National Strategy and Action Plan for Improving Community Health Services through Empowered Village Health Workers

2025 - 2030

Royal Government of Bhutan
Ministry of Health

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ACKNOWLEDGEMENT

On behalf of the Ministry of Health, we would like to extent our profound appreciation to all valued stakeholders who made valuable contributions to the successful formulation of the 'National Strategy and Action Plan on Improving Community Health through Empowered Village Health Workers, 2025-2030'. This noteworthy accomplishment is the result of our shared commitment, steadfast dedication, and collaborative efforts. We are deeply grateful to the Dzongkhag and Gewog administrations for their exceptional support and unfaltering commitment to improving community health services at the grassroots level. Special thanks go to village health workers for their active and valuable participation throughout the review phase. We express our deep appreciations go to district public health officers and PHC health workers, whose diligent efforts, insights and smooth facilitation of field work profoundly shaped this strategy document.

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Health Promotion and Risk Communication Division
Department of Public Health, Ministry of Health

FOREWORD

Prioritizing the health and well-being of our communities, especially those who are living in far-flung Gewogs, is fundamental to our nation's development. Formulated through a rigorous consultative process involving community themselves and all relevant stakeholders, the National Strategy and Action Plan for Improving Community Health Services through Empowered Village Health Workers, 2025-2030 frames a clear vision and provides the strategic pathway for strengthening community health systems and primary health care approach. It aims to unite all stakeholders to empower community leaders, Village Health Workers (VHWs) and community-based institutions and groups to work towards improving community health outcomes.

This Strategy reflects our shared commitment to providing universal access to basic health services for all, especially the ones who need the most. VHWs play a vital role in providing community health services, promoting healthy practices, and linking communities to the wider health system.

By enhancing the capacity, recognition, and support for VHWs, we intent to build informed, healthier and resilient communities. This plan emphasizes community ownership, inter-sectoral collaboration, and the integration of health promotion and disease prevention into daily life in communities. It aligns with Bhutan's national health priorities and our broader commitments to Universal Health Coverage.

The successful implementation of this strategy will hinge on the sustained and coordinated efforts of all stakeholders, including local governments, sectors beyond health, and communities themselves. With collective commitment and collaboration, I am confident that our empowered Village Health Workers supported by the local governments and communities, will play a transformative role in advancing community health and well-being across Bhutan in the years ahead.

(Pemba Wangchuk)
Secretary
Ministry of Health

ABBREVIATIONS

ASHA	Accredited Social Health Activists
CBSS	Community-based Support System
CEP	Community Engagement Platform
CH	Community Health
CHU	Community Health Unit
CHWs	Community Health Workers
CMO	Chief Medical Officer
CSOs	Civil Society Organizations
DPHO	District Public Health Officer
FGD	Focus Group Discussion
FYP	Five Year Plan
HiAP	Health in All Policies
KII	Key Informant Interview
LGs	Local Governments
MoH	Ministry of Health
MSTF	Multisectoral Task Force
NCDs	Noncommunicable diseases
ORCs	Outreach Clinics
PHC	Primary Health Care
PHCs	Primary Health Centres
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VHWs	Village Health Workers
WHO	World Health Organization
WoC	Whole of Community approach

CONTENTS

EXECUTIVE SUMMARY

1. Introduction

Primary Health Care (PHC), a comprehensive, society-wide approach reaffirmed by the 2018 Astana Declaration, is capable of delivering 90 percent of essential Universal Health Coverage (UHC) interventions and 75 percent of health-related Sustainable Development Goals. Accelerating this PHC model requires urgent investment in the recruitment, training, and retention of a dedicated workforce, especially for remote and rural communities. One key strategy identified to accelerate PHC is by investing in community health workers (CHWs). The WHO defines CHWs as community-based health providers who deliver essential health services beyond healthcare facilities, particularly to underserved populations, and serve as a crucial bridge between healthcare system and communities. Despite limited formal education, CHWs deliver vital preventive, promotive, and curative services, including maternal care, disease management, and psychosocial support. Their close presence within communities ensures accessible, cost-effective care, and fosters local trust. However, CHWs frequently face social undervaluation, poor systemic integration, and a lack of resources, leading to low motivation and high attrition. To unlock their full potential and improve community health outcomes, health systems must provide fair compensation, structured training, and supportive supervision.

Bhutan's healthcare system is built around the PHC model that emphasizes accessible, equitable and preventive health services for all. Following the Alma Ata Declaration in 1978, the Ministry of Health expanded PHC services, and introduced Village Health Workers (VHWs) to deliver essential health services to geographically scattered population, ensuring that even remote communities had access to essential health services. The VHW program achieved remarkable success throughout the 1990s and 2000s, playing a vital role in strengthening PHC. However, in recent years, the VHW workforce has declined sharply due to growing challenges in sustaining motivation and retention of VHWs. In response, the MoH is revamping the program to ensure the long-term sustainability of VHW services.

2. Situation Analysis

The review was undertaken to generate evidence for revitalizing the VHW program, focussing primarily on barriers and enablers influencing VHW motivation as well as the key drivers of performance and retention. The review findings showed that VHWs were largely self-motivated, driven by compassion, camaraderie, and even religious beliefs, with senior VHWs continuing to serve actively despite age. Others

remained committed because they were self-aware of the benefits their work brought, such as better health outcomes, reinforced by regular health trainings that deepened their understanding and pride in their role. Equally important was the acknowledgment of contributions by community leaders and members, which fostered trust, credibility, and morale, often proving more motivating than financial rewards. Together, these drivers, including personal conviction, awareness of impact, and community recognition, strengthened VHWs' enthusiasm and resilience in delivering essential health services. However, the review results revealed that VHWs faced significant challenges that undermined their motivation to serve. A major concern was the lack of social recognition that left many feeling undervalued despite their vital contributions. The absence of structured support mechanisms at local government levels compromised their efficiency, rendering recruitment and oversight inconsistent and unregulated. They often have to navigate long travel distances, competing household demands, poor basic amenities and inadequate incentives. Furthermore, at the national level, the VHW program was hindered by an unclear strategic approach, insufficient funding, weak communication, fragmented coordination, and disrupted capacity-building, especially during the COVID-19 pandemic. While Gewog administrations are mandated to promote and protect public health within their communities, they lacked a formalized governance to link with VHWs. This disconnect constrained collaboration with LG leaders such as Gups and Tshogpas. Other barriers included a lack of structured reporting mechanism that obscured contributions of VHWs, regulatory ambiguity over whether health or local authorities oversee them, and limited understanding among officials of how grassroots health initiatives drive universal health coverage. Addressing these challenges requires a deliberate, multisectoral approach that combines enhanced social recognition, structured local support, targeted incentives, clear guidelines, and improved coordination. Implementation of these measures is expected to restore the motivation of VHWs, and ensure the effective delivery of community health services.

3. Community-centric VHW Strategy and Action Plan (VHW SAP)

Vision: Empowered and thriving communities that contribute to the Ministry of Health's aspiration of achieving the nation with the best health.

Mission: Strengthening the Primary Health Care system in Gewogs to ensure equitable access to responsive and inclusive community health services, thereby supporting the attainment of Universal Health Coverage.

Goal: By 2030, every Gewog will have improved access to quality community health services, effectively supported by empowered

village health workers, resilient community health systems and strong local governance structures.

Purpose: The community-centric VHW SAP aims to improve access to community health services by strengthening community leadership, empowering communities, including VHWs, and promoting collaborative efforts to build resilient, inclusive and sustainable community health systems rooted in community participation and ownership.

Approach: The implementation of the strategy will be guided by the Whole-of-Community (WoC) approach, which is a collaborative framework where every individual, institution, and government entity works together to solve common local challenges. This approach will foster the development of resilient community health systems built on collaboration, inclusivity and a shared vision.

4. Strategic Action Areas and Objectives

Strategic Action Area 1: Community leadership and local governance for advancing community health services

- Strategic Objective 1.1: Strengthening community leadership and local governance to support and advance community health services.
- Strategic Objective 1.2: Fostering solidarity among community players for community health.
- Strategic Objective 1.3: Driving community engagement for better community health governance.
- Strategic Objective 1.4: Applying social determinants of health (SDH) to address community health issues.

Strategic Action Area 2: Redefining the roles of Village Health Workers (VHWs)

- Strategic Objective 2.1: VHWs as catalysts for advancing self-care and promoting community health and well-being.
- Strategic Objective 2.2: VHWs as focal points for multistakeholder collaboration in health.
- Strategic Objective 2.3: VHWs as champions in improving healthcare access among the vulnerable population.
- Strategic Objective 2.4: VHWs as team members in capacity building and peer-to-peer learning.

Strategic Action Area 3: Sustaining motivation and retention of Village Health Workers

- Strategic Objective 3.1: Elevating the social recognition and status of village health workers.
- Strategic Objective 3.2: Empowering VHWs to engage in local governance.
- Strategic Objective 3.3: Strengthening motivation of VHWs through logistical support.

Strategic Action Area 4: Systems support for VHWs and Community Health Services

- Strategic Objective 4.1: Fostering community embeddedness in the management of VHWs.
- Strategic Objective 4.2: Enhancing training and continuous skill development for VHWs.
- Strategic Objective 4.3: Providing supportive supervision and structured mentoring.
- Strategic Objective 4.4: Creating an enabling environment for effective service delivery.

Strategic Action Area 5: Partnership for community health at national and sub-national levels

- Strategic Objective 5.1: Fostering stakeholder collaboration at the national level.
- Strategic Objective 5.2: Reinforcing local partnerships to drive community health actions.

5. Implementation Framework

The VHW Strategy and Action Plan (VHW SAP 2025–2030) closely aligns with the Royal Government of Bhutan's 13th Five Year Plan, which prioritizes sustainability, equitable health and education, social security, and trusted governance ecosystem. The strategy directly contributes to the Ministry of Health's Healthy Drukyul Program, which targets healthy lifestyles, disease control, quality services, workforce competency, innovative financing, strong regulation, and technology-driven efficiency. By building on these foundations, the VHW SAP envisions empowered communities and VHWs through the effective implementation of the

strategic action areas and strategic objectives. Progress towards strategy's goals will be tracked and monitored through defined output and outcome indicators. Implementation of the VHW SAP will be operationalized through a detailed matrix comprising time-bound activities with designated collaborating partners.

6. Budget Outlay

The VHW SAP (2025–2030) earmarks Nu. 34.60 million to revitalize the VHW program, and address its long-standing underfunding. This costed plan aims to integrate VHWs into the broader PHC system through targeted interventions. Notably, the strategic action area 3 received the largest funding share, reflecting the importance of VHW motivation and retention. Moving away from fragmented and ad-hoc support, this financial framework provides a sustainable foundation for institutionalized community health services, directly contributing to the Ministry of Health's 13th Five-Year Plan goals.

1. INTRODUCTION

1.1 Significance of Primary Health Care

Primary Health Care (PHC) is a comprehensive, society-wide approach that ensures everyone's right to the highest level of health through integrated and multisectoral actions addressing social determinants of health, and empowering individuals and communities.[1] About 90% of the essential interventions[i] needed for Universal Health Coverage (UHC)[ii] can be delivered through PHC, and 75% of the health improvements targeted by the Sustainable Development Goals (SDGs) can be achieved through PHC.[2, 3]

The Astana Declaration (2018) reinforced the importance of Primary Health Care in achieving UHC and the Sustainable Development Goals (SDGs). Building on the 1978 Alma-Ata Declaration, it advocates for accessible, affordable, and high-quality healthcare, emphasizing prevention and people-centered[iii] care. The declaration called for greater investment, stronger health systems, and multi-sectoral collaboration to ensure equitable healthcare for all, highlighting the responsibility of governments, civil society organizations and stakeholders in advancing global health.[4]

The Astana Declaration[iv] emphasized the urgent need to invest in human resources for Primary Health Care through education, training, recruitment, development, motivation, and retention of health professionals and community health workers (CHWs). It stressed the importance of ensuring the availability of the PHC workforce in rural, remote, and less developed areas.[5]

1.2 The Role and Relevance of Community Health Workers

WHO defines CHWs as '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 of training but at least some training, if only for a few hours.' CHWs are with less formal education and training compared to professional healthcare workers like nurses and doctors. They have

i Interventions related to prevention, promotion, treatment, rehabilitation and palliative care.

ii According to WHO, UHC means all individuals and communities have access to quality health services they need without suffering financial hardship. It encompasses three key dimensions: population coverage, service coverage and financial protection.

iii Astana Declaration is a global commitment adopted at the Global Conference on Primary Health Care in Astana, Kazakhstan (2018) to strengthen PHC.

iv All individuals having equal access to health services regardless of their place of dwelling, income, race, gender, socioeconomic status, etc.

significant potential to expand healthcare services to vulnerable populations, particularly in remote and marginalized communities.[6]

Community Health Workers (CHWs) are crucial to primary health care systems, enhancing healthcare access, health promotion, and disease prevention, particularly in underserved areas. They offer a range of preventive, promotive, and curative services, support maternal and child health, manage diseases, build community trust, and aid in emergency responses. The efforts of CHWs have the potential to improve healthcare access, address unmet health needs, reduce healthcare costs, promote health equity[v] , and strengthen universal health coverage.[7, 8]

The systematic review by WHO found out that CHWs performed a variety of tasks, with six overlapping roles: (i) delivering diagnostic, treatment or clinical care; (ii) encouraging uptake of health services; (iii) providing health education and behaviour change motivation; (iv) data collection and record-keeping; (v) improving relationships between health system functionaries and community members; and (vi) providing psychosocial support.[9] In addition, CHWs also provided HIV counselling, delivered injectable contraceptives, and conducted rapid malaria diagnosis tests in some countries.[10]

Community Health Workers (CHWs) are key to improving health systems in resource-limited settings. CHWs reside within the communities they serve, unlike other healthcare professionals. Their close presence makes them readily available, easily trainable, and a cost-effective resource compared to higher-level staff.[11] Transforming community health systems entails the participation of all stakeholders to share the responsibility of empowering CHWs. Entire communities benefit from well-implemented, large-scale CHW programs, which are essentially crucial in resolving local health challenges. At the same time, policy level advocacy alongside implementation and monitoring at the local government level are imperative for establishing supportive regulations, securing sustainable funding, and ensuring comprehensive training, supervision, and logistical resources. Hence, health systems should prioritize cost-effective solutions like CHW programs to accelerate progress toward UHC and health-related Sustainable Development Goals (SDGs).[12, 13, 14, 15]

v All individuals having equal access to health services regardless of their place of dwelling, income, race, gender, socioeconomic status, etc.

1.3 The Challenges faced by CHWs globally

CHWs are often undervalued by both communities and healthcare professionals, which limit their ability to realize their full potentials, and carry out their assigned roles effectively. CHW programs in many middle- and low-income countries are facing persistent challenges that undermine their efficiency, impact and sustainability. Low motivation and high dropout rates among CHWs remain critical concerns, which limit program effectiveness and long-term viability. Several key factors that are commonly found to demotivate CHWs are: (i) absent or insufficient financial incentives, (ii) limited opportunities for career progression, (iii) heavy workloads, (iv) inadequate supervision, (v) insufficient training, and (vi) high opportunity costs relative to more lucrative employment or household responsibilities. Moreover, these challenges are exacerbated by systemic barriers such as poor integration of CHWs into the health system, community resistance, unclear professional roles, and a chronic lack of essential resources. Addressing these challenges requires a comprehensive framework that combines clear institutional policies with structured and standardized training programs. Health system must formally integrate CHWs into the health system, offering fair financial compensation, establishing supportive supervision and mentorship mechanisms, and consistent public acknowledgment of CHWs' contributions to community well-being.[9, 13, 14, 15]

Studies have shown that financial incentives have successfully improved service delivery outcomes. However, this has led to a task substitution effect, where CHWs neglect unincentivized tasks. There is currently a significant gap in research on the combined use of financial and non-financial incentives[vi], especially as resource-poor countries struggle to integrate their CHW programs into health systems. There is also a gap in skills to effectively integrate CHWs into health systems while maintaining their unique identity. On the other hand, non-financial incentives, including enhancing their social recognition, have proven highly effective at elevating motivation and performance of CHWs.[16, 17, 18]

1.4 Community Health in South Asia

In South Asia, despite substantial progress in child survival, many countries continue to grapple with persistent challenges such as malnutrition, stunting, and micronutrient deficiencies. These issues are largely driven by inadequate access to quality healthcare, including maternal and child health services in scattered and underserved communities. Increasing investments in community health programs can accelerate progress in child health outcomes. There are

vi See Annexture 2: Pros and cons of incentivizing CHW programs.

over three million CHWs in South Asia providing lifesaving services to millions of children every day.[19] They are also involved in delivering essential community health services, especially maternal and child health, nutrition, and reproductive health. For instance, Female Community Health Volunteers (FCHVs) in Nepal, Accredited Social Health Activists (ASHA) in India and Family Welfare Assistants (FWAs) in Bangladesh are actively engaged in promoting maternal and child health programs. Their responsibilities include encouraging institutional deliveries, supporting breast feeding practises and facilitating childhood immunization. However, in many countries, CHWs remain largely neglected, undervalued and under-supported. Leveraging their services is important to bridge critical gaps in healthcare access. Health systems must be strengthened at the community level to increase community engagement and foster multisectoral partnerships. All in all, the Region needs to step up its efforts and invest resources into comprehensive health systems strengthening. This requires data-driven decision-making, strategic community health planning, strong multisectoral collaboration, and active community engagement to sustain vital community health services.[20, 21]

The rapid mapping/assessment by the UNICEF Regional Office for South Asia revealed a mixed progress on community health and community systems strengthening. While the Region achieved moderate success in integrating the key pillars of CHWs, such as clear role delineation, defined recruitment criteria, essential service package, and community engagement, into health policy and plans, it underperformed in 7 of 12 pillars. Critical challenges persist in digital health, community health data and information systems, supervision and quality assurance, and sustainable financing. To address these gaps, five key lessons emerged, as follows: (i) Enhance coordination - foster communication, collaboration and regional integration; (ii) Align stakeholders - engage governments and partners through advocacy to build alignment across all levels; (iii) Contextualize strategies – tailor interventions to the unique contexts of individual countries and reject acknowledging one-size-fits-all models; (iv) Mobilize resources - leverage both domestic and external funding sources while ensuring alignment with priorities of partners; and (v) Promote innovation – advocate for the piloting of innovative models and using evidence to replicate and expand successful approaches for advancing community health.[19]

To improve access to affordable and effective PHC services, the Government of India established a cadre of trained female community health activists known as Accredited Social Health Activists (ASHAs). They mobilize rural communities to increase health service utilization and implement the national health programs. Although ASHAs are considered volunteers, they receive financial remuneration as

an incentive through a performance-based payment to improve service efficiency. However, this payment scheme faces critical challenges, including disbursement delays, a lack of clarity and transparency in the payment process, the neglect of non-incentivized services, and growing demands for higher compensation.[22, 23]

This regional backdrop underscores the importance of examining how CHW models operate within specific country systems. In Bhutan, the Village Health Worker (VHW) model has long served as a cornerstone of PHC, though it now faces mounting pressures that challenge its sustainability.

1.5 Health system, priorities and approaches in Bhutan

Bhutan's Constitution[24] guarantees free basic healthcare for all citizens. Since embarking on the path of modernization, the country has consistently prioritized health and well-being, ensuring fully subsidized healthcare services. Driven by the government's determined efforts, strong commitment and strategic leadership over several decades, Bhutan has achieved high health coverage with remarkable improvements in key health indicators,[25] including MMR, IMR and U5MR[vii]. However, escalating healthcare costs in recent years challenge fiscal sustainability, mainly driven by ever-increasing prevalence of noncommunicable diseases, a rising proportion of an aging population and high attrition of healthcare workers.[26] Between 2016 and 2020, the total current health expenditure (CHE) increased from Nu. 5.8 billion to Nu. 8.7 billion. NCDs accounted for a major share of health expenditures, with 35 percent of CHE[viii] in 2016 and 41 percent of CHE in 2020.[27, 28] Among the population, the per capita CHE was the highest for those aged 65 years and older. In terms of healthcare access, over a quarter of households must travel over 30 minutes to reach the nearest health centre, indicating persistent health equity gaps for the Bhutanese communities in geographically isolated areas.[26]

Bhutan's healthcare system is built around the Primary Health Care (PHC) model, which emphasizes accessible, equitable and community-based health services, stressing more on the provision of preventive and promotive services. Following the Alma-Ata Declaration in 1978, the country expanded PHC network by establishing basic health centres and deploying frontline health workers.[29] Throughout the 1980s and 1990s, the Ministry of Health (MoH) strengthened universal immunization, maternal and child health, sanitation, and disease control programs. By adopting the PHC approach, the MoH prioritized a decentralized

vii See Annexture 1: Maternal and Child Health indicators.

viii Current Health Expenditure (CHE) is the total amount spent on healthcare services and goods in a country within a specified period.

healthcare delivery, community engagement, and preventive health to achieve national health outcomes and goals. Given Bhutan's highly scattered settlements, Village Health Workers (VHWs), serving as dedicated community health workers, have played a pivotal role in strengthening and delivering PHC services since 1979.[30]

The MoH's 13th Five-Year-Plan, titled the 'Healthy Drukyul Program'[26] envisions a healthier and more resilient Bhutan. It aims to improve the quality of care, increase access to essential health services, strengthen the health workforce, and adapt the health system to meet the evolving health needs of the Bhutanese population. The overarching goal of the FYP is to ensure 'more Bhutanese enjoy improved health and well-being by 2029'. Among its six core outputs, outputs 1 ('more Bhutanese practise healthy lifestyle') and 3 ('access and delivery of quality health and health-related services and products improved') directly intersect with the VHW program to strengthen PHC and community-level health services.

One of the key strategic objectives of the 13th FYP of the Royal Government of Bhutan[31] is to foster 'a healthy and productive society founded on equitable and high-quality health, education and social protection', for ensuring improved health[ix] and well-being[x] for Bhutanese by 2029. Fulfilling this mandate requires strengthening preventive and curative health services, improving health governance with sustainable financing, and promoting behavioural changes to boost physical, mental, and psychosocial health. By adopting the whole-of-society approach, the government places health at the centre of social development, actively engaging communities in service delivery. Operationally, VHWs work hand-in-hand with the primary health care workers in Gewogs to improve community health, inevitably gearing the communities towards achieving UHC. In this context, the new strategy is befittingly positioned to embolden the roles of VHWs, and further bridge gaps in health service delivery. This strategy will invariably contribute to the national goals of enhancing equitable health services, reaching the underserved and securing the last mile targets. As a result, this framework directly drives the Ministry of Health's (MoH) core targets, specifically Output 1 ('more Bhutanese practise healthy lifestyles) and Output 3 ('improved access to quality health and health-related services and products').

ix WHO defines health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity'. It recognizes that health is influenced by multiple factors, including societal support and community engagement, and emphasizes holistic well-being.

x Well-being is the state of experiencing positive emotions such as contentment, satisfaction and happiness, encompassing physical, emotional, mental and social aspects of life, resulting from adopting healthy behaviours, achieving good health and longevity, fostering social connections, enhancing productivity and fulfilling basic needs of life.

Empowered by the Local Government Act of Bhutan (2009),[32] the Gewog Tshogde (block council), serves as the highest decision-making body at the Gewog level, with authority to formulate and implement local development plans and projects, including those related to infrastructure development, health programs, resource management. In addition, the Gewog Tshogde is mandated to enforce rules that protect the health, safety and well-being of its people. Within this framework, the power of the Gewog Administration and Tshogde can play a vital role in prioritizing and integrating community health initiatives into the local development agendas and plans. Advocacy and training programs can further strengthen the capacities of the local government leaders, equipping them with necessary knowledge and skills needed to champion and support the delivery of community health services across Gewogs.

1.6 Bhutan's Community Health Workers: Village Health Workers

Bhutan has a single cadre of community health workers known as Village Health Workers (VHWs). Formally established in 1979, the VHW program was designed to increase access to healthcare services, engage communities, serve as a vital link between the health system and communities, and improve health and well-being of rural communities. They are trained to: (i) inform and educate the community about healthy practises; (ii) raise awareness about maternal and child health, including family planning and nutrition; (iii) promote safe water, sanitation and hygiene for better health; (iv) notify the nearest health centre of any disease outbreak in a community; (v) provide basic first aid for emergencies and minor ailments; and (vi) refer serious patients to the nearest health centres; and (vii) disseminate information on key health topics. [33, 34]

The MoH recognizes and values the contributions of VHWs in advancing the country's overarching health goals, particularly in maternal and child health. For example, the maternal mortality ratio (MMR) declined drastically from 777 in 1984 to 53 in 2023. Similarly, infant mortality rate (IMR) reduced to 15.2 in 2023 from 102.8 in 1984. Today, immunization coverage has reached nearly 100 percent, while undernutrition persists, with about eight percent of children underweight and five percent affected by wasting.[35] To this end, VHWs have been instrumental in strengthening PHC, attaining health-related MDGs[xi] in 2015, and contributing to the achievement of other important global health targets.

Increasing the number of VHWs per health centre in Bhutan is associated with a measurable decline in hospital and clinic admissions for conditions such as diarrhea, dysentery, wound care, depression/anxiety, dental caries, and skin

xi The Millennium Development Goals (MDGs) were a set of eight international development goals established by the United Nations in 2000, with a target to achieve them by 2015.

infections. Annually, this results in averting 4682 hospital admissions. Moreover, there are yearly savings of $13,348 in transportation costs and $20,960 in wages for the community members served by VHWs.[36]

1.7 The challenges faced by VHWs

Despite their critical role in driving PHC programs and improving community health outcomes, there has been a noticeable decline in VHW participation, especially in the last decade. The number of VHWs has decreased from around 2000 in the early 2000s to 1300 in 2012, then further to 1100 in 2018. The latest count shows only about 800 VHWs remain, marking a 60 percent overall reduction.[37] This gradual attrition is a growing concern for the MoH and local governments, as it risks undermining the primary health care efforts in communities.

VHWs in Bhutan are, however, not financially compensated for their time and efforts. The past reviews of the VHW program have identified several factors contributing to VHWs' demotivation, including a lack of financial incentives, insufficient opportunities, limited social recognition, poor communication with local government administration, and inconsistent trainings. As a result, recruiting new VHWs has become increasingly challenging.[38, 39, 40] compounding this issue, due to rural-urban and international migration, communities in certain Gewogs are left with predominantly aging populations, who are often unable take on volunteer responsibilities. On the other hand, younger generations show little interest in VHW work, raising serious concerns about the continuity and sustainability of VHW services in Bhutan.[41]

A scoping review conducted in 2021 identified several potential approaches to address the current challenges faced by VHWs in Bhutan. These approaches were categorized into four key areas: (i) improving management practises and community expectations, (ii) enhancing societal support and recognition for VHWs, (iii) introducing monetary incentives, and (iv) expanding and improving training opportunities. Implementing such measures could help broaden access to health services, improve retention of VHWs and reduce healthcare costs in Bhutan.[42]

The implementation of the Village Health Workers Program Strategy and Action Plan (2017–2023) faced significant setbacks, largely due to the impact of the COVID-19 pandemic, and limited resources. Purposefully designed to address the core challenges of VHW motivation and retention in the 12th FYP[xii], the VHW strategy ultimately failed to achieve its targeted outcomes. A persistent issue with

xii Five Year Plan of the Royal Government of Bhutan. The 12th FYP covered the period 2018-2023, and the current 13th FYP will last until 2029.

the VHW program under the Department of Public Health has been a high turnover of program personnel, and often exacerbated by the absence of a dedicated focal officer to lead and manage the program. While several public health programs involve VHWs in their community level activities, and are encouraged to adopt an integrated approach to program planning and implementation, inter-program coordination, integrated programming and resource sharing have remained minimal and erratic. Furthermore, this institutional fragmentation is compounded by financial instability, external funding from development partners like UNICEF and WHO has been inadequate and inconsistent. The program faced severe resource constraints specifically in the last decade. Consequently, in spite of its immense relevance to primary health care and universal health coverage, the VHW program has remained an underfunded and underrated program for years.[43]

1.8 Revamping the VHW Program

The WHO recommends adopting a context-specific, system-wide approach to CHW programs, incorporating policy coherence and community engagement into healthcare systems to respond to community health needs effectively. To contextualize this model for Bhutan, embracing the WHO's 4Cs framework – culturally versatile, competence, compassion and commitment – can significantly strengthen the VHW program, including the recruitment and performance monitoring of VHWs. Reducing high attrition rates of VHWs will require a comprehensive support matrix. This must include exploring sustainable financial incentives, ensuring consistent access to health resources, providing continuous professional development, and establishing a robust mentorship system. These targeted measures will enhance VHW motivation and improve service efficiency, inevitably driving improved health and well-being across Bhutanese communities.[44]

The MoH's 2022 VHW program review identified systemic challenges, and outlined several interventions for integration into the forthcoming VHW program strategy. The interventions recommended were: (i) providing lump sum incentives; (ii) piloting a financial incentive project in selected districts; (iii) ensuring continuous monitoring and support at various levels; (iv) implementing regular exposure visits for VHWs; (v) awarding the best serving VHWs annually; (vi) enhancing social recognition, increasing community engagement, and integrating VHWs into the PHC system; and (vii) encouraging Tshogpas to take on the role of a VHW wherever feasible.[45]

Although the topic on making the VHW post more attractive surfaced multiple times in the past, even in Parliament,[46] past discussions did not yield any concrete

actionable plans. To address this gap, the Ministry of Health is revamping the VHW program by developing and implementing a well-informed strategy and action plan. The interventions in the new strategy will boost VHWs' motivation, and contribute towards sustaining community health services. It will ensure that VHWs continue to remain the cornerstone of the primary health care system, and invaluable contributors to the health and well-being of their community. The new strategy will integrate the VHW program into a broader community health domain to ensure synchronized planning and seamless service delivery, optimize resource sharing, and improve investment potential through community leadership, VHW empowerment and multistakeholder partnerships.

Aligned with the MoH's 13th FYP outputs, the new VHW strategy aims to elevate the roles of VHWs within the broader framework of community health. By leveraging the strong PHC system of Bhutan and empowering VHWs, this strategy will ensure the long-term sustainability of community health services and contribute to the attainment of UHC across every Gewog.

2. SITUATIONAL ANALYSIS

2.1 Review process

The review was undertaken to generate evidence to inform the development of the strategy for revitalizing the Village Health Worker (VHW) program as a key pillar of primary health care.

The specific objectives were to:

- Assess the current status and functionality of the VHW program;
- Identify key barriers and enablers to motivation;
- Analyse VHW performance and retention drivers;
- Examine systemic and institutional governance factors affecting community health service delivery through VHWs;
- Recommend actional community-level VHW program interventions.

The findings of this review were intended to directly inform national strategic planning, particularly the development of a fit-for-purpose strategic plan aligned with Bhutan's 13th Five-Year Plan and UHC goals. The evidence would support the Ministry of Health in refining the role of VHWs, defining institutional responsibilities, and prioritizing interventions that enhance community-based health service delivery. It would also contribute to improved multisectoral coordination, especially

with local governments and other sectors such as education and religion; and, guide the design of sustainable financing and incentive models. More broadly, the review would provide a policy and planning foundation to ensure that community health systems are adequately resourced, better integrated, and capable of reaching underserved populations.

A robust methodology was employed to assess the VHW program, ensuring that the key challenges and lessons learned were systematically identified to guide the design of effective interventions under the new community health strategy. The approach underscored the importance of reliable data and evidence in shaping the strategy. To achieve this, a comprehensive situation analysis was conducted through desk reviews, secondary data analysis, and field visits to Gewogs[xiii] and Chiwogs.[xiv] These visits provided firsthand insights and a deeper understanding of on-the-ground realities from VHWs, local government officials, and healthcare professionals.

The review involved a diverse group of participants to ensure a comprehensive understanding of community health challenges from various perspectives. This phase comprised a desk review and technical consultations to assess the state of VHWs, and their roles in primary health care. The desk review examined global, regional, and national developments, evaluated national policies and strategies over the past decade, measured progress against strategic objectives, and identified program gaps and challenges. Technical consultations with health programs and healthcare facilities focused on discussing policy issues, service provision, and community engagement. These consultations further explored emerging challenges faced by VHWs, revisited past incentive proposals, gathered insights from healthcare providers, and collected evidence on existing barriers, sustainability concerns, and local government support for community health services.

Focus Group Discussions (FGDs) conducted in Sarpang and Trashigang Dzongkhags[xv] explored the perceptions, experiences, and challenges of Village Health Workers (VHWs) in fulfilling their dedicated responsibilities. The discussions sought to strengthen community health services by addressing the key challenges encountered by VHWs. The participants shared their experiences, provided new ideas, and proposed strategies to revamp the VHW program. The FGDs sought

xiii A Gewog is an administrative division in a district consisting of a group of villages. A block is another term for a Gewog. There are 205 Gewogs presently headed by Gups.

xiv A Chiwog is a smaller subdivision or unit of a Gewog. Typically, one Gewog may have 5 to 6 Chiwogs. There are 1041 Chiwogs in the country. Tshogpas are the elected representatives of Chiwogs.

xv Dzongkhags are districts consisting of several Gewogs. There are 20 Dzongkhags, each governed by a Dzongdag.

to clarify VHWs' roles in primary health care, identify work-related challenges, and assess factors driving their willingness to continue serving. Both retired and active VHWs were engaged to ensure diverse perspectives, while VHWs from varied socioeconomic and cultural backgrounds contributed comprehensive insights from the central and eastern regions of the country.

Phone interviews were conducted with VHWs and other stakeholders in selected districts where field visits were not feasible. This interview aimed to gather detailed insights into VHWs' contributions to community health, understand the challenges they face, and explore ways to enhance their social status and motivation. The participants from Gasa, Samtse, and Zhemgang took part in the phone interview, with coordination support from the Ministry of Health and District Public Health Officers (DPHOs) in selecting participants and scheduling interviews. The interview dates and timings were arranged according to participants' availability. A phone interview format offered convenience, reducing travel cost and saving time for the participants.

In addition, the TWG meetings were conducted to provide technical guidance to the national consultant on the assessment tools and to ensure a well-coordinated strategy development process. These meetings helped align the proposed strategic actions with the national and sub-national health priorities, approaches, and goals. The TWG team emphasized adopting a whole-of-community and integrated approach to VHW strategy development, which was deemed suitable for strengthening primary health care and sustaining community health services.

Field visits to the Haa, Sarpang, and Trashigang Dzongkhags provided valuable insights into local realities, existing challenges, and the needs of VHWs. Interviews were conducted with local leaders, VHWs, and health professionals across eleven Gewogs, with two Gewogs in Paro included to broaden perspectives. Bilateral and group discussions with VHWs, local government officials, and other stakeholders provided a platform for open dialogue, enabling the exchange of information and ideas to address pressing issues grounded in community health needs. Phone interviews were held with village health workers, community leaders, and health professionals in remote Gewogs of Gasa, Samtse and Zhemgang, involving participants from 10 Gewogs. Their grassroots level perspectives enriched the assessment of community health services. Moreover, health coordinators from six religious institutes, including one nunnery, in Paro, Lhuntse, Mongar, Phuntsholing, Samtse, and Zhemgang, were interviewed to understand their role in promoting community health and managing health issues within their institutions. Similarly, five school health coordinators were interviewed, highlighting their contributions

to maintaining the health of their institutions, advocating for health promotion, and facilitating referral services.

2.2 Review findings

2.2.1 Village Health Workers

Of the 40 VHWs interviewed, the majority were male (83%), with only 17 percent female. Female participation was lower in the eastern and southern regions, where cultural factors were cited as contributing to this disparity. This imbalance reflects broader gender inequities within the VHW program, pointing towards structural and cultural barriers that limit women's participation in community-based and public service roles. A significant proportion (90%) of VHWs did not have formal education. However, most of them were able to read and write in Dzongkha (national language). However, their education background did not the service delivery, as VHWs continued to perform their responsibilities effectively.

Participant's ages ranged from 25 to 71 years, with an average age of 47 years. The largest proportion of VHWs belonged to the 45-54 age group (35%), while the oldest group (65-74 years) accounted for 10 percent. Overall, middle-aged and older individuals (65%) formed the backbone of the VHW workforce, indicating the continuation of service well into their later years. By contrast, relatively fewer younger individuals took on VHW roles. The majority of village health workers (60%) have served for more than 10 years, with half contributing over 15 years, demonstrating strong long-term commitment to their responsibilities.

Most VHWs (68%) had received at least some health training, with one-third having been trained more than 10 times. Despite carrying out VHW responsibilities for 2 to 3 years, 22 percent had never received any sort of trainings. However, the VHW training programs were disrupted by the COVID-19 pandemic between 2020 and 2023, limiting opportunities for capacity building during this period.

2.2.2 Motivations of VHWs

Village Health Workers (VHWs) were motivated by a combination of internal and external factors that sustain their commitment to serving their communities and contribute to broader social development. The following key drivers influenced their commitment and enthusiasm to improve community health and well-being:

- Self-motivated with genuine concerns for communities

Self-motivated VHWs were found to be driven primarily by internal motivation rather than external rewards. They remained proactive, dedicated, and committed to sustaining their work despite challenges, guided by a genuine concern for the

well-being of their communities, especially the elderly and those living in remote villages. Their desire to serve stemmed from sincere understanding, camaraderie and compassion for fellow citizens. Many also associated their volunteer work with religious beliefs, viewing it as a virtuous act and a means of earning positive merits, particularly among senior VHWs who were deeply religious. Age did not hinder their determination to serve. For instance, 71-year-old VHW in Samtse remains highly active and wishes to continue volunteering. Similarly, many VHWs in Yangneer (Trashigang) were senior citizens who continued to contribute meaningfully to community health.

- Self-aware of benefits to communities

VHWs who were aware of benefits their service brings to communities remained motivated and committed to work even in challenging situations. They recognized that their efforts contribute to improved health outcomes, particularly mother and child health, and to reducing the prevalence of water- and hygiene-related diseases. Many of these VHWs have received repeated health trainings, which enhanced their understanding of community health issues and the broader importance of their role. This awareness fostered pride in serving as a link between communities and the healthcare system. They remained enthusiastic, purposeful and dedicated, finding fulfilment in their contribution to community well-being and development.

- Acknowledgment of VHW's contributions by community leadership

The most enthusiastic VHWs were those who felt valued, appreciated, and recognized by their communities for their contributions. When local government officials such as Gups and Tshogpas, and community members expressed genuine support, gratitude, and acknowledgement, VHWs felt a heightened sense of pride and purpose, reinforcing their dedication to improving community health. Some even mentioned that public recognition and leadership backing their work mattered more to their morale than financial rewards. This support increased their credibility, fostered stronger relationships, and built trust within the community, thereby facilitating the implementation of health programs. For instance, a VHW in Lunana Gewog continues to serve two villages without road connectivity or infrastructure, sustained by the encouragement of the Gup and community members.

In conclusion, self-motivated and self-aware VHWs demonstrated noteworthy dedication, passion and resilience, driven by a deep sense of purpose and genuine concern for their communities, enabling them to overcome various barriers and remained devoted to their roles. Their recognition of the positive

impact of their work fostered pride and fulfilment, regardless of age or external rewards. In addition, acknowledgment and support from community members and local leaders played a crucial role in sustaining their motivation, strengthening their connection to the community, and enabling them to continue to serve even in difficult circumstances. Together, these factors created a powerful foundation for VHWs to continue volunteering with enthusiasm and commitment, ultimately contributing to the overall well-being and development of their communities.

2.3 Key Challenges identified among Stakeholders

2.3.1 Village Health Workers

VHWs face numerous challenges as they shoulder the responsibilities of delivering essential health services to their communities. Their motivation to reach out and serve those in need is often met with difficult working conditions, long travel distances in remote areas, limited support from local governments, and inadequate training opportunities. In addition, competing demands on their time for farming and family responsibilities, coupled with emotional toll of their work, often affect their morale and commitment. Despite these obstacles, VHWs continue to meaningfully engage in community health, driven by compassion, resilience and a deep sense of care for their fellow citizens.

Several key factors influenced the motivation of VHWs, shaping their commitment to serve and their resilience in overcoming challenges. These include:

Lack of social recognition for VHWs

VHWs consistently expressed the need for moral, social and leadership support from their community members, local government officials, and Dzongkhag administration. They sought appreciation, acceptance and acknowledgement for their volunteer work and contributions they make towards improving the health and well-being of their communities. More than monetary rewards, most VHWs reported that the lack of social recognition was the most significant demotivating factor affecting their commitment and work performance. When their hard work went unnoticed or undervalued by local government leaders and communities, they felt unimportant, unappreciated and taken for granted, with some even considering giving up their roles. Therefore, recognizing and celebrating their efforts, whether through verbal appreciation, inclusion in community decision-making processes, or public acknowledgment during important national events, would inevitably boost their morale, encourage long-term dedication and reduce attrition.

Absence of mechanism to support VHWs

VHWs are invaluable assets to Gewogs and Chiwogs, working diligently to keep their communities healthy through their preventive and health promotion efforts. They serve as vital links between communities and the healthcare system. By closely coordinating and collaborating with Dzongkhag and Gewog health authorities, they contribute significantly to the goal of building healthy, energetic, and vibrant communities. While their work is widely regarded as significant, the absence of structured mechanisms to support VHWs at the local government level undermines their efficiency and motivation. VHWs serve voluntarily, yet lack a policy framework or guidelines to facilitate their management. Currently, there is no formal system or written procedure to guide their recruitment, capacity development, monitoring, or replacement at the Gewog or Chiwog level. By default, the Primary Health Centre (PHC) staff are responsible for overseeing VHWs and their activities. However, when VHWs retire, their roles are often informally passed on to family members or acquaintances. In some cases, communities themselves identify and elect new VHWs. The lack of a standardized recruitment or replacement process leaves VHWs to navigate challenges on their own, which may weaken service delivery over time. Strengthening local government involvement through clear guidelines, defined oversight roles, and capacity-building programs is essential to enhance VHWs' effectiveness and ensure sustainable community health services.

Inadequate incentives

Inadequate financial and non-financial incentives are inadvertently impacting the motivation and retention of VHWs. Carrying out their responsibilities often involves a financial burden, especially when traveling to remote outreach clinics (ORCs), working long hours, or using personal mobile phones to coordinate health camps, advocacy, or cleaning campaigns. Without proper compensation, VHWs feel unappreciated, leading to low morale and high turnover rates. Furthermore, the absence of non-financial incentives, such as skills development training, exchange programs, or educational materials, exacerbate their frustrations. The lack of basic equipment like medical supplies, boots, bags, umbrellas, caps, torches, etc., can hinder their daily work. Providing these basic amenities and addressing the boarder issue of incentivization is vital to boosting VHW morale and ensuring the continuity of community health services.

Unclear program strategic approach

The effectiveness of the VHW program at both national and sub-national levels is often hindered by fragmented approaches. The primary challenge being a limited communication between VHWs and the broader health sector, especially at the

district level. Without official communication channels, VHWs struggle to reach out and consult higher authorities regarding their issues. Furthermore, there are no established mechanisms to collaborate with other relevant agencies like educational and religious institutions, which could play a significant role in health promotion, awareness creation, and community engagement. Besides, the lack of management guidelines has resulted in inconsistent supervision, support, and evaluation, leaving VHWs without clear direction. During the COVID-19 pandemic, capacity building activities for VHWs were disrupted, leaving many of them untrained and ill-equipped to address emerging health challenges such as non-communicable diseases (NCDs) and rising mental health concerns. Therefore, to safeguard community health outcomes and maintain high-quality service, the VHW program must urgently prioritize structured planning, dynamic coordination, and multi-sectoral collaboration to restore momentum and re-strengthen of the role of VHWs.

Time management conflicts

VHWs often struggle with time management conflicts, as their volunteer community duties frequently overlap with family and farm responsibilities. Their unpredictable schedules - such as emergency calls and ad-hoc health-related tasks, especially in far-flung villages - make balancing household work difficult, particularly for female VHWs. These challenges become even more pronounced during crop sowing and harvesting seasons when farm work demands are at their peak.

2.3.2 Local governments[xvi]

Although VHWs serve as health volunteers in villages, they lack an official role in local governance structures. The Gewog Administration is responsible for local governance, planning, and community development. Improving community health is one of its core responsibilities, including planning, implementing, and monitoring health programs. Even though VHWs are implicitly affiliated to the Gewog administration, there is limited communication and coordination between them. Past experiences indicate that VHWs rarely collaborate with LG leaders such as Gups or Tshogpas to execute community health programs.

The Gewog Administration encounters several challenges in coordinating and collaborating with VHWs, which are as follows:

- Poor visibility of VHWs' contributions: The work of VHWs is often overlooked due to the lack of a structured monitoring and reporting mechanism. Their

xvi Local governments comprise Dzongkhag Tshogdu, Gewog Tshogde and Thromde Tshogde. They do not have legislative powers, but, amongst other duties, they are responsible for area-based planning and implementing socio-economic strategies and protecting public health of their communities.

efforts and impact on community health outcomes are not systematically documented or acknowledged by the local government authorities.

- Absence of administrative guidelines: There is no clear directive as to who is administratively responsible for managing and supporting VHWs - whether it is the local government, health authorities, or the community itself. Currently, Primary Health Centre staff members solely coordinate and supervise VHW activities, leaving local governments without a defined role.
- Limited understanding of the significance of community health: The local government officials often fail to grasp the wider implications of VHW's work in advancing district and national heath goals. This limited understanding and narrow view of local governments may reduce engagement of and support for VHWs. Consequently, this can undermine progress towards universal health coverage at the grassroots level.
- Compulsory community labour contribution (Wola): Unlike in the past, community labour contributions are largely non-existent today. VHWs are exempted from Wola due to their voluntary contributions to community health services. However, some VHWs are still required to participate in Wola, particularly in Gewogs with smaller and aging population, adding to their workload.

2.3.3 Health Professionals

Healthcare workers at Primary Health Centres (PHCs) and Community Health Units (CHUs) of district hospitals serve as the primary contact points for VHWs, and are responsible for managing community health programs at the Gewog levels. VHWs act as a connector between health centres and local communities. In the past, the number of VHWs across Gewogs was sufficient to meet the needs of the population. However, their numbers have declined in recent years, creating significant gaps in service delivery. This shortage places additional pressure on healthcare workers, particularly those tasked with outreach clinics and public health activities. The decline in VHWs is particularly worrying for primary health centers already struggling with limited staff, with reduced capacity to deliver essential health services. This may have adverse consequences on community health outcomes.

Some of the significant issues that healthcare workers are grappling with are as follows:

- VHW retention and replacement: It is increasingly becoming challenging for PHCs to retain VHWs, and find suitable replacements when they leave. This

high turnover rate risks, without replacements, disrupting community health services. Attrition is mainly driven by a lack of tangible incentives, limited professional advancement opportunities, and increased workloads. Some VHWs migrate to urban areas or retire. Finding replacements is difficult, particularly in villages where young people show little interest in VHW work, and older residents are physically unable to take up the role. Critically, health workers lack the power to recruit new volunteers, and there are no official guidelines outlining the process to request them. As a result, the current practice relies on informal approach where health staff consult with outgoing VHWs and Tshogpas to identify and encourage potential recruits. This absence of a formal framework creates inconsistencies in how new VHWs are selected and integrated into the community health system.

- Disruption of outreach clinic (ORC) activities: High attrition rates significantly compromise the implementation of outreach (ORC) activities, leading to diminished services and delayed interventions, especially in remote areas where grassroots support is critical. Health staff at PHCs experience increased pressure on ORC days. The absence of adequate VHWs affects vulnerable population, particularly chronic patients needing home-based care. Furthermore, ORCs depend heavily on VHWs to inform and mobilize community members for health campaigns and advocacy activities. Without their support, engaging communities effectively becomes increasingly challenging. The reduced number of VHWs can disrupt the continuity of health efforts, particularly in underserved and remote areas.

- Impact on public health efforts: Without the support of VHWs, community-based disease prevention and health promotion programs are weakened. The absence of VHWs can reduce opportunities for community awareness and health education on critical topics like hygiene, sanitation, nutrition, and disease prevention. VHWs are essential for tracking maternal and child health indicators, disease outbreaks, and other vital community information in villages or Chiwogs. A decline of VHWs can hamper the community health information system, making it harder to generate data. Over time, this can exacerbate health disparities, particularly in rural and unreached pockets of Gewogs, worsening inequality in healthcare access. Ultimately, the shortage of VHWs threatens progress towards the goal of UHC.

- Inadequate budgetary provision for VHW training: Budget allocations for VHW training is irregular and inadequate at both district health sector and Ministry of Health. This has resulted in limited access to regular, comprehensive training, leading to knowledge and skill gaps and

inconsistent service quality across Dzongkhags. In some cases, districts had to cancel scheduled training sessions due to lack of funds. Financial constraints also hindered follow-up refresher training, mentorship, and field supervision, undermining knowledge retention and the ability to respond to evolving community health needs. These challenges contribute to lower VHW retention, reduced service effectiveness, and widening gaps in access to community outreach services. ensuring regular and sufficient budget allocation is critical to standardizing training, supporting continuous skill development, and eventually strengthening the VHW program to improve community health outcomes.

2.3.4 Health Coordinators in Religious Institutions

Health coordinators based in religious institutions play a crucial role, much like VHWs, in promoting community health and well-being among monks and nuns. They contribute by raising awareness, facilitating access to healthcare services, and supporting public health initiatives within their institutions. However, they encounter several challenges that may undermine their efforts and long-term engagement.

- Limited access to training: The central monastic body (Dratshang Lhentshog) coordinates and organizes various health training programs for religious institutions across all 20 Dzongkhags. However, many institutions, particularly autonomous and private ones, have limited access to structured training programs. Thus, religious health coordinators remain disconnected from updated health guidelines, disease prevention strategies, health promotion approaches and health emergency response protocols.

- Difficulty in retention: Retaining trained and motivated health coordinators is a persistent challenge. Many leave due to promotions to higher institutes or transfer to another institutes, creating gaps in continuity and weakening the sustainability of health programs.

- Weak communication and collaboration: Health coordinators often face barriers in establishing strong linkages with the broader health system and schools. The lack of formal communication channels and collaboration framework restricts coordination, resource sharing, and alignment with common goals. Besides, differences in organizational cultures and priorities between religious institutions and the health sector further hinder effective collaboration.

2.3.5 School Health Coordinators

All schools in Bhutan have designated school health coordinators, who are entrusted to oversee the health and well-being of students. The Ministry of Education and Skills Development in collaboration with the Ministry of Health started this initiative in schools to promote better physical and mental wellness among students. These coordinators manage the implementation of the school health program activities, including annul health check-ups, micronutrient supplementation, vaccinations, WASH and menstrual hygiene practises. In addition, schools also have well-being focal persons who focus on mental health well-being of students. Despite their important roles in maintaining student's well-being, school health coordinators face hurdles that impede their effectiveness, including budget constraints for extracurricular wellness activities, insufficient trainings, and inadequate administrative support. Specifically, the challenges in inter-sectoral collaboration and participation in community health programs are as follows:

- Limited collaboration with the health sector: Currently, there is a lack of coordination mechanism between school health coordinators and the health sector to facilitate interactions and promote community health. This limited coordination results in unclear guidance, overlapping responsibilities, and minimal engagement in community-based health activities. Training opportunities, joint programs and data sharing are inconsistent and inadequate, weakening the impact of overall health initiatives.

- Lack of participation in community health: School health coordinators rarely engage in community health promotion beyond their school boundaries, reflecting systemic barriers such as narrowly prescribed responsibilities, limited capacity to involve in community health and the absence of time allocation for community health activities. Without clear directives from the education and health ministries, school health coordinators' potential contribution to broader community health promotion remains unexplored.

- Absence of school health guidelines: Schools do not have holistic school health guidelines or tools to guide their health activities. School health coordinators often operate in silo, uncertain about the scope of their responsibilities. This may hamper their performance and efficiency in addressing school health issues. In the long run, the absence of standardized guidelines risks inconsistent implementation, weak accountability, and ineffective school health programs. However, encouragingly, the MoH and Ministry of Education and Skills Development are developing the national health promotion guideline for schools and religious institutions, which could address these gaps.

2.4 Strategic Reflection Questions

2.4.1 Can Tshogpas take up the VHW's role?

According to the Local Government Act of Bhutan (2009), Tshogpas are elected representatives of the Gewog Tshogde (Block Council). This Tshogde, comprising the Gup, Mangmi, and five to eight Tshogpas, is the highest decision-making body in each Gewog. Tshogpas represent their communities in Gewog Tshogde, engage in community decision-making, and oversee the implementation of local development policies and plans. Just like VHWs, Tshogpas serve as the link between the Gewog Administration and communities, and have certain authority as bestowed upon them by the LG Act.

Since communities in Chiwogs (sub-divisions of the Gewog) are represented by Tshogpas, the possibility of Tshogpas taking up the roles of VHWs has arisen many times in the past. Tshogpas possess deep knowledge of their communities and hold administrative authority to implement sectoral plans and programs, placing them in a stronger position to manage community health services compared to VHWs. However, field data revealed that there are both advantages and disadvantages to Tshogpas assuming the VHW responsibilities.

Advantages

- Paid employees of Local Government (LG) Offices: Tshogpas are already compensated for their position, eliminating the need for additional financial incentives. In contrast, VHWs may require some form of incentives in the future.
- Administrative and coordinating responsibilities: Tshogpas already handle administrative tasks, which can be leveraged to coordinate health-related activities.
- Authority to conduct community meetings: Their position allows them to organize and lead community meetings (zomdus), during which they can include the community health agenda can be integrated as needed.
- Easy access to communities in Chiwogs: Tshogpas have established connections and access to local communities and resources, enabling better outreach and easier implementation of social development programs, including health.
- Focal person for multiple sectors: Serving as a central point of contact for various social sectors, Tshogpas enhance coordination and collaboration between health initiatives and boarder community development efforts.

Disadvantages

- Availability issues: Tshogpas from larger Chiwogs may be less available due to their heavy workload and multiple official engagements.
- Priority of LG work: Tshogpas' primary mandate is LG administrative responsibilities, which may take precedence over health-related duties.
- Retention challenges: In absence of a clear policy directives or legal obligations, retaining Tshogpas in dual roles could be difficult.
- Comfort level of healthcare workers: Health professionals may prefer working with dedicated VHWs given their established relationships and trust they share. Some health workers hesitant to request support from Tshogpas as they are LG officials with certain authority.

Assigning Tshogpas to take up VHW responsibilities presents both potential advantages and notable challenges. On the positive side, Tshogpas are already paid employees of local government, eliminating the need for additional financial incentives. Their administrative and coordinating experience as well as their ability to convene community meetings (zomdus) positions them well to integrate community health agenda into to local governance. In addition, their easy access to communities, and role as sectoral focal points at the grassroots level enhance their suitability for coordination community health programs. However, several challenges must be considered. Tshogpas' primary focus on LG work may limit their attention to health-related duties, while availability issues are more pronounced in larger Chiwogs due to workload and official commitments. Health workers often prefer collaborating with VHWs due to their long-standing working relationships. Moreover, retention challenges could arise without clear policy directives to sustain their dual role in community health.

2.4.2 Do we need VHWs at all?

Various stakeholders emphasized the critical role of VHWs in strengthening community health systems, ensuring healthcare access, and supporting public health efforts.

- Local Government (LG) Leaders: LG officials underscored the importance of VHWs, noting strong demand from communities and the immense benefits accrued by local population. There are general understanding and consensus among LG officials that VHWs do contribute to improved community health outcomes.

- Health Workers: Health workers regard VHWs as a pillar of support for Primary Health Care (PHC). They play an important role in mobilizing communities, engaging families, and ensuring that healthcare services reach even the most remote population.
- Public health programs: Major public health programs, including NCD prevention and control, disability prevention, immunization, elderly care, vector-borne disease programs, depend on community-based interventions. The active participation of VHWs is essential for the effective implementation, monitoring and sustainability of these program components.
- Ministry of Health: Guided by the principle of Leave No One Behind, the MoH acknowledges that accessibility issues still exist, and the sustainability of primary health care (PHC) at grassroots level depends on the continued support of VHWs. Their roles are crucial for bridging healthcare gaps and advancing Universal Health Coverage.

All stakeholders emphasized the indispensable role of VHWs in addressing community health needs, supporting public health initiatives, and achieving broader health sector goals such as Universal Health Coverage and health-related Sustainable Development Goals. The perspectives of various stakeholders collectively affirm the importance of maintaining and strengthening the VHW program as a cornerstone of Bhutan's community health system.

In conclusion, the findings of this Situational Analysis underscored the indispensable role that VHWs play in Bhutan's PHC system, especially in extending services to underserved populations in remote Chiwogs. While their contributions are widely recognized, the sustainability and effectiveness of the VHW program are being undermined by persistent structural, operational, and motivational challenges. These include the lack of formal coordination mechanisms, inadequate and inconsistent financing, absence of standardized recruitment and training frameworks, limited support systems, and insufficient integration with local governance and national health systems.

Addressing these gaps requires a deliberate, multisectoral response that is evidence driven and responsive to Bhutan's evolving health needs. The next section outlines the Strategic Action Plan to revitalize the VHW program.

Summary of Key Findings and Strategic Recommendations		
Key Findings	**Implications**	**Strategic Recommendations**
• No formal mechanism between LGs and MoH for coordinating VHWs and their engagements in community health. • Limited collaboration within the health system at local government levels due to a lack of formal linkages and shared platforms. • There is currently no mechanism to collaborate with other relevant agencies like educational and religious institutions, despite their potential to play a significant role in community engagement for health promotion.	• Missed opportunities in efficiency gains to meet and address the health needs at community levels. • Missed opportunities to create synergies between health sector and other non-health sectors to apply whole-of-community approach to community health planning, implementation and monitoring.	• Integrating a coordination mechanism for involving VHWs in community health within the existing structures. • Clarifying administrative responsibilities and coordination frameworks for VHWs.
• Funding for VHWs was irregular and mostly dependent on development partners. There was no dedicated or predictable budget for VHW-related training, materials, or incentives at the national or district level.	• Inconsistent and insufficient funding undermines the ability to plan, train, and retain VHWs. It resulted in service interruptions, deferred trainings, and demotivation, jeopardizing the continuity and effectiveness of community health services.	• Establish a dedicated funding mechanism for the VHW program under national and sub-national health budgets. • Integrate community health-specific funding lines in annual planning and budgeting processes.

Summary of Key Findings and Strategic Recommendations		
Key Findings	**Implications**	**Strategic Recommendations**
• Role often informally defined; recruitment and replacement not standardized. • Unclear administrative responsibility for managing and replacing VHWs. • A lack of continuity plan when VHWs once retired, a role was often informally passed on, or taken up by family members or acquaintances. • No formal recruitment mechanism existed.	• Unstandardized procedures in recruitment leading to varying performances, and leaving VHWs to navigate on their own. • PHCs struggle to retain and replace VHWs. • A low count of VHWs significantly limit outreach activities, thereby compromising service delivery in hard-to-reach areas.	• Develop national recruitment guidelines for VHWs to ensure their succession. • Assign accountability for VHW recruitment at LG and district health sector level. • Develop clear recruitment and onboarding SOPs to ensure smooth replacement processes.
• Motivated by intrinsic factors (self-awareness, community impact, and religious beliefs), however, a lack of social recognition remained a critical demotivating factor, undermining their commitment and work performance. • The VHW program did not have financial incentives. • Farm work and family obligations often clashed with volunteer duties. Volunteer work not well-integrated with livelihood realities. • VHW attrition weakened outreach and public health activities.	• A lack of appreciation created a cycle of demotivation, where having the feeling of taken for granted lowers their morale, leading to poor performance, and eventually resulting om vacant posts. • Coupled with the inadequate public recognition, a lack of financial incentives leaves VHWs feeling further neglected. • Constant pressure of daily responsibilities often forces VHWs to overlook or neglect their duties.	• Introduce proper incentive packages and public recognition systems. • Design flexible workload management approaches for VHWs. • Expand VHW networks to distribute certain responsibilities, and reduce individual pressure, ensuring volunteer duties are shared.

Summary of Key Findings and Strategic Recommendations		
Key Findings	**Implications**	**Strategic Recommendations**
• Training disrupted by COVID-19; 22% of VHWs never received any formal training. • Many lacked access to new and refresher trainings. • Structured health-related trainings largely absent in religious and educational institutions. And, challenging to retain trained health coordinators due to their transfers or promotions. • Irregular and insufficient training budgets hindered trainings for health coordinators in schools and religious institutes.	• Budget constraints led to cancelations of VHW training programs.	• Secure dedicated training budgets across all levels for VHWs. • Institutionalize regular training schedules and refresher modules. • Introduce retention plans and scheduled trainings for health coordinators.
• VHWs delivered a basic package of services focused on health promotion, hygiene awareness, and maternal/child health. However, absence of structured support, motivation, and clearly defined service scope hampered consistent service delivery.	• Service delivery became fragmented and varied across communities. • Missed opportunities for VHWs to contribute meaningfully to disease prevention, elderly care, and NCD interventions.	• Review and operationalize a standardized essential community health service package aligned with national health priorities.
• Supervision was inconsistent and lacked structured tools to do so, and quality assurance system was not in place. • No routine feedback or performance evaluation framework existed for VHWs.	• Absence of guidance could result in performance variation, knowledge gaps, and disengagement. • A lack of quality assurance could undermine trust in the system.	• Develop and implement a national supervision and mentorship framework for VHWs, including standardized supervision tools and indicators.

Summary of Key Findings and Strategic Recommendations		
Key Findings	**Implications**	**Strategic Recommendations**
• Recognition from Gups or Tshogpas could have boosted VHWs' morale significantly. • Formal community engagement mechanisms remained limited. • Although community labour contributions were not required for VHWs, some still had to take them up.	• The absence of meaningful community engagement reduced the perceived value of VHWs.	• Formalize LG and community roles to support and recognize VHWs.
• VHWs facilitated patient referrals to health centers, especially during emergencies and for serious cases. However, referral processes were largely informal, undocumented, and lacked standard protocols, or tracking mechanisms.	• Gaps could widen in the continuity of care, delayed treatment, or missed follow-ups. • This undermined the role of VHWs as effective entry points into the formal health referral system.	• Standardize referral systems with clear and simple referral forms, feedback mechanisms, and basic orientation on when and how to refer by VHWs at the village level.
• No evidence of digital tools being used by VHWs. • Communication, mobilization, and reporting tasks were conducted manually.	• Opportunities to improve efficiency, and connectivity through digital solutions were missed. • Data flow remained slow or fragmented.	• Review national digital health strategy, and implement user-friendly digital tools (e.g., mobile apps, SMS-based platforms) to support data capture, reporting, and task reminders.
• VHW contributions were neither monitored nor reported through any formal system, rendering their efforts less visible. • There were limited to no mechanisms for data collection or community-level reporting.	• The absence of community-level data collection and use made planning, accountability, and resource allocation difficult for VHW activities.	• Create simple data reporting tools for community health work by VHWs.

Summary of Key Findings and Strategic Recommendations		
Key Findings	**Implications**	**Strategic Recommendations**
• A lack of essential items like boots, umbrellas, medical kits, IEC materials, etc., affected service delivery.	• VHWs could not serve communities optimally without essential supplies and materials.	• Ensure provision of essential tools and equipment for field service.

3. COMMUNITY-CENTRIC VHW STRATEGY & ACTION PLAN

Vision Statement

Empowered and thriving communities that contribute to the Ministy of Health's aspiration of achieving the nation with the best health.

Mission Statement

Strengthning the Primary Health Care system in Gewogs to ensure equitable access to responsive and inclusive community health services, thereby supporting the attainment of Universal Health Coverage.

Purpose of the Community-centric VHW Strategy and Action Plan (VHW SAP)

The community-centric VHW SAP aims to improve access to community health services, particularly for the population in hard-to-reach communities.[xvii] By fostering community leadership, empowering communities and supporting village health workers, the strategy will promote collaborative efforts to advance community health and well-being. This strategy will contribute to building resilient, inclusive, and sustainable commuity health systems rooted in community particaption and ownership.

The specific objectives of the VHW SAP are:

- To enable communities[xviii] to promote science-informed, responsive, inclusive and sustainable community health services, supported by national and local government resources, to achieve good health and optimal well-being.
- To optimize the Village Health Worker (VHW) program by enhancing its effectiveness in delivering quality and equitable community health services that address emerging health needs and improve health outcomes.

xvii Communities include those facing geographical, financial and socio-cultural barriers in accessing health services.

xviii A community refers to a group of people, institutions and resources in a rural setting who share common socioeconomic conditions and cultural practises.

- To foster a collaborative environment where community members, including LG leaders, VHWs, and institutions, collectively make decisions, and use a whole-of-community (WoC) approach to enhance equitable health access, minimize health disparities, and reduce key preventable health threats.
- To strengthen the roles and responsibilities of key stakeholders, including LG leaders, and community-based institutions, to improve access to quality, equitable and responsive community health services for all population groups.
- To empower communities with knowledge, skills, values and resources for promoting self-care, healthy lifestyle and best community health practices.

Goal of Community-centric VHW SAP

By 2030, every Gewog will have improved access[xix] to quality community health services, effectively supported by empowered village health workers, resilient communty health systems and strong local governance structures.

Guiding principles

The implementaiton of the VHW SAP will be guided by the following principles:

- **Community-centric:** Local governments and relevant stakeholders at all levels will prioritize health needs, values and well-being of commuities in decision-making, programming and service delivery. Communities themselves will be integral partners in all health initiatives.
- **Equity and inclusiveness:** VHW SAP will expand universal access to quality community health services, particularly to vulnerable populations who need them most, across Gewogs. Active engagment of LG leaders and VHWs will ensure that no one is left behind.
- **PHC-based:** The VHW SAP implementation will be guided by the PHC approach, ensuring accessible, holistic and people-centric community health services. This places a strong emphasis on prevention, health promotion, community engagement, multisectoral collaboration, and Universal Health Coverage, using VHWs to bridge gaps for unreached and vulnerable population.
- **Good governance and accountability:** The VHW SAP will uphold transparency, efficiency and equity in community health systems. These principles will help

xix Health services are physically within reach, available when needed, delivered by trained health workers, adequately supplied, and culturally appropriate.

enforce effective monitoring system to tract program performance, reduce disparities and build public trust, esnuring accountability at all levels.

Strategic actions for revamping community health programs

To ensure sustainable community health[xx] services, the key areas of support must be addressed through a whole-of-community approach. The VHW program review revealed that the local government leadership is one of the most critical factors for elevating the status of VHWs and promoting community well-being. Institutional and systemic support, especially through skills enhancement trainings and provision of amenities, is crucial to boosting the motivation of VHWs. Establishing networking platforms for collaboration and partnership will further empower VHWs, while creating an enabling environment through standardized operational guidelines will maximize their efficiency. To effectively and meaningufully engage with their communities and local institutions, VHWs require advocacy tools and Information, Education and Communication (IEC) materials. Combined, these interventions are expected to increase VHW motivation, lower attrition rates and enhance service efficiency. In the long term, this VHW SAP will contribute to the Ministry of Health's goal of promoting healthy lifestyle at the grassroots level, while strengthening Primary Health Care and advancing towards Universal Health Coverage targets.

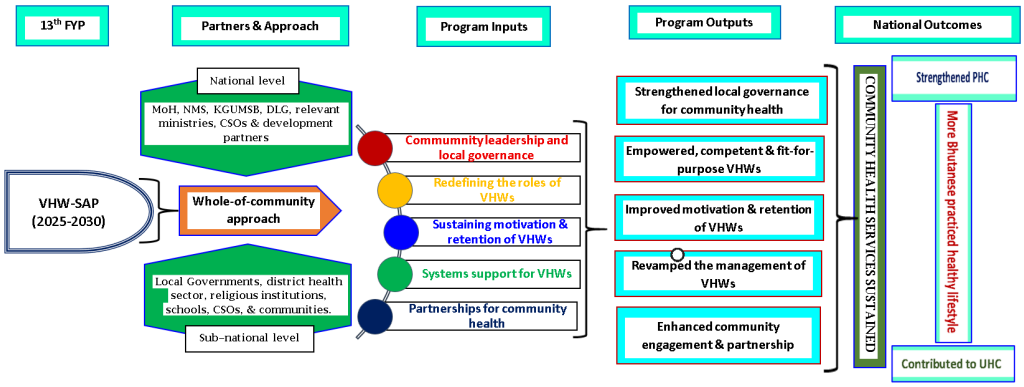

Figure 1: The strategic pathway to sustainable community health services

The Ministry of Health is set to revamp the Village Health Worker program through a strategic and multifaceted approach to close existing gaps, enhance the delivery of community health care, and ensure long-term sustainability.

xx Community health refers to a public health practise that focusses on people in a community and their role as determinants of their own and other people's health. It is a multi-sectoral and multi-disciplinary approach that uses public health science, and evidence-based strategies to engage and work with communities to optimize the health and quality of life of all persons in a community. Key community health services include nutrition, maternal and child health, NCDs, priority communicable diseases, etc.

Recognizing the evolving health challenges faced by communities, the strategy will be evidence-based, inclusive, and responsive, using a whole-of-community approach. Key strategic actions will focus on leveraging community leadership to advance community health, strengthening the capacity of village health workers, improving community engagement, and fostering institutional collaboration. The ultimate goal is to build resilient community health systems that promote equity and well-being, ensuring that no individual is left behind in the pursuit of Universal Health Coverage.

Whole-of-Community Approach

A whole-of-community (WoC) approach is based on the understanding that every individual, family and institution have a role to play in a community, and that only through collective efforts can communities achieve equitable, responsive interventions and effective outcomes. Adopted from the widely employed 'whole-of-society' (WoS)[xxi] approach in sustainable development, public health, climate change, and disaster management,47 the WoC approach is a method of engaging and collaborating stakeholders across all parts of a community to address common challenges affecting the whole population, and taking concerted actions to achieve their shared and interdependent goals. It emphasizes the active involvement of governments, communities, academia, religious institutions, civil society organizations, media and other stakeholders in governance, local planning, implementation, monitoring and evaluation of community programs or services. This approach can help overcome compartmentalism and siloed work, and ensure policy coherence, collaborative ventures and effective program outcomes, ultimately strengthening resilience and inclusivity in community health systems.

Figure 2: WoC approach: Connection, communication and collaboration

xxi Generally, WoS is defined as an approach that embraces both formal and informal institutions as well as communities in seeking a collective agreement or consensus across society about policy or program goals and the means to achieve them.

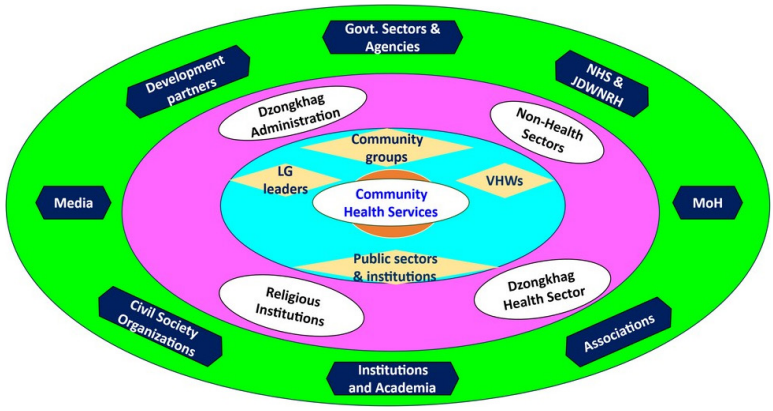

Figure 3: WoC approach to community health services

The WoC approach is a collaborative framework that underpins proactive engagements of community members, systems, institutions, and organizations to carry out shared responsibilities and inclusive decision-making and planning with a singular aim of creating well-being for all. It is grounded in a belief that sound community policies and effective governance can spark enthusiasm and help leverage collective efforts that support accountability and strategic vision. By ensuring community engagement, the WoC approach enables all relevant stakeholders to contribute to solutions for issues that affect the entire community. Central to this framework are resource sharing and community ownership, which maximize impact and sustain programs and services. Thriving on inclusive and equitable practices, the WoC approach ultimately supports the creation of empowered, socially cohesive, resilient, and sustainable communities.

The WoC approach, in the context of community health, is the community space or a tool where all stakeholders in a Gewog or Chiwog collaborate to deliberate on, advocate for, invest in, and implement community-based health policies and interventions. By fostering coordinated and synergistic efforts, this approach can bridge gaps in healthcare access, reduce health disparities and eradicate preventable diseases, eventually enhancing overall community health and well-being. The WoC approach will help prioritize health initiatives at the Gewog and Chiwog levels, with particular improvements expected in areas such as maternal and child health, nutritional status, breastfeeding practises, immunization rates, sanitation and hygiene practises. In response to the emerging health issues, the WoC approach can support the design of comprehensive community health interventions, the drive for self-care and the adoption of positive behaviour changes for a healthier lifestyle, and the promotion of preventive health services, thereby laying the foundation for resilient and inclusive community health systems.

Strategic Action Area 1: Community leadership[xxii] and local governance[xxiii] for advancing community health services

Community leadership plays a crucial role in promoting community health by fostering solidarity among diverse community players, bridging gaps between health systems and communities, ensuring adequate resource allocation, and driving community engagement to support community health initiatives. Local government leaders, including Tshogpas, act as catalysts in strengthening community health services by advocating for disease prevention measures, promoting health awareness, and encouraging communities to adopt self-care practises. Their influence can be leveraged to champion better community health services, enhance the effectiveness of health strategy implementation through robust feedback mechanisms, and facilitate collaboration between Gewog administration, healthcare system and communities. This approach ensures that shared community health concerns are addressed collectively.

Strategic Objective 1.1: Strengthening community leadership and local governance to support and advance community health services

1.1.1. Empower LG leaders to advocate for and support national health policies, primary health care, UHC and health-related SDGs in Dzongkhags, Thromdes, and Gewogs.

- » Conduct advocacy workshops for LG leaders on health policies, FYP strategies and goals, and priority diseases in collaboration with MSTF-CBSS.
- » Build capacities of LG leaders and VHWs in health governance, community leadership and health systems strengthening at a grassroots level.
- » Carry out an orientation program for LG leaders on the importance of integrating community health strategies into local government plans, demonstrating inclusive decision making, planning and implementation.

xxii Community leadership is the collective and value-driven responsibility of mobilizing, guiding and empowering people in a community to respond effectively to common health issues and achieve shared community health goals. Its key features include grassroots participation, community empowerment and collective action.

xxiii Local governance in the Bhutanese context is the process of engaging local government leaders and community members in decision-making and taking appropriate action in Dzongkhags and Gewogs to improve the health and well-being of everyone in a community, guided by the whole-of-community approach. Key features of good governance include participation, inclusiveness, equity and accountability.

1.1.2. Strengthen the roles of community members, health officials and VHWs in promoting community health initiatives by influencing community decisions on health issues, and advocating for community health during MSTF[xxiv], CBSS[xxv] and Gewog-based committee meetings, and on the Community Engagement Platform (CEP).

- » Organize orientation workshops on addressing health issues through community health strategic plans.
- » Conduct IPC-based community leadership trainings for VHWs and under-represented community members such as women, young people, people who have disability, and other marginalized groups.
- » Engage health officials, PHC in-charges and VHWs in monitoring and reporting of annual LG workplans on to promote transparency and accountability.

Strategic Objective 1.2: Fostering solidarity among community players for community health

1.2.1 Harness the local platforms such as Dzongkhag Tshogdu and Gewog Tsogde in facilitating community dialogues, prioritizing resources, and coordinating efforts for sharing responsibilities towards achieving community health goals and targets among key community players, including social sectors, CSOs, and VHWs.

- » Organize periodic meetings to bring together key community actors to lobby for community health priorities.
- » Provide technical support to the LG platforms to facilitate the inclusion of health agenda in the local planning and prioritization for community health issues.

1.2.2 Promote inclusive discussions on community health priorities in Dzongkhags, Thromdes and Gewogs, ensuring participatory decision-making where community voices are heard, and valued.

- » Facilitate open and inclusive community dialogues with LG leaders to identify and prioritize key community health priorities.

xxiv Multi-Sectoral Task Force is a multistakeholder body established in 1999 across 20 districts primarily to address the issues and prevention of HIV/ AIDS & STIs through advocacy and public awareness programs.

xxv Community Based Support System is a network of local organizations and volunteers which work towards addressing social and public health issues such as domestic violence, GBV, mental health, NDCs, etc. Since 2014, the MSTF & CBSS work in partnership at Dzongkhag and Gewog levels.

» Coordinate the participation of relevant health representatives at all levels in decision making and planning for local development plans.

1.2.3 Mainstream community health into local development plans in line with the Local Government Act (2009) provisions by incorporating community health issues and allocating resources to community health initiatives.

» Organize the community health integration workshop for LG leaders to build their capacity to systematically incorporate community health priorities into local development plans.

» Provide technical support to LGs for budget advocacy and resource allocation to mainstream community health.

1.2.4 Strengthen a coordination mechanism to engage VHWs and other community actors to promote collaborative efforts and accelerate the implementation of community health initiatives.

» Build the capacity of MSTF-CBSS working and action groups spearheaded by Dzongdags, Thrompons, and Gups on the coordination and collaboration framework for community health.

» Set up a VHW peer learning and feedback forum for sharing community feedback, best practises and challenges.

Strategic Objective 1.3: Driving community engagement for better community health governance

1.3.1 Promote multisectoral alliances and synergy through a community engagement mechanism for a coordinated and consensus-based governance for community health.

» Leverage the community platforms such as Community Engagement Platform (CEP), and MSTF-CBSS to discuss shared goals, align resources, and foster community stewardship[xxvi] among key sectors and institutions in Gewogs to advance community health programs.

» Develop and implement a robust community engagement framework to build consensus, coordinate and track joint community framework program activities, measure outcomes, and ensure accountability.

xxvi It is the practise of making collective efforts, engaging all relevant stakeholders, in managing and sharing resources, facilities and systems in a sustainable way in a community setting.

Strategic Objective 1.4: Applying social determinants of health[xxvii] (SDH) to address community health issues

1.4.1 Advocate for and integrate the concepts of social determinants of health (SDH)into Dzongkhag, Thromdes, and Gewog policy-making and planning processes, particularly emphasizing on the inter-relatedness or interdependence of sectors and the impact of their decisions or actions on the community health outcomes.

- » Conduct policy integration workshops for the LG leaders to deepen their understanding of SDH and applying SDH frameworks to local policy development, planning and implementation.
- » Build the capacity of the community health team (healthcare professionals, VHWs, Tshogpas and community members) on the HiAP, health equity, WoC approach, etc. to understand how decisions in various sectors affect community health outcomes.

1.4.2 Conduct a community-based health assessment to systematically gather and use data on social, economic and environmental factors that influence community health outcomes.

- » Train the community health team in adapting standard assessment tools as applicable to a community context.
- » Conduct assessments in selected Dzongkhags or Gewogs to obtain data that can provide insights into community health needs and help reshape community health interventions.

1.4.3 Promote SDH-driven and whole-of-community approach to community health programming for mutual gains and shared benefits.

- » Organize interactive sessions with LG leaders and VHWs to advocate for integrating WoC approach into community dialogues or in relevant discussion forums and applying it in co-creating the community health initiatives.
- » Facilitate community dialogues on the role of SDH in addressing the root causes of health inequities by understanding the interdependence of sectors.

xxvii WHO defines SDH as the conditions in which people are born, grow, live, work and age. Key social determinants include education, income, working conditions, culture, gender, polices, etc., which significantly influence health outcomes and can contribute to health inequities. Addressing SDH requires action across multiple sectors and actors.

» Advocate for the allocation of adequate funds for community-based public health programme activities to address social determinants of health.

Strategic Action Area 2: Redefining the roles of Village Health Workers

VHWs, dratshang health coordinators, school counsellors, health counsellors, and other community-based volunteers must be equipped to address the evolving health needs of communities they serve. Among these, VHWs in particular need to transform and remain relevant to the changing health challenges that communities are facing, including the emerging public health issues, inadequate nutritional practices and the alarming rise of non-communicable diseases (NCDs) in rural areas, the prevalence of people with disabilities, aging population and mental health issues among young people. Local governments and community health systems must support the transformation of VHWs by redefining current roles of VHWs, revamping their traditional responsibilities, and exploring the feasibility of incorporating more comprehensive functions, such as home-based chronic disease management, mental health support, life-saving interventions, self-care advocacy in preventive health, and the promotion of digital health literacy. As technology becomes more integrated into healthcare, VHWs can be equipped with skills to help communities navigate digital health tools, such as mobile health apps, ensuring that technological advancements benefit particularly those living in remote villages. Reshaping the roles of VHWs will not only increase their relevance to the present context but also reinforce the overall community health system, resulting in better health outcomes and increased community resilience.

Strategic Objective 2.1: VHWs as catalysts for advancing self-care[xxviii] and promoting community health and well-being

2.1.1 Empower and capacitate VHWs to deliver targeted and context-specific health education and behavioural change self-care actions focusing on preventive measures, and lifestyle modifications, covering interventions on mental well-being, elderly care, disability, sexual and reproductive health, nutritional practices and other important NCDs.

» Develop culturally relevant IEC materials for VHWs to use when guiding communities on lifestyle modifications, preventive health measures and self-care practises.

xxviii WHO defines self-care as the ability of individuals, families and communities to promote health, prevent diseases, maintain health, and cope with illness and disability with or without the support of a healthcare professional. Self-care interventions can include medicines, devises, diagnostics and digital tools while the self-care actions can include healthy practises, habits and lifestyle choices. https://www.who.int/health-topics/self-care#tab=tab_1 refer to the annexture 3 for the types of self-care.

- » Organize workshops to equip VHWs with necessary knowledge and skills to effectively deliver targeted health education on important public health concerns and help improve community health literacy.
- » Conduct on-site training, regular formative supervision, tutoring and coaching.

2.1.2 Develop comprehensive self-care manuals/tools/booklets for VHWs and community members to improve self-care awareness and practise positive lifestyle modifications in response to both existing and emerging health issues people are concerned with.

- » Design interactive, visually alluring and user-friendly self-care guides and digital tools on 'My Healthy Life'[xxix] tailored to local literacy levels and health needs.
- » Conduct workshops on self-care tools through demonstrations and active discussions.

2.1.3 Equip VHWs to act as tech-enabled self-care advocates by providing them with knowledge and skills on digital tools such as mobile apps, eHealth, etc., to effectively disseminate health information, encourage early health screening and disease detection, and help initiate timely referrals and treatment.

- » Conduct digital health workshops to familiarize VHWs with mobile apps, eHealth platforms and other digital tools on community health promotion.
- » Develop a mobile-based support digital network to connect VHWs with healthcare workers for remote consultations, guidance and referrals.

Strategic Objective 2.2: VHWs as focal points for multistakeholder collaboration in health[xxx]

2.2.1 Engage VHWs with local governments at Dzongkhag and Gewog levels, non-health sectors, MSTF-CBSS, and religious institutions in community dialogues, local planning, resource allocation for community health programs, and aligning community health outcomes with the broader community development goals.

xxix Covering themes such as 'Mind Matters', 'NCD Fighters', 'SRH Choices', 'Disability Inclusion', etc.

xxx It is an approach where all relevant stakeholders work concertedly as a team to address complex health challenges, formulate polices and implement new interventions that no single stakeholder can solve alone. This approach helps leverage resources by pooling diverse expertise, sharing financial burden, streamlining logistics, etc.

» Organize 'community dialogues' with all stakeholders to align community health with community development priorities and foster multi-stakeholder collaboration.

2.2.2. Involve VHWs in mobilizing community support, fostering community participation, garnering multi-stakeholder efforts, driving community health advocacy, and conducting community health awareness campaigns.

» Strengthen a community health team in Gewogs and Chiwogs to conduct multi-stakeholder health advocacy campaigns for garnering support for community health-related initiatives.

Strategic Objective 2.3: VHWs as champions in improving healthcare access among the vulnerable population

2.3.1 Support in conducting the annual household-health surveillance (AHS)[xxxi] in gewogs, and carry out the profiling of vulnerable populations, including elderly persons, homebound patients, and those with chronic health conditions.

» Integrate VHWs in the AHS program of the MoH.

» Provide capacity building trainings to health workers and VHWs on standardized AHS tools for data collection.

» Coordinate with the AHS program in developing a digital health registry for vulnerable populations.

2.3.2 Organize home visits, under the supervision of PHC healthcare workers, to provide essential services, including medication refills, follow ups, health education and referrals.

2.3.3 Improve health literacy by initiating community-embedded health awareness and advocacy programs during community social gatherings (tshechus, religious events, local festivals) on preventive care, self-care, mental health, noncommunicable diseases, etc.

» Embed culturally tailored health literacy topics into local festivals and community gatherings in collaboration with religious figures and LG leaders.

xxxi AHS is a recently launched initiative of the MoH that is aimed at strengthening primary healthcare by bringing essential services directly to the doorsteps of communities. It is a service-oriented program where the health workers will deliver basic health services while simultaneously gathering real-time data at the household level. The AHS will include hygiene promotion, screening for NCDs, elderly care and health education. It will be institutionalised nationwide as a core public heath function with dedicated structures for planning, budgeting and oversight.

» Organize health education booths for the general public during religious events and local festivals. Trained VHWs can disseminate information on self-care, preventive care, NCDs, etc, and provide educational materials on adopting healthy lifestyles.

2.3.4 Utilize the CEP to effectively discuss emerging health issues, disseminate health messages, and secure support for future disease prevention activities.

» Conduct interactive sessions with the community stakeholders using the CEP to address emerging community health issues, discuss pressing concerns, and propose possible solutions.

Strategic Objective 2.4: VHWs as team members in capacity building and peer-to-peer learning

2.4.1 Involve VHWs in supporting training programs on community health, under the supervision of healthcare professionals, for volunteers in their communities.

» Conduct a VHW-led training sessions on self-care strategies and community health initiatives for other community-based volunteers such as religious health coordinators, CBSS members from community, and traditional healers.

» Develop a mentorship program for new VHW volunteers (particularly those who have not received a formal VHW training by providing hands-on training and practical demonstrations by their seniors.

2.4.2 Coordinate and participate in inter-dzongkhag learning exchange programs where VHWs from different Dzongkhags share best practises, challenges and innovative solutions.

» Organize peer-to-peer learning workshops for VHWs from different Dzongkhags to present their best practises, challenges and innovation solutions.

» Engage in organizing 'VHW Day' in Dzongkhags on the international volunteer day.

» Develop a digital VHW learning and networking platform to connect VHWs from different Gewogs for sharing leaning materials, experiences and success stories.

2.4.3 Support PHCs in coordinating and monitoring the distribution of and maintaining the inventory of essential medical supplies to ensure uninterrupted community health services.

Strategic Action Area 3: Sustaining motivation and retention of Village Health Workers

Sustaining the motivation and retention of VHWs require a multifaceted approach that combines social recognition, incentives, and continuous institutional support. Publicly acknowledging their contributions, providing supportive supervision, and improving access to necessary resources can elevate their morale, work satisfaction and long-term commitment. Involving VHWs in the decision-making process at Gewog and Chiwog levels, bolstering partnership between VHWs and community-based institutions, and increasing community engagement in program activities will further reinforce their sense of purpose and confidence. Together, these strategies create a supportive environment that not only enhances motivation but also improves retention rates, thereby ensuring that VHWs remain a resilient and integral force in accelerating community health services.

Strategic Objective 3.1: Elevating the social recognition and status of village health workers

3.1.1 Enhance the perceived social value and significance of VHWs.

- » Rename their titles to align with their empowered roles, reflecting their multifaceted and leadership role in promoting community health.
- » Provide an official VHW identification card/badge with their new title and personal information, validating their role and uplifting their credibility in the community.
- » Provide public recognition and acknowledgement to VHWs for their dedication, hard work, and contributions to the community well-being at national and local events, and in media and government communications.

3.1.2 Develop the competency and confidence of VHWs in primary healthcare, community leadership, and partnership building supported by the Dzongkhag Health Sector, Ministry of Health and Gewog Administration.

3.1.3 Ensure uniform exemption of VHWs from mandatory community labour contributions across the country, acknowledging their volunteer work as an equivalent contribution, and supporting their long-term engagement in the delivery of quality community health services.

» Issue an executive order from the appropriate government body or Ministry to all the Dzongkhags and Gewogs to ensure uniform implementation of the Wola exemption practice.

Strategic Objective 3.2: Empowering VHWs to engage in local governance

3.2.1 Advocate for strategic involvement of Village Health Workers (VHWs), as and when required, in Gewog-level planning to ensure that community health priorities are adequately reflected, and health interventions are context-appropriate.

» Organize policy advocacy meetings with local governments to emphasize the importance of VHW engagement in the local government decision-making forums.

» Build the capacity of VHWs through a structured leadership program (focussing on health governance, policy advocacy, negotiation skills and interpersonal communication) to enable effective engagement and sustained influence in local policy-making, planning and service delivery.

3.2.2 Institutionalize VHW representation in all relevant zomdus (community meetings) to ensure that health remains a priority on the community development agendas.

» Formalize the participation of VHWs (along with PHC staff if required) in all community meetings/zomdus.

3.2.4 Establish a feedback mechanism to submit health issues to Dzongkhag and Gewog officials before annual planning and budget allocation sessions.

» Develop a reporting framework for VHWs and any community members to submit community health concerns through standardised reporting forms or a digital enabled system like SMS-based reporting or voice message hotline or mobile apps enabled reporting.

Strategic Objective 3.3: Strengthening motivations of VHWs through logistical support

3.3.1 Equip VHWs with basic filed kits and supplies to help them overcome environmental and logistical challenges in delivering community health services. specifically, such supplies may include raincoats, boots, umbrellas, backpacks, chargeable torches, water bottles, etc.

3.3.2 Enhance service efficiency and quality by providing VHWs with medical kits, tools and information, education and communication (IEC) materials to support health literacy activities, including self-care.

3.3.3 Improve service delivery capacity of VHWs through comprehensive training programs on the effective use of health equipment and IEC materials.

Strategic Action Area 4: Systems support for VHWs and Community Health Services

A systems support is crucial to maximize the efficiency of VHWs and ensure the delivery of quality community health services. This includes integrated training and continuous capacity building to equip them with the updated skills, knowledge and values on diverse health issues, service delivery methods and other best practises. The development and implementation of clear standards and guidelines will help define roles and responsibilities of VHWs, maintain consistent quality of care, and standardize selection and recruitment processes. An effective supply chain system is essential to guarantee uninterrupted supplies of essential medical supplies, appropriate digital tools, and health education materials, thereby sustaining the quality services. In addition, a monitoring framework to provide regular supervision and mentorship will foster team building and a sense of belonging and shared responsibility. These measures will strengthen the support system, enhance the effectiveness of VHWs in delivering services, and invariably bolster the community health services.

Strategic Objective 4.1: Fostering community embeddedness in the management of VHWs

4.1.1 Establish structured mechanisms to institutionalize the community ownership of VHW programs and engage LG leaders and community members in the management of VHWs.

- » Integrate the VHW management and retention plan in the VHW recruitment guideline in consultation with the Dzongkhag and Gewog Administrations.
- » Devise a framework for shared responsibility of Gewog resources to invest in community health priorities and interventions.
- » Engage VHWs in community action groups or Gewog or Chiwog Committees for community health development in Gewogs or Chiwogs under the chairmanship of a Gup using the whole-of-community approach within the framework of LG provisions.

4.1.2 Promote participatory monitoring and social accountability by embedding community voices in community health program performance and improvement (tracking VHW activities, resource management and community feedback platform).

- » Develop a system or a platform to implement a community-led monitoring of community health services through transparent performance tracking or participatory scorecard system where community stakeholders assess the progress of community health program implementation.
- » Develop a public dashboard to be displayed at Primary Health Centers with information on VHW performance ratings, complaints received, issues resolved, resources mobilized, etc.

Strategic Objective 4.2: Enhancing training and continuous skill development for VHWs

4.2.1 Develop the national VHW service standards covering both core technical areas (MCH, NCDs, SRH, mental health, etc.) and essential soft skills (IPC, counselling, leadership, etc.) to ensure uniformity and consistency in service delivery.

- » Set up a multi-disciplinary team with representatives from Dzongkhags or Gewogs to guide the formulation of standards, with integration of community perspectives.
- » Organize expert consultations and national workshops to valid the draft standards.

4.2.2 Establish a tiered certification system with clearly defined levels – basic, intermediate and advanced – each level linking to the specific training requirements and the readiness of VHWs to render quality community health services.

- » Collaborate with the quality assurance and accreditation divisions of the MoH and KGUMSB to establish certification requirements for the three-level VHW training manuals.
- » Update the VHW training manuals in accordance with the national VHW national service standards and international (WHO/UN) guidelines.

4.2.3 Enhance the capacity of VHWs to address emerging community health needs.

- » Provide trainings to VHWs on the revised/updated training manual.
- » Prepare VHWs as frontline health emergency responders in times of disease outbreaks, natural disasters and casualty incidents.
- » Build competencies in climate-related health risks, disaster readiness, minimum initial service package (MISP) in humanitarian crisis, and the social determinants of health to tackle wider community health issues.
- » Equip VHWs with digital health tools, such as mHealth and eHealth applications, to enable technology-driven learning, seamless information exchange and peer-to-peer communications.
- » Organize national and international programs to share best practise experiences and innovations in community health service delivery.
- » Partner with KGUMSB to expand educational and training opportunities, strengthening VHW knowledge and skills.

Strategic Objective 4.3: Providing supportive supervision and structured mentoring

4.3.1 Establish a supportive supervision system for VHWs at Dzongkhag and Gewog levels to provide mentorship, ensure adherence to work standards, track community health targets, identify issues early, and enforce accountability.

- » Designate trained supervisors for VHWs with well-defined roles and expertise in mentorship techniques, including adult learning principles, positive reinforcement methods and solution-based coaching.
- » Develop a standardised monitoring checklist to assess service quality, accuracy of record keeping, and effectiveness of community engagement and leadership.
- » Conduct an annual supervisor-VHW meeting to facilitate the exchange of feedback, evaluate performance indicators, and collaboratively discuss challenges and solutions.
- » Conduct satisfaction surveys for both VHWs and beneficiaries of VHW services.

4.3.2 Enhance communications between supervisors and VHWs using appropriate digital platforms such as WhatsApp, Telegram, and WeChat to facilitate efficient information exchange, case consultations, announcements, discussions, reporting, referrals, and emergency response coordination.

Strategic Objective 4.4: Creating an enabling environment for effective service delivery

4.4.1 Develop a national guideline to manage and operate the VHW workforce in a cohesive and coordinated manner, delineating roles and responsibilities of VHWs, covering operational frameworks and a clear channel of communication and command hierarchy to streamline service delivery and ensure effective implementation of community health programs across Dzongkhags and Gewogs. The guideline will include:

- Mandate, legal status, rights and protections,
- Operational structures and accountability lines,
- Role specifications and limitations,
- Communication pathway.

4.4.2 Establish efficient support systems at Dzongkhag and Gewog levels through VHW resource centres for supply replenishment (first aid kits, equipment, IEC materials, manuals) and multisectoral support.

4.4.3 Develop a community engagement toolkit containing community facilitation guide, feedback checklist and community satisfaction survey forms.

- Design a user-friendly community engagement toolkit to standardize community engagements in community health programs.
- Train LG leaders and VHWs on toolkit utilization for facilitating open discussions, obtaining feedback and evaluating community satisfaction.

Strategic Action Area 5: Partnership for community health at national and sub-national levels

Strengthening partnerships for community health requires a whole-of-community approach that brings together local governments, healthcare system, institutions, religious bodies, community volunteers, and community members to ensure program alignment, shared responsibility and accountability. Engaging stakeholders of relevant sectors and organizations at national and sub-national

levels is essential to forge dynamic multisectoral collaborations that drive the successful implementation and sustainability of community health programs at the grassroots level. Establishing clear communication channels and collaboration platforms among these agencies will enhance coordination, resource-sharing, and strategic alignment across national, district, and Gewog levels. Furthermore, engaging local government leaders, health workers, religious institutions, and community groups (Tshogpas) enables the design of effective, targeted interventions that address the most pressing health issues affecting the wider community. To foster collaboration, relevant community stakeholders will jointly implement a monitoring and evaluation framework to measure program outputs and outcomes. Ultimately, building strong partnerships will pool vital resources, expertise, and efforts, while ensuring the vertical integration (national to sub-national) and horizontal linkages (cross-sectoral) necessary to transform the community health program into a true whole-of-community movement.

Strategic Objective 5.1: Fostering stakeholder collaboration at the national level

5.1.1 Leverage the MSTF-CBSS forum to steer the national-level multisectoral community health governance, ensuring policy alignment, program directives, inter-agency collaboration, and effective resource mobilization. Key stakeholders, including the government ministries (MoESD, MoF, MoAF, MoHCA, etc.), development partners (UNICEF, WHO, UNFPA, WB, UNDP, etc.), public institutions (Dratshang Lhentshog and KGUMSB) and civil society organizations (RENEW, Red Cross, Ability Bhutan, etc.), along with the representatives from Dzongkhags, should participate to promote inclusive governance and strategic coordination.

- » Align with the existing national guideline on partnership frameworks.
- » Promote collaboration across relevant government departments, public health programs, academic institutions, JDWNRH and civil society organizations to support the integrated programming and implementation of community health initiatives.
- » Enhance platforms and mechanisms that align partner efforts with national priorities, ensuring policy and program coherence.

5.1.2 Evaluate the impact of VHW program initiatives on community health outcomes by conducting quality research supported through multistakeholder partnerships.

- » Establish institutional linkages with academic institutions, research institutes, government agencies and CSOs to foster collaboration in high-quality community health studies.
- » Study the effectiveness of the VHW program using robust research methods on community health outcomes, behavioural changes and systems efficiencies.

Strategic Objective 5.2: Reinforcing local partnerships to drive community health actions

To maximize resources and expertise for community health interventions, the VHW SAP will strengthen and sustain strategic partnerships among local civil society organizations (CSOs), community-based organizations (CBOs), and private sector stakeholders. By actively engaging grassroots networks, the initiative aims to foster synergies in community health planning and implementation, with representation from the Dzongkhag Health Sector (DPHOs), Gewog Administration (Gups, Mangmis and Tshogpas) and diverse community members (religious figures, teachers, women, youth, elderly, etc.). Such coordination and collaboration will help identify health priorities, equitable resource allocation, and effective oversight of community health activities.

5.2.1 Build capacities of local government actors in Dzongkhags and Gewogs to strengthen local leadership, enhance evidence-based planning, and foster accountability in the delivery of community health services by conducting community health partnership and leadership seminars, training sessions on community health prioritization and programming, and joint monitoring and evaluation workshops.

4. VHW SAP INDICATORS

Country's Vision	A HIGH-INCOME GROSS NATIONAL HAPPINESS ECONOMY BY 2034
13th FYP priorities of RGoB	(1) Be a high-income country driven by innovation and sustainability. (2) Have a healthy and productive society founded on equitable and high-quality health, education and social protection. (3) Safeguard and strengthen sovereignty, territorial integrity, security, unity, well-being, resilience and economic prosperity. (4) Have a transformed and trusted governance ecosystem that drives accelerated economic growth and improves people's lives.
13th FYP's Mission and Outputs of MoH (Healthy Drukyul Program)	By 2029, More Bhutanese enjoy improved health and well-being. Outputs: (i) More Bhutanese practice healthy lifestyle; (ii) Control and elimination of priority diseases achieved; (iii) Quality health and health-related services & produced improved; (iv) Adequacy and competency of health workforce ensured; (v) Innovative governance and health financing systems are in place; (vi) Regulatory, monitoring & health security system strengthened; (vii) Information & technology harnessed to enhance healthy systems efficiency.

	Vision: Empowered and thriving communities that contribute to the MoH's aspiration of achieving the nation with the best health. **Mission:** Strengthening the Primary Health Care system in Gewogs to ensure equitable access to responsive and inclusive health services, thereby supporting the attainment of Universal Health Coverage. **Goal of VHW SAP:** By 2030, every Gewog will have improved access to high quality community health services, effectively supported by empowered village health workers, resilient community health systems and strong local governance structures.					
VHW-SAP (2025 - 2030) Strategic Priorities (in a health systems framework)	**LEADERSHIP AND GOVERNANCE**	**SERVICE DELIVERY**	**HEALTH SYSTEMS FINANCING**	**HEALTH WORKFORCE**	**MEDICINES, EQUIPMENT AND TECHNOLOGIES**	**MONITORING AND EVALUATION**
	Strengthening community leadership and local governance to support and advance community health programs. Fostering solidarity among community players for community health governance.	Empowering VHWs to deliver targeted and context-specific health education and behavioral change self-care actions. Improving healthcare access among the vulnerable population.	Exploring incentives for VHWs. Collaborating for sustaining community health services. Reinforcing community level partnerships for community health actions.	Fostering community embeddedness in managing VHWs. Enhancing training and continuous skill development for VHWs. Elevating the social status of VHWs.	Creating an enabling environment for service delivery. Supplies for boosting motivations of VHWs Transform VHWs into tech-enabled self-care advocates using appropriate digital applications.	Providing supportive supervision and mentoring to VHWs. Engage LG officials and VHWs in developing and implementing a monitoring and reporting framework.

Strategic Areas	Strategic Objectives	Strategic Outcomes	Output Indicators	Outcome Indicators (by 2030)	Sources of Data
I. COMMUNITY LEADERSHIP AND LOCAL GOVERNANCE FOR ADVANCING COMMUNITY HEALTH SERVICES	SO 1.1: Strengthening community leadership and local governance to support and advance community health services.	LG leaders advocated for community health mainstreaming in local planning.	Indicator: Number of trained LG leaders on community health programs and priorities. Baseline – 0; Target – At least two LG officials from each Gewog. Indicator: Community health issues addressed through an integrated planning. Baseline – No; Target – Yes	Indicator: Percentage of Gewogs that implemented integrated community health planning. Baseline – 0%; Target – 90%	• LG meeting reports. • Dzongkhag Health Sector reports.
	SO 1.2: Fostering solidarity among community players for community health.	Promoted community health integration through inclusive planning.	Indicator: Community health priorities discussed in LG meetings with participation of VHWs and health workers. Baseline – No; Target – Yes	Indicator: Percentage of Gewogs with community health strategies as part of the local development plans. Baseline – NA; Target – >90%	• DT and GT reports.
	SO 1.3: Driving community engagement for better community health governance.	Strengthened community health governance through community engagement.	Indicator: Number of times VHWs represented in LG meetings. Baseline – 0; Target – > 2 times in a year. Indicator: Community health priorities discussed in LG meetings. Baseline – No; Target – Yes.	Indicator: Percentage of Gewogs engaging community members in community health decision-making process. Baseline – 0; Target – >90%	• LG meeting reports. • DHS data.
	SO 1.4: Applying social determinants of health (SDH) to address community health issues.	Integrated SDH concepts into community health policy making and planning at the LG level.	Indicator: Awareness programs on SDH for LG leaders. Baseline – No; Target – Yes. Indicator: Percentage of VHWs & PHC staff trained on SDH per Gewog. Baseline – 0%; Target – 50%. Indicator: Number of intersectoral collaboration meetings addressing community health in a Gewog. Baseline – 0; Target – at least 2 times in a year. Indicator: Number of Gewogs undertaken HIA/SDH trainings. Baseline – 0; Target – >20.	Indicator: Composite health indicators related to WASH, RMNCAH, NCDs, Disability, HIV/STI, Malaria, etc. Indicator: Percentage of selected Gewogs with SDH data. Baseline – 0; Target – 100% Indicator: Proportion of community health interventions influenced by SDH data in selected Gewogs. Baseline – 0; Target – 50%	• MoH HMIS data. • Public Health Program data. • DHS data.

Strategic Areas	Strategic Objectives	Strategic Outcomes	Output Indicators	Outcome Indicators (by 2030)	Sources of Data
II. REDEFINING THE ROLES OF VILLAGE HEALTH WORKERS	SO 2.1: VHWs as catalysts for advancing self-care and promoting community health and well-being.	Communities adopted preventive health behaviours.	Indicator: Number of VHWs trained on self-care tools in each selected Gewog. Baseline – 0; Target – 2. Indicator: Number of self-care sessions conducted by VHWs in each pilot Gewog. Baseline – 0; Target – 5. Indicator: Number of communities using self-care tools and resources in each selected Gewog. Baseline – 0; Target – 2.	Indicator: Percentage of selected Gewogs with health literacy rate on self-care. Baseline – 0%; Target – 95%. Indicator: Percentage of communities practicing self-care behaviours in selected Gewogs. Baseline – 0%; Target – > 90%.	• VHW program data. • DHS data.
	SO 2.2: VHWs as focal points for multistakeholder collaboration in health.	Strengthened multistakeholder support for community health initiatives.	Indicator: Number of times VHWs facilitated community stakeholder meetings in a year. Baseline – 0; Target – > 2. Indicator: Number of joint initiatives participated by VHWs in a year. Baseline – 0; Target – > 2.	Indicator: Percentage of stakeholders engaged in community health collaborative efforts. Baseline – 0; Target – 95%. Indicator: Community support secured through VHW-led advocacy and coordination programs. Baseline – No; Target – Yes.	• VHW program data. • DHS data.
	SO 2.3: VHWs as champions in improving healthcare access among vulnerable population.	Vulnerable populations gained increased access to community health services.	Indicator: Number of tailored outreach programs for vulnerable populations in selected Gewogs. Baseline – No; Target – 3/year. Indicator: Supported in referrals for advanced medical care in selected Gewogs. Baseline – NA; Target – Yes.	Indicator: Percentage of vulnerable population receiving community health services in selected Gewogs. Baseline – O%; Target – >90%.	• VHW program data. • DHS data.
	SO 2.4: VHWs as team members in capacity building and peer-to-peer learning.	Enhanced efficiency in health service delivery.	Indicator: Number of training sessions assisted by VHWs. Baseline – 0; Target – minimum of 2. Indicator: Increased ability of VHWs to deliver community health services. Baseline – No; Target – Yes. Indicator: Communities have access to essential health commodities facilitated by VHWs. Baseline – NA; Target – Yes.	Indicator: Improved community health service delivery. Baseline – NA; Target – Yes.	• VHW program data. • DHS data.

Strategic Areas	Strategic Objectives	Strategic Outcomes	Output Indicators	Outcome Indicators (by 2030)	Sources of Data
III. SUSTAINING MOTIVATION AND RETENTION OF VILLAGE HEALTH WORKERS	SO 3.1: Elevating the social recognition and retention of village health workers.	Motivated VHWs sustained the community health services.	Indicator: Number of Dzongkhags awarding a merit certificate to VHWs. Baseline – 0; Target – 20. Indicator: Number of VHWs formally recognized for their outstanding performance. Baseline – 0; Target – 20 VHWs per year. Indicator: Increase in community participation in VHW-led community health activities. Baseline – No; Target – Yes.	Indicator: Reduced attrition rate. Baseline – About 20 VHWs leaving per year; Target – Reduce by 50%. Indicator: Percentage of VHWs motivated. Baseline – No data; Target – >90%.	• VHW program data. • DHS data.
	SO 3.2: Empowering VHWs to engage in local governance.	Improved local governance for community health through empowered VHWs.	Indicator: Number of VHWs attending LG meetings advocating for community health. Baseline – 0; Target – 100 per year. Indicator: Community awareness of VHW-led community health initiatives. Baseline – No; Target – Yes. Indicator: Number of health-related recommendations made by VHWs. Baseline – 0; Target – 2 per year per Gewog.	Indicator: Percentage of Gewogs with community health program initiatives influenced by VHW's participation. Baseline – 0%; Target – 90% . Indicator: Percentage of LG members satisfied with VHWs' engagement with local governance. Baseline – No data; Target – >90%.	• VHW program data. • DHS data.
	SO 3.3: Strengthening motivation of VHWs through logistical support.	Enhanced community health service delivery supported by motivated VHWs. Improved performance and service delivery by motivated VHWs.	Indicator: Number of community health interventions implemented by VHWs. Baseline – No data; Target – 2 per Gewog. Indicator: Increased community participation in community health initiatives. Baseline – No; Target – Yes. Indicator: Number of HHs expressing satisfaction with VHW-led community health interventions. Baseline – No data; Target – 5 per Chiwog.	Indicator: Percentage of VHWs demonstrating improved service delivery. Baseline – No data; Target – 95% . Indicator: Percentage of VHWs reporting increased work satisfaction. Baseline – No data; Target – >90%. Indicator: Percentage of HHs seeking community health services from VHWs. Baseline – No data; Target – >90% .	• VHW program data. • DHS data.

Strategic Areas	Strategic Objectives	Strategic Outcomes	Output Indicators	Outcome Indicators (by 2030)	Sources of Data
IV. SYSTEMS SUPPORT FOR VHWs AND COMMUNITY HEALTH SERVICES	SO 4.1: Fostering community embeddedness in the management of VHWs.	Sustained VHW services in communities.	Indicator: Involvement of LG leaders in the management of VHWs. Baseline – No; Target – Yes. Indicator: Improved community perception score on VHWs contributions. Baseline – No data; Target – Yes. Indicator: Increased community engagement in VHW-supported community health activities. Baseline – No data; Target – Yes.	Indicator: Percentage of local resources mobilized for community health initiatives. Baseline – No data; Target – 10% per Gewog. Indicator: Percentage of HHs seeking services from VHWs. Baseline – No data; Target – >50% per Chiwog.	• DHS data.
	SO 4.2: Enhancing training and continuous skill development for VHWs.	Empowered VHWs sustained community health services in Gewogs.	Indicator: Percentage of VHWs who completed mandated training programs. Baseline – No data; Target – >95%. Indicator: Availability of national VHW competency standards. Baseline – No; Target – Yes. Indicator: Number of VHWs participating in AHS program. Baseline – 0; Target – All VHWs per Gewog. Indicator: Number of VHWs participating in emergency response and outbreak management. Baseline – No data; Target – >5 VHWs per Gewog.	Indicator: Reduction in preventable health issues in Gewogs. Baseline – No data; Target – Yes. Indicator: Number of successful community health interventions supported by trained VHWs Baseline – 0; Target – >2 per Gewog.	• DHS data.
	SO 4.3: Providing supportive supervision and structured mentoring.	Improved community health outcomes supported by competent and confident VHWs.	Indicator: Percentage of VHWs who completed mentorship training program. Baseline – 0%; Target – >90% of VHWs per Gewog. Indicator: Number of VHWs receiving regular feedback and coaching. Baseline – 0; Target – >5 VHWs per Gewog.	Indicator: Number of successful community health programs supported by confident VHWs. Baseline – 0; Target – >3 per Gewog.	• DHS data.
	SO 4.4: Creating an enabling environment for effective service delivery.	Systems for VHW functioning optimally strengthened.	Indicator: Increased availability of logistical support. Baseline – No data; Target – Yes. Indicator: Availability of VHW guidelines and protocols. Baseline – No; Target – Yes. Indicator: Increased work satisfaction scores of VHWs. Baseline – No data; Target – Yes.	Indicator: Percentage of VHWs receiving adequate resources. Baseline – No data; Target – >95% of VHWs per Gewog. Indicator: Policies and programs implemented to support VHWs. Baseline – No data; Target – Yes.	• VHW program data.

Strategic Areas	Strategic Objectives	Strategic Outcomes	Output Indicators	Outcome Indicators (by 2030)	Sources of Data
V. PARTNERSHIP FOR COMMUNITY HEALTH AT NATIONAL AND SUB-NATIONAL LEVELS	SO 5.1: Fostering stakeholder collaboration to at the national level.	Enhanced multisectoral governance and collaboration for community health programs.	Indicator: Number of MSTF-CBSS meetings conducted to address community health issues. Baseline – 0; Target – 2 times/year /Gewog. Indicator: Number of joint programs implemented to address community health issues. Baseline – 0; Target – 3/year. Indicator: Stakeholders actively participating in knowledge-sharing platforms. Baseline – No; Target – Yes. Indicator: Number of studies on best practices & the effectiveness of VHWs conducted. Baseline – 0; Target – 2 in the 13th FYP period.	Indicator: Mobilized resources for community health programs though multistakeholder partnerships. Baseline – No; Target – Yes. Indicator: Improved stakeholder participation for advancing community health. Baseline – No; Target – Yes.	• VHW program data.
	SO 5.2 Reinforcing local partnerships to drive community health actions.	Enhanced knowledge sharing and community health program alignment at the LG level.	Indicator: Partnerships formed between VHWs and local institutions. Baseline – No; Target – Yes.	Indicator: Number of community health interventions formulated through stakeholder collaboration. Baseline – 0; Target – 2/gewog.	• DHS data.

5. VHW SAP OPERATIONAL & IMPLEMENTATION MATRIX

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
I. COMMUNITY LEADERSHIP AND LOCAL GOVERNANCE FOR ADVANCING COMMUNITY HEALTH SERVICES	Strengthening community leadership and local governance to support and advance community health services.	• Conduct advocacy workshops for LG leaders on health policies, FYP strategies and goals, and priority diseases in collaboration with MSTF-CBSS. • Build capacities of LG leaders and VHWs in health governance, community leadership and health systems strengthening at a grassroots level. • Carry out an orientation program for LG leaders on the importance of integrating community health strategies into local government plans, demonstrating inclusive decision making, planning and implementation. • Organize orientation workshops on addressing health issues through community health strategic plans. • Conduct IPC-based community leadership trainings for VHWs and under-represented community members such as women, young people, people who have disability, and other marginalized groups. • Engage health officials, PHC in-charges and VHWs in monitoring and reporting of annual LG workplans on to promote transparency and accountability.	x	x	x			MoH & DHS	Dzongkhag and Gewog Administrations and Thromdes
	Fostering solidarity among community players for community health.	• Organize periodic meetings to bring together key community actors to lobby for community health priorities. • Provide technical support to the LG platforms to facilitate the inclusion of health agenda in the local planning and prioritization for community health issues. • Facilitate open and inclusive community dialogues with LG leaders to identify and prioritize key community health priorities. • Coordinate the participation of relevant health representatives at all levels in decision making and planning for local development plans. • Organize the community health integration workshop for LG leaders to build their capacity to systematically incorporate community health priorities into local development plans. • Provide technical support to LGs for budget advocacy and resource allocation to mainstream community health. • Build the capacity of MSTF-CBSS working and action groups spearheaded by Dzongdags, Thrompons, and Gups on the coordination and collaboration framework for community health. • Set up a VHW peer learning and feedback forum for sharing community feedback, best practises and challenges.	x	x	x			MoH & DHS	Dzongkhag and Gewog Administrations and Thromdes

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
I. COMMUNITY LEADERSHIP AND LOCAL GOVERNANCE FOR ADVANCING COMMUNITY HEALTH SERVICES	Driving community engagement for better community health governance.	• Leverage the community platforms such as Community Engagement Platform (CEP), and MSTF-CBSS to discuss shared goals, align resources, and foster community stewardship among key sectors and institutions in Gewogs to advance community health programs. • Develop and implement a robust community engagement framework to build consensus, coordinate and track joint community framework program activities, measure outcomes, and ensure accountability.	x	x				MoH & DHS	Dzongkhag and Gewog Administrations and Thromdes
	Applying social determinants of health (SDH) to address community health issues.	• decisions or actions on the community health outcomes. • Conduct policy integration workshops for the LG leaders to deepen their understanding of SDH and applying SDH frameworks to local policy development, planning and implementation. • Build the capacity of the community health team (healthcare professionals, VHWs, Tshogpas and community members) on the HiAP, health equity, WoC approach, etc. to understand how decisions in various sectors affect community health outcomes. • Train the community health team in adapting standard assessment tools as applicable to a community context. • Conduct assessments in selected Dzongkhags or Gewogs to obtain data that can provide insights into community health needs and help reshape community health interventions. • Organize interactive sessions with LG leaders and VHWs to advocate for integrating WoC approach into community dialogues or in relevant discussion forums and applying it in co-creating the community health initiatives. • Facilitate community dialogues on the role of SDH in addressing the root causes of health inequities by understanding the interdependence of sectors. • Advocate for the allocation of adequate funds for community-based public health programme activities to address social determinants of health.	x	x	x	x		MoH	Dzongkhag and Gewog Administrations and Thromdes

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
II. REDEFINING THE ROLES OF VILLAGE HEALTH WORKERS	VHWs as catalysts for advancing self-care and promoting community health and well-being.	• Develop culturally relevant IEC materials for VHWs to use when guiding communities on lifestyle modifications, preventive health measures and self-care practises. • Organize workshops to equip VHWs with necessary knowledge and skills to effectively deliver targeted health education on important public health concerns and help improve community health literacy. • Conduct on-site training, regular formative supervision, tutoring and coaching. • Design interactive, visually alluring and user-friendly self-care guides and digital tools on 'My Healthy Life' tailored to local literacy levels and health needs. • Conduct workshops on self-care tools through demonstrations and active discussions. • Conduct digital health workshops to familiarize VHWs with mobile apps, eHealth platforms and other digital tools on community health promotion. • Develop a mobile-based support digital network to connect VHWs with healthcare workers for remote consultations, guidance and referrals.	x	x	x			MoH	DHS, Gewog Administration & VHWs
	VHWs as focal points for multistakeholder collaboration in health.	• Organize 'community dialogues' with all stakeholders to align community health with community development priorities and foster multi-stakeholder collaboration. • Establish a community health team in a community to conduct multi-stakeholder health advocacy campaigns for garnering support for community health-related initiatives.	x	x				MoH	DHS, Gewog Administration & VHWs
	VHWs as champions in improving healthcare access among vulnerable population.	• Integrate VHWs in the AHS program of the MoH. • Provide capacity building trainings to health workers and VHWs on standardized AHS tools for data collection. • Coordinate with the AHS program in developing a digital health registry for vulnerable populations. • Organize home visits, under the supervision of PHC healthcare workers, to provide essential services, including medication refills, follow ups, health education and referrals. • Embed culturally tailored health literacy topics into local festivals and community gatherings in collaboration with religious figures and LG leaders. • Organize health education booths for the general public during religious events and local festivals. Trained VHWs can disseminate information on self-care, preventive care, NCDs, etc, and provide educational materials on adopting healthy lifestyles. • Conduct interactive sessions with the community stakeholders using the CEP to address emerging community health issues, discuss pressing concerns, and propose possible solutions.	x	x	x			MoH	DHS, Gewog Administration & VHWs

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
II. REDEFINING THE ROLES OF VILLAGE HEALTH WORKERS	VHWs as team members in capacity building and peer-to-peer learning.	• Conduct a VHW-led training sessions on self-care strategies and community health initiatives for other community-based volunteers such as religious health coordinators, CBSS members from community, and traditional healers. • Develop a mentorship program for new VHW volunteers (particularly those who have not received a formal VHW training by providing hands-on training and practical demonstrations by their seniors. • Organize peer-to-peer learning workshops for VHWs from different Dzongkhags to present their best practises, challenges and innovation solutions. • Engage in organizing 'VHW Day' in Dzongkhags on the international volunteer day. • Develop a digital VHW learning and networking platform to connect VHWs from different Gewogs for sharing leaning materials, experiences and success stories. • Support PHCs in coordinating and monitoring the distribution of and maintaining the inventory of essential medical supplies to ensure uninterrupted community health services.	x	x	x			MoH	DHS, Gewog Administration
III. SUSTAINING MOTIVATION AND RETENTION OF VILLAGE HEALTH WORKERS	Elevating the social recognition and status of village health workers.	• Rename their titles to align with their empowered roles, reflecting their multifaceted and leadership role in promoting community health. • Provide an official VHW identification card/badge with their new title and personal information, validating their role and uplifting their credibility in the community. • Provide public recognition and acknowledgement to VHWs for their dedication, hard work, and contributions to the community well-being at national and local events, and in media and government communications.	x	x	x	x	x	DHS	Gewog Administration & MoH
	Empowering VHWs to engage in local governance.	• Organize policy advocacy meetings with local governments to emphasize the importance of VHW engagement in the local government decision-making forums. • Build the capacity of VHWs through a structured leadership program (focussing on health governance, policy advocacy, negotiation skills and interpersonal communication) to enable effective engagement and sustained influence in local policy-making, planning and service delivery. • Formalize the participation of VHWs (along with PHC staff if required) in all community meetings/zomdus. • Develop a reporting framework for VHWs and any community members to submit community health concerns through standardised reporting forms or a digital enabled system like SMS-based reporting or voice message hotline or mobile apps enabled reporting.	x	x	x			MoH& DHS	Gewog Administrations

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
III. SUSTAINING MOTIVATION AND RETENTION OF VILLAGE HEALTH WORKERS	Strengthening motivation of VHWs through logistical support.	• Equip VHWs with basic filed kits and supplies to help them overcome environmental and logistical challenges in delivering community health services. specifically, such supplies may include raincoats, boots, umbrellas, backpacks, chargeable torches, water bottles, etc. • Enhance service efficiency and quality by providing VHWs with medical kits, tools and information, education and communication (IEC) materials to support health literacy activities, including self-care. • Improve service delivery capacity of VHWs through comprehensive training programs on the effective use of health equipment and IEC materials.	x	x	x	x	x	MoH	Dzongkhag and Gewog Administrations
IV. SYSTEMS SUPPORT FOR VHWS AND COMMUNITY HEALTH SERVICES	Fostering community embeddedness in the management of VHWs.	• Integrate the VHW management and retention plan in the VHW recruitment guideline in consultation with the Dzongkhag and Gewog Administrations. • Devise a framework for shared responsibility of Gewog resources to invest in community health priorities and interventions. • Engage VHWs in community action groups or Gewog or Chiwog Committees for community health development in Gewogs or Chiwogs under the chairmanship of a Gup using the whole-of-community approach within the framework of LG provisions. • Develop a system or a platform to implement a community-led monitoring of community health services through transparent performance tracking or participatory scorecard system where community stakeholders assess the progress of community health program implementation. • Develop a public dashboard to be displayed at Primary Health Centers with information on VHW performance ratings, complaints received, issues resolved, resources mobilized, etc.	x	x	x	x	x	MoH	Dzongkhag and Gewog Administrations

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
IV. SYSTEMS SUPPORT FOR VHWS AND COMMUNITY HEALTH SERVICES	Enhancing training and continuous skill development for VHWs.	• Set up a multi-disciplinary team with representatives from Dzongkhags or Gewogs to guide the formulation of standards, with integration of community perspectives. • Organize expert consultations and national workshops to valid the draft standards. • Collaborate with the quality assurance and accreditation divisions of the MoH and KGUMSB to establish certification requirements for the three-level VHW training manuals. • Update the VHW training manuals in accordance with the national VHW national service standards and international (WHO/UN) guidelines. • Provide trainings to VHWs on the revised/updated training manual. • Prepare VHWs as frontline health emergency responders in times of disease outbreaks, natural disasters and casualty incidents. • Build competencies in climate-related health risks, disaster readiness, minimum initial service package (MISP) in humanitarian crisis, and the social determinants of health to tackle wider community health issues. • Equip VHWs with digital health tools, such as mHealth and eHealth applications, to enable technology-driven learning, seamless information exchange and peer-to-peer communications. • Organize national and international programs to share best practise experiences and innovations in community health service delivery. • Partner with KGUMSB to expand educational and training opportunities, strengthening VHW knowledge and skills.	x	x	x	x	x	MoH	Dzongkhag and Gewog Administrations
	Providing supportive supervision and structured mentoring.	• Designate trained supervisors for VHWs with well-defined roles and expertise in mentorship techniques, including adult learning principles, positive reinforcement methods and solution-based coaching. • Develop a standardised monitoring checklist to assess service quality, accuracy of record keeping, and effectiveness of community engagement and leadership. • Conduct an annual supervisor-VHW meeting to facilitate the exchange of feedback, evaluate performance indicators, and collaboratively discuss challenges and solutions. • Conduct satisfaction surveys for both VHWs and beneficiaries of VHW services. • Enhance communications between supervisors and VHWs using appropriate digital platforms such as WhatsApp, Telegram, and WeChat to facilitate efficient information exchange, case consultations, announcements, discussions, reporting, referrals, and emergency response coordination.	x	x	x	x	x	DHS	MoH & Gewog Administrations

Strategic Area	Key Strategic Action	Key Activities	Timeline					Lead Agency	Collaborating Partners
			2025 - 2026	2026 - 2027	2027 - 2028	2028 - 2029	2029 - 2030		
IV. SYSTEMS SUPPORT FOR VHWS AND COMMUNITY HEALTH SERVICES	Creating an enabling environment for effective service delivery.	• Develop a national guideline to manage and operate the VHW workforce in a cohesive and coordinated manner, delineating roles and responsibilities of VHWs, covering operational frameworks and a clear channel of communication. • Establish efficient support systems at Dzongkhag and Gewog levels through VHW resource centres for supply replenishment (first aid kits, equipment, IEC materials, manuals) and multisectoral support. • Design a user-friendly community engagement toolkit to standardize community engagements in community health programs. • Train LG leaders and VHWs on toolkit utilization for facilitating open discussions, obtaining feedback and evaluating community satisfaction.	x	x	x	x		MoH	DHS and Gewog Administrations
V. PARTNERSHIP FOR COMMUNITY HEALTH AT NATIONAL AND SUB-NATIONAL LEVELS	Fostering stakeholder collaboration among for at the national level.	• Align with the existing national guideline on partnership frameworks. • Promote collaboration across relevant government departments, public health programs, academic institutions, JDWNRH and civil society organizations to support the integrated programming and implementation of community health initiatives. • Enhance platforms and mechanisms that align partner efforts with national priorities, ensuring policy and program coherence. • Establish institutional linkages with academic institutions, research institutes, government agencies and CSOs to foster collaboration in high-quality community health studies. • Study the effectiveness of the VHW program using robust research methods on community health outcomes, behavioural changes and systems efficiencies.	x	x				MoH	MoESD, Dratshang, DoLG, CSOs, DHS, JDWNRH, KGUMSB
	Reinforcing local partnerships to drive community health actions.	• Build capacities of local government actors in Dzongkhags and Gewogs to strengthen local leadership, enhance evidence-based planning, and foster accountability in the delivery of community health services by conducting community health partnership and leadership seminars, training sessions on community health prioritization and programming, and joint monitoring and evaluation workshops.	x	x	x			DHS & Gewog Adm	MoH

6. BUDGET SUMMARY

The total estimated cost of implementing the VHW Strategy and Action Plan over the five-year period (2025-2030) is Nu. 34.60 million. The VHW program faced chronic underfunding for decades that inevitably constrained it from integrating into a broader community health system. This budget allocation is a deliberate response to redress this issue, and to support the program in rolling out horizontal integration activities within the framework of primary health care strengthening. Adequate financing is essential to address the challenges faced by VHWs, especially gaps in training, motivation and retention. Reflecting this priority, Strategic Area 3 - 'Sustaining motivation of VHWs' has the largest share of the budget, highlighting the importance of both financial and non-financial support in improving the performance and retention of VHWs.

Estimates by Strategic Areas	2025-2026	2026-2027	2027-2028	2028-2029	2029-2030	Total (Nu.)
Strategic Area 1: Community leadership & local governance	1674000	2687000	2492400	1440000	765400	9058800
Strategic Area 2: Redefining roles of VHWs	0.00	1400000	500000	1000000	500000	3400000
Strategic Area 3: Motivation & retention of VHWs	3115000	2292000	1606000	0.00	7013000	14026000
Strategic Area 4: Systems support for VHWs	3276000	1000000	1000000	1000000	1000000	7276000
Strategic Area 5: Partnership for community health	50000	250000	250000	250000	50000.00	850000
Grand total (in Nu.)	**8,115,000**	**7,629,000**	**5,848,400**	**3,690,000**	**9,328,400**	**34,610,800**

Historically, the VHW program has relied on fragmented, unplanned and ad-hoc support. However, this costed action plan provides a good foundation for mobilizing adequate resources needed to implement a more sustainable and institutionalized model of community health service delivery. This structured budget approach is important in enabling timely implementation of the strategy, and significantly contributing to the Ministry of Health's 13th FYP goals.

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ANNEXURE

Annexure 1: Maternal and Child Health indicators

SDG Targets	SDG Indicators	National Equivalent SDGI	Current status	Source
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio (Per 100,000)	3.1.1 Maternal Mortality Ratio (Per 100,000)	53	NHS 2023
	3.1.2 Deliveries attended by skilled health worker (%)	3.1.2 Deliveries attended by skilled health worker (%)	98.5	NHS 2023
		Institutional delivery (%)	98	NHS 2023
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-5 mortality rate (Per 1000)	3.2.1 Under-5 mortality rate (Per 1000)	19.5	NHS 2023
	3.2.2 Neonatal Mortality Rate (Per 1000)	3.2.2 Neonatal Mortality Rate (Per 1000)	6.9	NHS 2023

Source: Annual Health Bulletin 2024, MoH

Annexure 2: Pros and cons of incentivizing CHW program

Incentives Pros and Cons

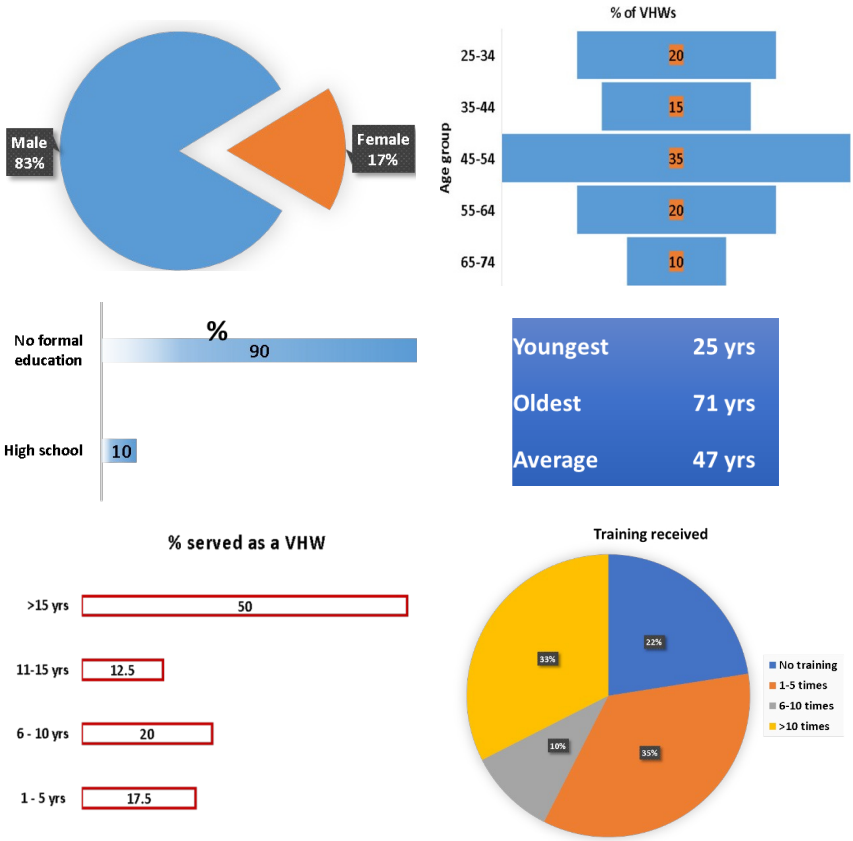
	TYPE	PROS	CONS	EXAMPLES
Financial	**Salaries & Stipends**	• Provides income security and professional recognition. • Reduces attrition rates. • Can lead to better integration of CHWs into formal health systems.	• Requires sustainable funding sources. • Risk of delayed payments causing demotivation. • May create disparities between salaried and volunteer CHWs.	• Ethiopia's Health Extension Workers (HEWs) receive government salaries, improving retention. • Bangladesh's BRAC CHWs receive performance-based commissions on health product sales.
	Performance-Based Payments (P4P)	• Encourages CHWs to achieve specific health targets. • Links incentives to health outcomes.	• May prioritize easily measurable targets over holistic care. • Risk of neglecting non-incentivized activities.	• Rwanda's CHW Program pays CHWs based on performance in maternal and child health indicators.
	Allowances and Reimbursements	• Supports CHWs for transport, supplies, and food. • Reduces financial burden of volunteering.	• Insufficient amounts may not fully cover costs. • Irregular or delayed payments can create frustration.	• Nepal's Female Community Health Volunteers (FCHVs) receive small allowances for attending training.
Non-Financial	**Training & Career Progression**	• Enhances skills and job satisfaction. • Can lead to formal employment pathways.	• Without financial support, training alone may not sustain motivation.	• India's ASHAs receive training and may transition to formal health worker roles.
	Community & Peer Recognition	• Strengthens social status and intrinsic motivation. • Encourages long-term engagement.	• May not be enough to sustain participation w/o financial support.	• Pakistan's LHWs are recognized as key health actors in their communities.
	Equipment & Work Materials	• Supports CHWs perform their duties effectively. • Reduces out-of-pocket costs.	• If irregularly provided, CHWs may struggle to perform tasks efficiently.	• Indonesia's CHWs (Kaders) receive bicycles and uniforms to aid mobility and identification.
	Supportive Supervision & Networking	• Provides mentoring and professional guidance. • Encourages peer learning and motivation.	• Poorly structured supervision may lead to demotivation.	• Myanmar's Community Health Volunteers benefit from peer support networks.

Source: UNICEF ROSA

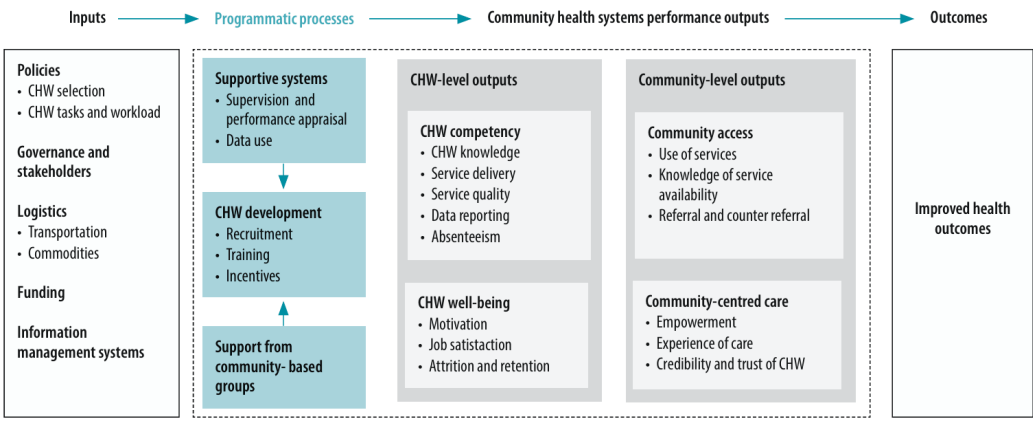
Annexure 3: Data on review findings

District Administrators 1 Dzongda (District Governor) 1 Dzongrab (Deputy District Governor)	***Local Government (LG) Officials*** 5 Gups (Block leaders) 1 GAO (Gewog Administrative Officer) 3 Mangmi (gewog officer) 9 Tshogpas (village representatives)
Health Professionals 1 MS (Medical Superintendent) 3 CMOs (Chief Medical Officers) 5 CHU in-charges (Community Health Unit in-charges of hospitals) 14 PHC in-charges (Primary Health Centre in-charges) 5 DPHOs (District Public Health Officers) 1 TPHO (Thromde Public Health Officer) 1 THC (Thromde Health Centre)	***Village Health Workers (VHWs)*** 37 Current VHWs (actively serving) 3 Retired VHWs (no longer active) ***Dratshang Health Coordinators*** 6 Health Coordinators of religious institutions.

(b) Charetirstics of village health volunteers

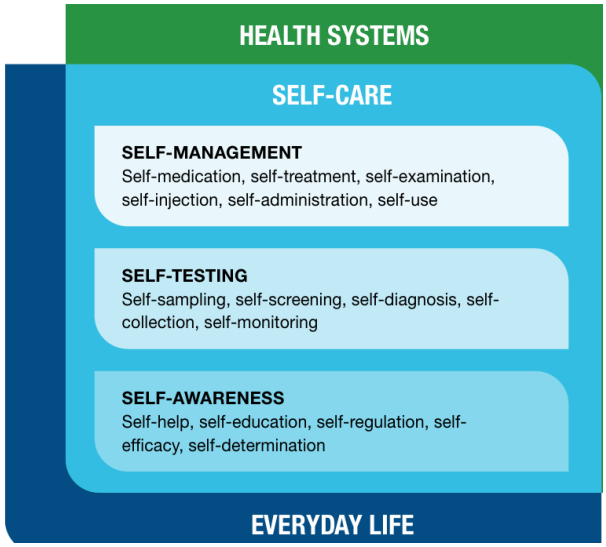


Annexure 5: CHW performance measurement framework



Source: Performance-based incentives and community health workers' outputs, a systematic review. T Gadsden, SA Mabunda, A Palagyi, A Maharani, S Sujarwoto, M Baddeley, S Jan. Bulletin of the World Health Organization, 2021.

Annexure 6: Self-care interventions linked to health systems



PERSONAL DETERMINANTS

- Knowledge
- Health literacy
- Daily choices (hygiene, safe sex, risk avoidance, nutrition/diet, work-life balance, adherence to treatment)

SITUATIONAL, ECONOMIC, EMOTIONAL AND SOCIAL DETERMINANTS

- Peer-to-peer actions
- Support
- Counselling
- Engagement in health decisions

HEALTH SYSTEMS DETERMINANTS

- Identify opportunities to promote self-care
- Provide written or visual materials
- Support development of action/calendar/follow-up plan with increased severity of health condition
- Promote tools, interventions, information for improved autonomy
- Support caregivers

Source: WHO guideline on self-care interventions for health and well-being, 2022 revision


VILLAGE HEALTH WORKER