framework for Primary health Care by WHO and UNICEF
 - WHO gender responsiveness assessment scale

This policy brief (technical brief?) presents the key findings from a formative evaluation of CHW programmes in the South Asia region conducted by the Centre for Maternal and Newborn Health, Liverpool School of Tropical Medicine, with support from UNICEF Regional office for South Asia. It details the policy and system support available for diverse cadres of CHWs in the region and measures to optimize the contribution of CHWs to PHC. It also highlights the reforms needed in CHW programmes and will be useful to inform the design of a set of feasibility and prioritization criteria that will support countries to develop an action plan aimed at optimizing the contribution of CHWs to Reproductive maternal, newborn, child and adolescent health (RMNCAH) and to the strengthening of PHC. This brief is intended for policy makers at national and sub-national level in the South Asian region.

Bhutan - 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. Most of the population lives in rural settings and the remote and difficult terrain makes health service delivery difficult.

Bhutan achieved Millennium Development Goals (MDG) 4 and 5. There is a high coverage in Reproductive, Maternal, Newborn and Child Health (RMCH) services which has translated into a drastic reduction of maternal and child morbidities with concomitant reduction in mortality due to preventable causes. 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.

However, a few challenges remain. Bhutan currently strives to address the triple burden of disease. Malnutrition remains a major public health issue and reducing neonatal mortality is one of the key challenges. 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. Mental health issues are on the increase.

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. Shortages of human resources, especially





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doctors, and specialists is the major challenge faced by the Ministry of Health.

Community Health Worker programme in Bhutan

There is only one CHW cadre in Bhutan, called the Village Health Worker (VHW). 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 in the country. 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 mobilise the community for health promotion (particularly in reproductive, maternal and child health) and improving sanitation.

A profile of the VHW is presented below.

	VHW
Total number (2018)	1,150
Gender	Both men and women, but majority (77%) men
Sector located in	Completely in the public sector
Place of location	Community
Population covered	Approximately 20-30 households per VHW
Payment structure	Voluntary, no payment or incentives except for some allowances

As there is no VHW or any other CHW cadre in urban areas, urban populations are under-served in relation to PHC in Bhutan.

Health policy and system support for Community Health Worker programme

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. Bhutan's 2008 Constitution mandates universal access to health as part of the government's commitment to GNH. The country's PHC approach and impact on public health are widely recognised and the first national GNH surveys found a close link between citizen happiness and the health domain.

Build a healthy and happy nation through a dynamic professional health system, and to make health available, accessible, acceptable, and of sufficient quality.

2011 National Health Policy

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.

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. The health system in Bhutan emphasizes the importance of community health to ensure quality health services with equity to the public. All the health programs are expected to support the VHW.

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. A VHW Program Officer, based in Thimphu in the Non-Communicable Diseases Division (NCDD) of the Ministry of Health (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 and 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. The district health office (DHO) 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 labour for public projects. There are various groups and committees at the district and community levels for health promotion and disease prevention.

BHUs provide services at PHC level including basic medical care, maternal and child care services, and prevention interventions, and conduct the ORCs for more remote communities. Although the VHWs are not paid government employees, they are a valuable resource to support health system activities at the PHC level.

However, challenges related to the VHW programme were identified.

- Lack of guidance on VHW and MoH engagement:** There is a lack of detailed guiding policy documents that direct the VHWs and clearly outline their engagement within the MOH more broadly. The Village Health Worker Program: Policy and Strategic Plan developed for the period 2013 to 2018 has not been revised or updated.
- Lack of prioritization for the VHW programme:** Over the years the VHW program has not been prioritized. 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.
- Dissonance between policy and local implementation:** The lack of leadership and support may be linked to the decentralisation of decision-making authority. While there are guiding principles for the management of the VHW program developed at the central level, the application of these principles and standards is at the discretion of the local government. Centrally formulated policies may be difficult to enforce and may cause problems at the local level.

Roles and responsibilities of Community Health Workers

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

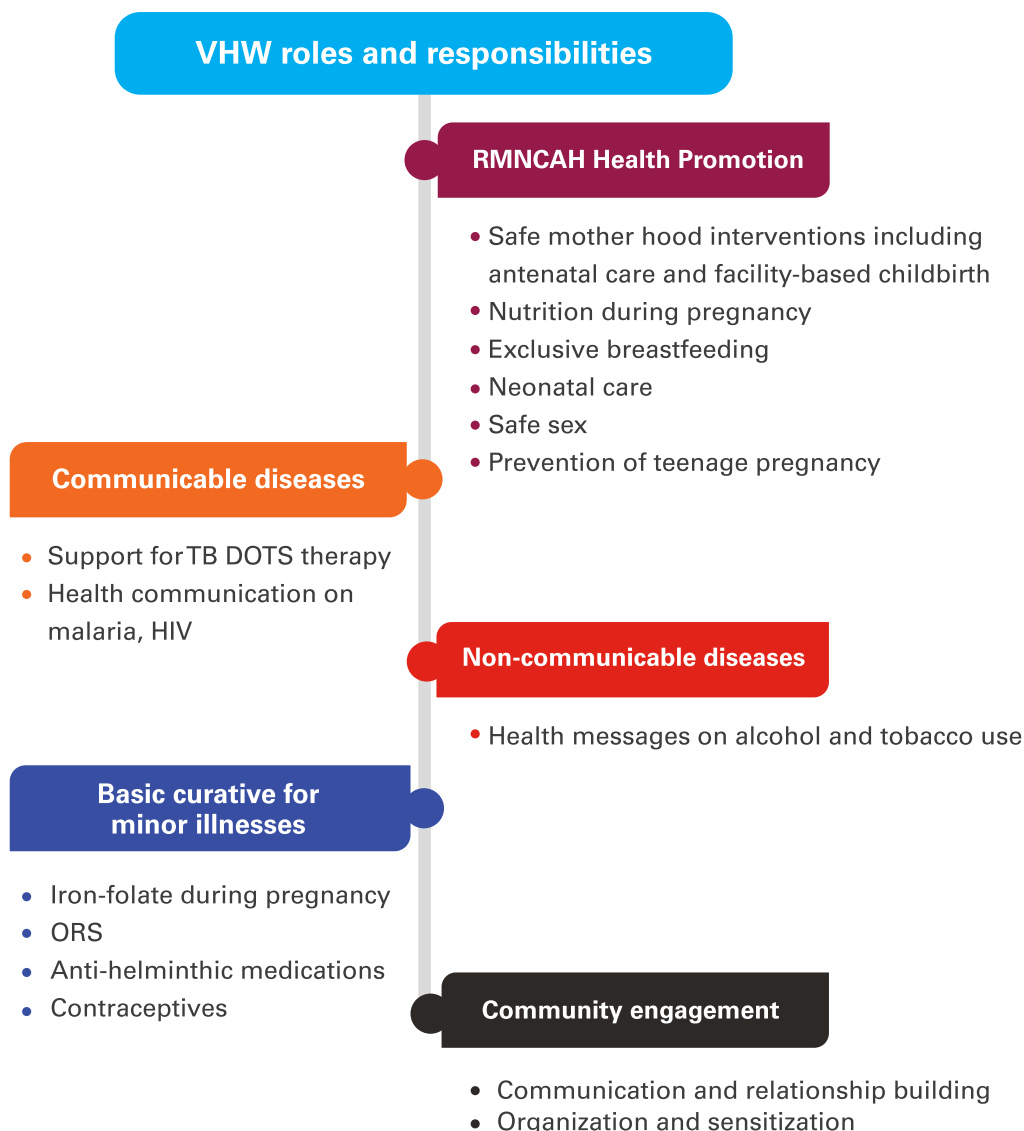
Strategic Plan. A similar set of VHW roles and responsibilities, as well as a Code of Conduct are set out in a bulleted list in the revised 2015 MOH Handbook for Village Health Workers. Figure 1 depicts the different roles and responsibilities of VHWs.

VHWs are estimated to work around 40–50 hours per month, though this may be less in smaller communities. However, 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.

VHW roles and responsibilities

Function as an effective catalyst for health promotion and disease prevention in the communities, and not just as a mere advocate of health information.
2015 MoH handbook for VHWs

Figure 1: Village Health Worker roles and responsibilities



Selection, education and certification

Figure 2: Selection and training pathway of Village Health Workers



Several challenges were identified in the VHW selection and training.

- **Illiteracy:** While being literate is a selection criterion, in reality, many of the more senior VHWs are illiterate. 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.
- **Lack of training material in local language:** 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, contributing to ineffective retention and application of learning.
- **High turnover and attrition of VHWs:** This has been related to the lack of recognition and inadequate remuneration and compensation for VHWs. This 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 not always being strictly adhered to at the community level.
- **Gender imbalance:** In 2018, only 23% of VHWs were female. Various reasons have been cited for this gender imbalance such as lack of mobility for women, the need to navigate difficult terrain, lower female literacy rates, gender norms that perceive

women's primary role as domestic work, community leadership positions being held predominantly by men, thus preferentially treating and trusting other men, and unpaid nature of the work. 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.

The central level should focus on the commitment and residential criteria, leaving the rest to the community to ponder.

Review of the VHW programme 2012

Management and Supervision

Remuneration Career progression

VHWs are a non-salaried and voluntary cadre. They receive a few allowances for attending training and for immunization campaigns, but do not receive any other monetary incentives. The high attrition of VHWs, which has been an ongoing challenge, has been attributed to the lack of remuneration and fair compensation for travel and participation in training. However, the community recognizes the importance of the VHW services and households reportedly take turns to take on the VHW

role. The lack of remuneration was also seen as a cause for the poor accountability of VHWs.

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. The spiritual influences of Buddhist tradition, such as the belief that voluntary community work will improve their karma for the next life, were also contributors to the voluntarism of VHWs. However, these beliefs and norms are changing nowadays.

Career advancement

Although the 2013-2018 VHW Program Policy and Strategic Plan provides for extra weightage to experienced VHWs with the requisite qualification for selection in health science courses, in practice, most VHWs lack the minimum educational qualifications required to take up or be considered for such courses. Career progression is therefore limited.

Supervision

Health Assistants (HAs) based in the health facility are the VHWs first point of contact with the formal health system. They 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 *chivog tshogpa*, once every year or more frequently if required. Members of the *Gewog Yargay Gewog Tshogde (GYT)* or Block Development Committee also monitor the VHWs' activities in their catchment area. 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 Village Health Workers 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, facilities training, and provides them with supplies and kits. In turn the VHW supports facility-based staff with outreach clinics in the community, provides up to date health information on community members, and refers and mobilises clients to take up facility-based services.

VHWs live within the community they provide services for. The community is expected to play an active role in providing feedback, solving problems, and helping to establish VHW as leaders in the community. Further, the community can monitor the activities of the VHWs through the *chewog tshogpa* (village health committee). 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.

Data collection and use

VHWs receive training on how to collect data and how to keep information private and confidential. They keep simple records of their activities and submit specific information through monthly reports to the HA who oversees their work. VHWs also contribute to quarterly reporting of births and deaths in their community.

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. They also receive a mobile phone. However, in recent years, these may not be consistently available.



Fulfilment of World Health Organisation recommendations by the Community Health Worker programmes

The following table lists the recommendations by WHO on the policy areas around CHW

programmes and depicts the fulfilments of these recommendations by the CHW programme in Bhutan using a colour code. (Green – complete fulfilment of all dimensions of the recommendation, Yellow – Partial fulfilment of some dimensions, but not others, Red – All or almost all dimensions of the recommendation not fulfilled)

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels	Yellow	Specified, but not always adhered to at local level during selection
	Require community membership and acceptance	Green	
	Consider personal capacities and skills	Green	
	Apply appropriate gender equity to context	Red	Not considered, men preferentially selected over women
Pre-service training duration	Based on scope of work, roles and responsibilities	Yellow	Short duration of training
	Consider competencies required	Green	
	Consider pre-existing knowledge and skills	Green	
	Social economic and geographic circumstances of trainees	Green	
	Institutional capacity to provide training	Green	Provided by HA and DHO at the local facility
	Expected conditions of practice	Green	
Competencies in pre-service training curriculum	Include core competencies domains-preventive & promotive, diagnostic, integration with wider health system, interpersonal skills, social determinants of health, personal safety	Green	
	Include additional competency domains- treatment and care services - if required	Green	
Training Modalities	Balance theory and practice	Yellow	
	Use face-to-face and e-learning	Green	
	Conduct training in or near the community	Green	
	Consider interprofessional training approaches where relevant	Yellow	
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training	Green	
Supportive supervision	Establish appropriate supervisor – CHW ratios	Green	
	Train supervisors	Green	
	Coach and mentor CHWs	Green	
	Use of observation of service delivery, performance data and community feedback	Green	
	Prioritise improving quality of supervision	Red	Not prioritized
Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles	Red	Voluntary cadre, no remuneration or performance-based incentives

Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.	Green	Scope of work provided
Career Ladder	Offer career ladder to practising CHWs	Red	No career pathway
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review	Red	
Target population size	Expected workload	Green	
	Frequency of contacts	Green	
	Local geography	Green	
	Nature and time requirements of the services provided	Green	
Collection and use of data	CHWs document the services they provide	Green	
	CHWs collect, collate and use health data on routine activities	Green	
	Train CHWs and provide feedback on performance based on data	Green	
	Minimize reporting burden, harmonize requirements	Green	
Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams	Green	
	CHWs with more selective/specific tasks to play a complementary role based on population health needs, cultural context and workforce configuration	Yellow	Only one type of CHW
Community Engagement	Involve communities in selecting & monitoring CHWs & in priority setting of CHW activities	Green	
	Support to community-based structures	Green	
	Engage relevant community representatives in decision making, planning, budgeting & problem-solving	Green	
Mobilization of Community Resources	CHWs to identify priority health and social problems and action plans	Green	
	Community needs and develop required responses	Green	
	CHWs mobilise and coordinate local resources	Green	
	CHWs to facilitate community participation and links to health facilities.	Green	
Availability of supplies	Ensure CHWs have adequate and quality-assured commodities and consumables through the integration in overall health supply chain;	Yellow	Frequent stockouts
	Adequate reporting, supervision, management, training, and mHealth to support supply chain functions	Yellow	

Private sector contribution to Community Health Worker programs

There is little private sector involvement in health in Bhutan and there is no private sector involvement or contribution to CHW programs.

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). The total health expenditure as a percentage of GDP has declined over the last few years.

Within the Royal Government of Bhutan (RGOB), financial commitment to the VHW program 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 program.

UNICEF provides some support to implement the VHW program in the form of delivery of specific training and development of training aids.

Prioritized measures to optimize the contribution of Community Health Workers to respond to post-Astana requirements and Primary Health Care strengthening

This section identifies measures that could be prioritized to optimize the contribution of CHWs to Primary Health Care and help the country meet Post Astana requirements. The section is organised into two sub-sections – policy support measures and system support measures.



Policy support measures

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

Funding for the VHW program is mostly opportunistic. 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. A potential funding stream for the VHW program 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.

Advocacy for health as a priority on the district development agenda

Under decentralisation, local governments have greater roles and responsibilities in the prioritisation and allocation of resources to respond to the needs of their districts. 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 program

The VHW program needs to be strengthened as VHWs play a very important role providing doorstep services and reaching households as well as supporting RGOB efforts to achieve UHC. Including the VHW workforce in national and district HR plans and budgets and recognising 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 programs in health promotion activities

Bhutan currently has non-formal education centres and non-formal educators based in every gewog whose role is to improve literacy in the population. Though non-formal educators are not currently involved in health-related activities, they could be potentially trained to provide health messages and mobilise 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.

Strengthening primary health care in urban settings

Increasing urban migration has created challenges to the provision of PHC in urban settings. Establishing a cadre like the VHW for urban health could ensure the provision and effective coverage of services across the whole area.

System support measures

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. 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.

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. Proactively recruiting more women as VHWs would help to improve the uptake and acceptability of services for women and girls.

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. Appropriate job aids and visual educational materials, preferably in local languages should also be made available to all VHWs.

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.

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.

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 RMNCH services, and as agents of change.

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.

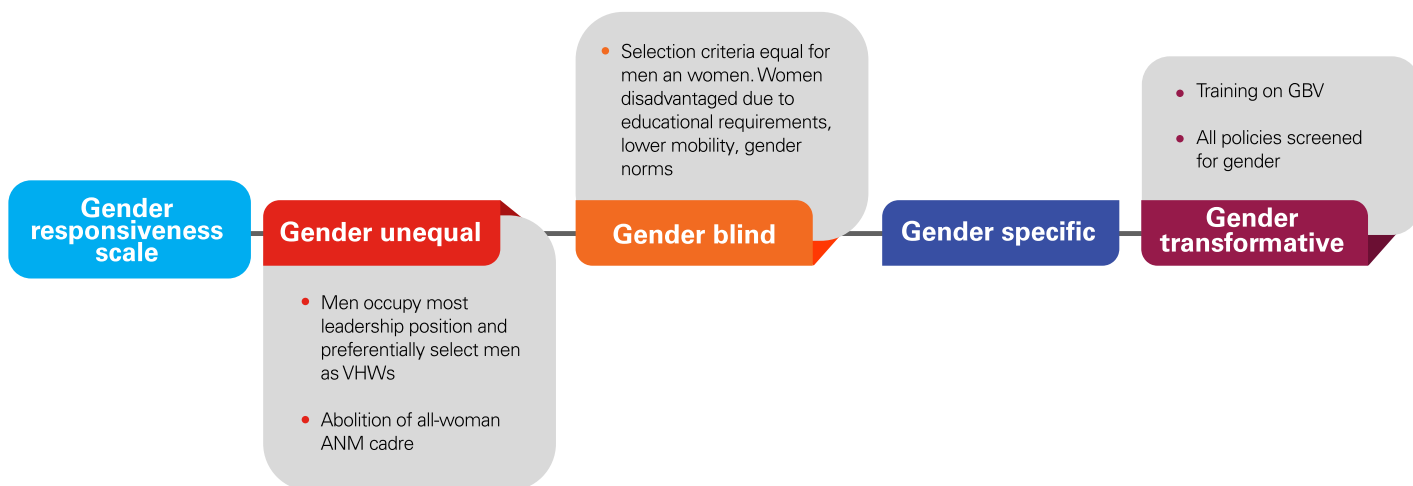
Expanding the role of VHWs

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.

Making the Community Health Worker programme gender transformative

Assessing the VHW program against the WHO's gender responsiveness scale showed that some aspects of the current VHW program were gender unequal, and a few gender blind. The figure below depicts some aspects of the CHW programme in Nepal along the WHO gender responsiveness scale.

Figure 3: Gender assessment of the CHW programme



Mainstreaming and provisioning for gender in policies

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. 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 programs should be also be periodically reviewed with a gender, social inclusion and disability lens.

Address gender imbalances in VHWs and in leadership positions

The gender imbalance in the VHW workforce could potentially impact the utilization and uptake of health services by women and adolescent females. 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. Achieving increased female participation in this role will require addressing cultural, social and gender barriers, as well as improving the conditions of employment. Girls who drop out from school continue to stay in villages and they could be targeted and recruited into VHW roles, if they were provided with basic training and some incentives.

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. 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.

Conclusions

The Kingdom of Bhutan has made tremendous progress in health and wellbeing in recent decades and health and wellbeing are key domains in the country's Gross National Happiness plans. The RGOB is committed to PHC and achieving UHC. The country is going through an epidemiological transition from predominantly communicable diseases to non-communicable diseases.

VHWs provide the link between the formal health system and the communities. These community-based health workers have and continue to play a key role in the provision of community based PHC services in Bhutan. It is time to review their roles and responsibilities in the post-Astana agenda, and provide the required policy and systems support to the program.





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