

Community health workers for universal health-care coverage: from fragmentation to synergy

Kate Tulenko,^a Sigrun Møgedal,^b Muhammad Mahmood Afzal,^c Diana Frymus,^d Adetokunbo Oshin,^e Muhammad Pate,^e Estelle Quain,^d Arletty Pinel,^f Shona Wynd^g & Sanjay Zodpey^h

Abstract To achieve universal health coverage, health systems will have to reach into every community, including the poorest and hardest to access. Since Alma-Ata, inconsistent support of community health workers (CHWs) and failure to integrate them into the health system have impeded full realization of their potential contribution in the context of primary health care. Scaling up and maintaining CHW programmes is fraught with a host of challenges: poor planning; multiple competing actors with little coordination; fragmented, disease-specific training; donor-driven management and funding; tenuous linkage with the health system; poor coordination, supervision and support, and under-recognition of CHWs' contribution.

The current drive towards universal health coverage (UHC) presents an opportunity to enhance people's access to health services and their trust, demand and use of such services through CHWs. For their potential to be fully realized, however, CHWs will need to be better integrated into national health-care systems in terms of employment, supervision, support and career development. Partners at the global, national and district levels will have to harmonize and synchronize their engagement in CHW support while maintaining enough flexibility for programmes to innovate and respond to local needs. Strong leadership from the public sector will be needed to facilitate alignment with national policy frameworks and country-led coordination and to achieve synergies and accountability, universal coverage and sustainability. In moving towards UHC, much can be gained by investing in building CHWs' skills and supporting them as valued members of the health team. Stand-alone investments in CHWs are no shortcut to progress.

Abstracts in **عربي**, **中文**, **Français**, **Русский** and **Español** at the end of each article.

From Alma-Ata to universal health coverage

From the early years of primary health care, community-based health workers and volunteers (henceforth referred to as community health workers [CHWs]) have played a key role in satisfying the need and demand for essential health services. The Alma-Ata Declaration states that primary health care "relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community".¹

The values and principles set down at Alma-Ata continue to be relevant today, even though the primary-health-care movement has encountered difficulties in many countries and at many levels when seeking to put them into practice. With the growing momentum for making universal health coverage (UHC) a core strategy for shaping the post-2015 global health agenda, known barriers to coverage and access must be overcome.² This also applies to factors that undermine the role of CHWs in the health system.

The path-finding pilots for community-based primary health care and CHW models took place in nongovernmental settings in the beginning of the 1970s. The Christian Medical Commission of the World Council of Churches, in proactive engagement with the World Health Organization (WHO),³

was instrumental in making the case for this paradigm shift in health care by joining efforts with lead projects in Guatemala, India, Indonesia and elsewhere, among them the Comprehensive Rural Health Programme in Jamkhed, India, established in 1970,⁴ which continues today. After the Commission's pioneering work, hundreds of other faith-based groups and nongovernmental organizations (NGOs) have continued to refine community-based health-care models and CHW programmes.

After Alma-Ata, the eagerness of public health authorities to produce national blueprints for the rapid scale-up of primary health care did, however, generally miss out on creating ample space for community participation. The comprehensiveness and continuity of care – so basic to the model – were soon replaced by selective interventions for focused results, including selected maternal and child health interventions and family planning. Well-intended, top down national planning and external support created wave after wave of CHWs in the making and reshaping, under different names and with different roles. Many countries and many communities can recall a history of training, deployment and failure of several repeating initiatives, such as that in the United Republic of Tanzania in the 1980s.⁵ Caught between the formal health system and the community and often in a "grey zone" between public, nongovernmental and private health systems, CHWs were for a long time seen as a stopgap measure and did not

^a CapacityPlus, IntraHealth, 1776 I St, NW, Washington, DC 20006, United States of America (USA).

^b Norwegian Knowledge Center for the Health Services, Oslo, Norway.

^c Global Health Workforce Alliance, Geneva, Switzerland.

^d United States Agency for International Development, Washington, USA.

^e Federal Ministry of Health, Abuja, Nigeria.

^f Genos Global, Panama City, Panama.

^g Joint United Nations Programme on HIV/AIDS, Geneva, Switzerland.

^h Public Health Foundation of India, New Delhi, India.

Correspondence to Kate Tulenko (e-mail: ktulenko@capacityplus.org).

(Submitted: 10 March 2013 – Revised version received: 24 May 2013 – Accepted: 1 July 2013)

receive the adequate support needed for sustainability.

When the epidemic of HIV infection set in, community-based care models found new expressions. The need to act grew organically out of the affected communities in the early days of the epidemic. People living with HIV infection had no choice but to help one another. What evolved was a system rooted in the local context and born out of friendship and a shared experience: mothers supported mothers, gay men supported gay men and grandmothers helped grandmothers. When the early antiretrovirals became available, projects and programmes funded by governments, donors and NGOs spotted the opportunity to utilize existing community HIV support networks and began funding training and development for CHW programmes specific to the needs of HIV programmes, yet largely without being part of the local health services and clinics. What started out as community-based responses began to evolve into multiple, stand-alone CHW programmes focused on HIV care with varying degrees of formality, sustainability, success, support and reporting.⁶

The use of CHWs for childhood development and maternal, neonatal and child health care has a long history, as illustrated in India. The Accredited Social Health Activists (ASHA) model for the follow-up of women during pregnancy, delivery and the postnatal period has been relatively successful in overcoming barriers to service delivery and increasing institutional deliveries.⁷ The ASHA programme has attained roughly 70% coverage of both mothers and neonates in participating areas.⁸

Lady health workers in Pakistan, *beharz* in the Islamic Republic of Iran, *agentes comunitários de saúde* in Brazil, BRAC community health workers in Bangladesh, village health volunteers in Thailand, and health extension workers in Ethiopia all represent different successful CHW models.⁹ Zambia agreed on a national CHW strategy in 2010 and implemented a community health assistant programme in 2012. In August 2011 Nigeria held its very first national meeting on human resources for health, which brought together various partners and representatives of all levels of government. Similar national meetings have taken place in Kenya in 2011 and in 2013 the United Republic of Tanzania. These programmes and processes have, in dif-

Box 1. Commonly noted contributions of community health workers (CHWs)

- CHWs who are properly trained, equipped and supported can take on a range of tasks that otherwise depend on mid-level health workers.
- CHWs extend care to underserved communities, where they enhance access to health services and promote people's trust, demand and use of such services.
- CHWs who speak the local language and identify with the local community convey health messages more effectively.
- CHW training and service contribute to capacity for community leadership.
- CHWs recruited from the communities they serve are less likely to go elsewhere because of difficult living conditions.
- CHWs can help service users avoid trips to health facilities, which translates into saved transportation costs and time.
- CHWs can meet some of the needs of homebound patients.

ferent ways, brought in the voices of the CHWs and their communities and seek to optimize the potential contribution of skilled and supported CHWs to primary health care (Box 1).

Scale-up and sustainability

Although some sustainable national CHW programmes exist, such programmes have not achieved the scale-up and sustainability envisioned at Alma-Ata. CHWs have traditionally been recruited, trained, employed and supervised at the periphery of health ministry structures. Donors have generally supported CHW programmes to achieve goals linked to disease-specific vertical programmes or for the performance of specific tasks such as family planning, nutrition and immunization. Moreover, CHWs often lack a career ladder or professional associations. Although such vertical approaches may have resulted in short-term gains, programme fragmentation, ownership and sustainability have been major concerns.

The impact of CHWs can no longer be taken on faith; rigorous effectiveness and cost-effectiveness data are needed. Systematic reviews of studies comparing CHWs with usual practices have shown the effectiveness of CHWs in promoting immunization and breastfeeding, improving tuberculosis treatment outcomes and reducing child morbidity and mortality. The importance of integrating CHWs into the health system on the basis of a core set of skills defined at the national level and with appropriate supervision and support cannot be sufficiently underscored. In this process, due attention must be paid to the need for diverse training in keeping with the various roles and tasks performed by CHWs on the ground.^{10,11}

In 2012, several initiatives were implemented to engage the services of CHWs and other health workers at the front line in providing improved access to life-saving care. Together, these initiatives brought to light a dearth of operational research and a need for better synergies in knowledge management and operations. They also revealed that CHW programmes are still fragmented, with many different programmes of different origins having evolved over time, and that this fragmentation can be linked in part to the way programmes and initiatives are funded by external partners and coordinated at the country level.^{12,13} The Global Health Workforce Alliance synthesized the findings from these consultations and has initiated work to improve synergies across initiatives and partners.

The experience with CHW programmes points to six key challenges in terms of policy and practice, with implications for scale-up and sustainability. These are discussed in the following sections.

Neglect of CHWs in health workforce planning

In most countries' health workforce strategies, district and local authorities are responsible for hiring, managing and supporting CHWs at the front-line facility and community levels without strong guidance from the national level. The creation of CHW programmes in multiple "waves" throughout the past 30 years has contributed to severe fragmentation on the ground. There is a need for explicit principles and guidance from the national level on ways of integrating and aligning these efforts to optimize synergies and build sustainable platforms for the scale-up of CHW programmes towards achieving UHC.

Multiple actors without coordination

United Nations partners working in the sphere of health have direct or indirect engagement with CHW programmes and other community-based health initiatives – often in diverging ways within the same country. Partners engaged in supporting CHW and community-based programmes are seldom present at the district or lower level but work through contractors and implementers without national or local mechanisms for coordination. Faith-based and NGO-related private or community-based CHW programmes have their own contracts and arrangements for health workers and barriers to communication between public and NGO providers are not uncommon.

Fragmented, disease-specific focus

Differences in the way interventions – in family planning, nutrition, malaria, immunization, HIV-related care and maternal and child health – are structured and supported add to the complexity of the situation. Training, management and incentive structures differ widely. Results and accountability frameworks for these programmes are not structured to drive synergies across initiatives. Be they local and free-standing or part of nationwide efforts, programmes and initiatives often stimulate piloting and innovation. Yet because resulting innovations are not coordinated, they do not spread and programmes are not scaled up.

Unclear link to the health system

There is an urgent need for supervision and support for CHWs at the level of programme implementation. The role of the district and subdistrict levels in facilitating coordination and ensuring synergy among multiple stakeholders and initiatives is often unclear. This is also true of the accountability of CHW programmes to the district and community governance structures for health and development. This lack of clarity in the link of CHW programmes to the health system undermines overall commitment to and capacity for supervision and support.

Competing nongovernmental organizations

The “NGO challenge” acts as a further barrier to synergy across CHW initia-

tives and partners. Although competition for funding among international, regional and national NGOs fosters creativity and momentum, it makes competing NGOs disinterested in cooperating with one another. When NGOs bid for contracts they feel compelled to offer a product that is different from what other NGOs offer. It therefore behoves donors to incentivize cooperation among NGOs or to make it mandatory.

Unclear identity

CHWs often operate in an environment in which it is not clear whether they represent the community, an NGO, the health system or a combination of these. This can lead to confused responsibilities and accountabilities among the various actors and deprives CHWs of the support they need. CHWs interface between their communities and formal health systems and their roles and expectations must therefore be clarified and understood by all parties. CHWs also face opposition from more established health professionals, such as physicians and nurses, who may see them as a potential threat to their job security and salaries. In most countries, CHWs have never been integrated into the established, salaried team of health system workers, have never been professionalized and have never been given a voice in the affairs of the health system or the non-state health sector.¹⁴

Synergy, integration and sustainability

The challenges identified in this paper stem from the “going it alone” approach applied by most funders and implementers of CHW programmes, which has left us with a legacy of parallel initiatives funded separately, delivering separately and reporting separately. If the isolated health gains that have been achieved through CHW programmes are to be sustained and scaled up to meet UHC targets, a clear strategy for optimizing synergies and integration is needed.

Major steps have been taken at the national level, through a variety of collaborative frameworks, plans and strategies, to harmonize and coordinate the actions of multiple entities in support of health system development and service delivery. Examples include sector-wide support platforms, the International Health Partnership and the Global

Health Workforce Alliance’s programme of Country Coordination and Facilitation for Human Resources for Health. However, these coordination mechanisms seldom cover programmes implemented under district-level authority at the health facility and community levels, including CHW programmes.

With the growing focus on scaling up CHW programmes of differing scope and fit within the formal health system, decisive steps to ensure operational synergies are essential. Such steps must be taken through agreed national policies and with guidance and alignment by all partners and they must allow for flexibility and innovation. The aim must be to optimize a health team approach at the front line of the health system, fit for the local context, with facility-based and community-based health workers working together. This approach may result in slower progress at the outset but will ensure long-term results and sustainability.

It is the responsibility of every national government to establish guidelines for scaling up CHW programmes that respond to local needs and realities. A national inventory of ongoing programmes and community-based CHW initiatives is key to alignment among different programmes. The policy framework for integration and alignment of the tasks performed by different types of CHWs across different vertical initiatives must be agreed on by both funders and implementers. Specifically, the question of incorporating CHWs into the formal health system and the greater health workforce must be addressed, together with the mechanisms for regulating their performance – i.e. setting standards for training, licencing, scope of work, career ladders and supervision.

District health management teams and local governments need to be given the authority to bring together the implementing partners to enhance synergies and programme alignment in accordance with national guidance, make full use of the space for innovation, and facilitate mutual learning. District health managers will need to work with their community counterparts as appropriate to track and act on CHW-related service data, keep coverage maps, ensure the necessary supervision and guidance, and track performance.

Key to engaging CHWs to attain UHC is the readiness of global and

national partners and implementers to (i) value collaboration; (ii) comply with national- and district-level guidance on synergies and integration; (iii) share information; (iv) ensure sufficient local flexibility and (v) monitor established indicators. As an alliance of key stakeholders, the Global Health Workforce Alliance is well placed to promote a health system approach, with coordination across CHW initiatives, when seeking programme scale-up at the global, national and district levels. In this context, new initiatives such as the One Million Community Health Workers Campaign, hosted by the United Nations Sustainable Development Solutions Network and the Earth Institute, represent important opportunities for aligned action. Multilateral partners,

global initiatives, donors and international NGOs need to closely examine programming, funding and reporting to minimize fragmentation and duplication and ensure the scale-up of CHW programmes in the context of a trained, equipped and supported health team.

Conclusion

As was made clear in the Alma-Ata Declaration and as is valid today, CHWs, whether hired by the formal health system or selected and supported by communities, cannot be left to serve on their own.¹⁵ CHW programmes need to be comprehensive rather than vertical and they should rely on both the community and the formal health system for supplies, communications and referrals.

Isolated investment in CHWs is no shortcut to progress.

CHWs can be effective, integral members of the health team. They can go beyond the provision of care and foster community-based action. As the MDG era comes to an end and a new era focused on UHC begins, the global health community has a unique opportunity to work with CHWs to create lasting health improvements everywhere. ■

Funding: The views expressed in this publication are solely the authors'; they do not necessarily reflect the views of the United States Agency for International Development or the Government of the United States.

Competing interests: None declared.

ملخص

العاملون في مجال الصحة المجتمعية من أجل التغطية الشاملة في الرعاية الصحية: من التجزئة إلى التآزر المجتمعية. ومع ذلك، لتحقيق إمكاناتهم بشكل كامل، سوف يتعين دمج العاملين في مجال الصحة المجتمعية بشكل أفضل في نظم الرعاية الصحية الوطنية فيما يتعلق بالتوظيف والإشراف والدعم والتطوير المهني. وسوف يتعين على الشركاء على المستويات العالمية والوطنية ومستويات المناطق تنسيق ومزامنة مشاركتهم في دعم العاملين في مجال الصحة المجتمعية مع الحفاظ على مرونة كافية للبرامج من أجل الابتكار والاستجابة للاحتياجات المحلية. وسوف توجد حاجة إلى قيادة قوية من القطاع العام لتسهيل المواءمة مع أطر السياسة الوطنية والتنسيق بقيادة الدولة ولتحقيق أوجه التآزر والمساءلة والتغطية الشاملة والاستدامة. وعند التحرك صوب التغطية الصحية الشاملة، يمكن تحقيق المزيد عن طريق الاستشارة في بناء مهارات العاملين في مجال الصحة المجتمعية ودعمهم كأفراد ذوي قيمة في الفريق الصحي. وليست الاستشارات القائمة بذاتها في العاملين في مجال الصحة المجتمعية مسارا مختصرا إلى التقدم.

لكي تتحقق التغطية الصحية الشاملة، سيتعين على النظم الصحية الوصول إلى كل مجتمع، بما في ذلك المجتمعات الأكثر فقرا وصعوبة في الوصول إليها. ومنذ إعلان ألما - آتا، أدى الدعم المتضارب من جانب العاملين في مجال الصحة المجتمعية والفشل في دمجهم في النظام الصحي إلى عرقلة الإدراك الكامل لمساهماتهم المحتملة في سياق الرعاية الصحية الأولية. ويشتمل تعزيز برامج العاملين في مجال الصحة المجتمعية والحفاظ عليها على مجموعة من التحديات، هي: سوء التخطيط؛ وتعدد الأطراف المتنافسة مع قلة التنسيق فيما بينها؛ وتشتت التدريب المحدد لكل مرض؛ والإدارة والتمويل عن طريق الجهة المانحة؛ وهشاشة الربط بالنظام الصحي؛ وسوء التنسيق والإشراف والدعم، ونقص الاعتراف بمساهمة العاملين في مجال الصحة المجتمعية.

يقدم الاتجاه الراهن صوب التغطية الصحية الشاملة فرصة لتعزيز وصول الأشخاص إلى الخدمات الصحية وثقتهم وطلبهم واستخدامهم لهذه الخدمات من خلال العاملين في مجال الصحة

摘要

全民医疗保障的社区卫生工作者：从零散到协同

为实现全民医疗保障，卫生系统必须深入每个社区，包括最贫穷和最偏远的地方。阿拉木图对社区卫生工作者 (CHW) 的支持不一致，无法将其融入卫生系统，因而阻碍了卫生工作者在初级卫生保健中充分发挥自身的潜力。扩大和维护 CHW 计划充满各种挑战：规划不周；多个行动者相互竞争、缺乏协调；培训零散且针对特定疾病；管理和融资由捐赠者驱动；卫生系统联动薄弱；协调、监督和支持不力以及对社区卫生工作者的贡献没有充分的认识。

当前实现全民医保 (UHC) 的动力带来了这样的机会：改善人们使用卫生服务的状况，并增强人们对

CHW 服务的信任、需求和使用。然而，要充分发挥潜力，CHW 需要在就业、监督、支持和职业发展方面更好地融入国家卫生保健系统。全球、国家以及区域级别的合作者必须协调和同步对 CHW 的支持，同时保持足够的计划灵活性以便创新和响应地方需求。需要来自公共部门的强有力领导，以便更好地向国家政策框架和国家主导的协作看齐，从而实现协同效应和问责制、全民覆盖和可持续性。在实现 UHC 过程中，在培养 CHW 的技能并支持其成为卫生团队宝贵成员方面加大投入力度，会有不少收获。对 CHW 的孤立投入不是发展的捷径。

Résumé

Les agents sanitaires des collectivités pour la couverture sanitaire universelle: de la fragmentation à la synergie

Pour parvenir à une couverture sanitaire universelle, les systèmes de santé devront étendre leur portée à toutes les communautés, y compris celles qui sont les plus pauvres et les plus difficiles d'accès. Depuis la Déclaration de Alma-Ata, le soutien inégal des agents sanitaires des collectivités et l'échec de leur intégration dans les systèmes de santé ont empêché la pleine réalisation de leur contribution potentielle dans le contexte des soins de santé primaires. Le développement et le maintien des programmes des agents sanitaires des collectivités se heurtent à une multitude de défis à relever: mauvaise planification; multitude d'acteurs concurrents avec peu de coordination; formation fragmentée et spécifique aux maladies; gestion et financement à l'initiative des donateurs; lien ténu avec le système de santé; coordination, supervision et soutien de mauvaise qualité, et sous-reconnaissance de la contribution des agents sanitaires des collectivités.

La campagne actuelle vers une couverture sanitaire universelle offre une opportunité d'améliorer l'accès des personnes à des services de santé, ainsi que leur confiance, demande et utilisation de tels services par le biais des agents sanitaires des collectivités. Pour que leur potentiel

puisse être pleinement réalisé, les agents sanitaires des collectivités devront toutefois être mieux intégrés dans les systèmes nationaux de soins de santé en termes d'embauche, de supervision, de soutien et d'évolution de carrière. Les partenaires au niveau du monde, du pays et du district devront harmoniser et synchroniser leurs engagements dans le soutien aux agents sanitaires des collectivités tout en maintenant suffisamment de flexibilité pour permettre aux programmes d'innover et de répondre aux besoins locaux. Un leadership fort du secteur public sera nécessaire pour faciliter l'alignement avec les cadres politiques nationaux et la coordination dirigée par le pays et pour réaliser des synergies et des responsabilités, la couverture universelle et la durabilité. En avançant vers la couverture sanitaire universelle, il y a beaucoup à gagner en investissant dans l'acquisition de compétences des agents sanitaires des collectivités et en les soutenant en tant que membres à part entière des équipes de santé. Les investissements autonomes au bénéfice des agents sanitaires des collectivités ne sont pas des raccourcis vers le progrès.

Резюме

Роль местных медработников в деле обеспечения всеобщего охвата медико-санитарной помощью: от отдельных инициатив к взаимодействию

Для обеспечения всеобщего охвата медико-санитарной помощью системы здравоохранения должны быть внедрены во всех сообществах, включая самые бедные слои населения и жителей, проживающих в труднодоступных регионах. Кроме Алматы, отсутствует стабильная поддержка местных медицинских работников (ММР), как и их полная интеграция в систему здравоохранения, что препятствует полноценной реализации их полноценного вклада в оказание первичной медико-санитарной помощи. Расширение охвата и программ поддержки ММР усложняется значительным количеством проблем: несовершенное планирование; множество конкурирующих участников, практически не координирующих между собой свою деятельность; фрагментированная подготовка, специализирующаяся только на определенных заболеваниях; значительная зависимость управления и финансирования от спонсоров; непрочные связи с системой здравоохранения; недостаточный уровень координации, надзора и поддержки, а также недооценка вклада ММР.

Текущая тенденция к внедрению всеобщего охвата медико-санитарной помощью предоставляет возможности улучшить доступ населения к службам здравоохранения, а также

повысить доверие, уровень спроса и использование таких служб через ММР. Тем не менее, чтобы в полной мере реализовать свой потенциал, местные медработники должны быть в большей степени интегрированы в национальные системы здравоохранения в вопросах трудоустройства, надзора, поддержки и карьерного роста. Организации-партнеры на глобальном, национальном и региональном уровнях должны гармонизировать и синхронизировать свою деятельность по поддержке ММР, сохраняя при этом достаточную гибкость для программ по внедрению инициатив и реагирования на локальные потребности. Понадобится проявление руководящей воли со стороны государственных служб, чтобы обеспечить согласованность данных усилий с положениями национальной политики и координацию в масштабах страны для достижения взаимодействия и контролируемости, всеобщего охвата и устойчивого развития. На пути внедрения всеобщего охвата медико-санитарной помощью много можно достигнуть путем инвестиций в развитие профессиональных навыков у ММР и поддержки их как ценных членов системы здравоохранения. Отдельные инвестиции в ММР не так перспективны для ускорения прогресса в данном направлении.

Resumen

Los trabajadores comunitarios de salud en la cobertura universal de la salud: de la fragmentación a la sinergia

A fin de lograr la cobertura universal de la salud, los sistemas sanitarios deben llegar a todas las comunidades, incluidas las más pobres y de difícil acceso. Desde la conferencia de Alma-Ata, el apoyo inconstante de los trabajadores comunitarios de salud (TCS) y la falta de integración de estos en el sistema sanitario han impedido la plena realización de su contribución potencial en el contexto de la atención primaria de la salud. La ampliación y el mantenimiento de los programas de trabajadores comunitarios de salud suponen muchos desafíos: la mala planificación, los agentes múltiples que compiten con insuficiente coordinación, la fragmentación en los programas de capacitación orientados a combatir

enfermedades específicas, la gestión y la financiación impulsadas por los donantes, la escasa unión con el sistema sanitario, la falta de coordinación, supervisión y apoyo, y la infravaloración de la contribución de los trabajadores comunitarios de la salud.

El avance actual hacia la cobertura universal de la salud (CUS) ofrece una oportunidad para mejorar el acceso de la población a los servicios de salud, así como para aumentar la confianza, la demanda y el uso de dichos servicios a través de los trabajadores comunitarios de salud. Sin embargo, es necesario integrar mejor a los trabajadores comunitarios de salud, en términos de empleo, supervisión, apoyo y desarrollo

profesional, en los sistemas nacionales sanitarios para aprovechar plenamente su potencial. Los socios a nivel mundial, nacional y local deben armonizar y sincronizar su compromiso a favor de los trabajadores comunitarios de salud, manteniendo la flexibilidad suficiente para que los programas tengan capacidad de innovación y respuesta frente a las necesidades locales. Se requiere un fuerte liderazgo por parte del sector público para facilitar la alineación con los marcos de las políticas

nacionales y la coordinación dirigida por el país, y para lograr sinergias y la rendición de cuentas, la cobertura universal y la sostenibilidad. En la consecución de la cobertura universal de la salud, pueden obtenerse grandes beneficios si se invierte en el desarrollo de competencias de los trabajadores comunitarios de salud, y se les apoya como miembros valiosos del equipo sanitario. Por el contrario, las inversiones aisladas en trabajadores comunitarios de salud no son atajos hacia el progreso.

References

- World Health Organization. *Declaration of Alma-Ata*. Geneva: WHO; 1978. Available from: http://www.who.int/publications/almaata_declaration_en.pdf [accessed 19 July 2013].
- World Health Organization [Internet]. Universal health coverage: five questions. Geneva: WHO; 2013. Available from: http://www.who.int/health_financing/universal_health_coverage_5_questions.pdf [accessed 15 July 2013].
- Litsios S. The Christian Medical Commission and the development of the World Health Organization's primary health care approach. *Am J Public Health* 2004;94:1884–93. doi: <http://dx.doi.org/10.2105/AJPH.94.11.1884> PMID:15514223
- Mann V, Eble A, Frost C, Premkumar R, Boone P. Retrospective comparative evaluation of the lasting impact of a community-based primary health care programme on under-5 mortality in villages around Jamkhed, India. *Bull World Health Organ* 2010;88:727–36. doi: <http://dx.doi.org/10.2471/BLT.09.064469> PMID:20931057
- Heggenhougen KV, Muhondwa E, Rutabanzibwa-ngaiza J. *Community health workers: the Tanzanian experience*. Oxford: Oxford Medical Publications; 1987. pp. 154–71.
- Hermann K, Van Damme W, Pariyo GW, Schouten E, Assefa Y, Cirera A et al. Community health workers for ART in sub-Saharan Africa: learning from experience—capitalizing on new opportunities. *Hum Resour Health* 2009;7:31. doi: <http://dx.doi.org/10.1186/1478-4491-7-31> PMID:19358701
- Gopalan SS, Mohanty S, Das A. Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. *BMJ Open* 2012;2:e001557. doi: <http://dx.doi.org/10.1136/bmjopen-2012-001557> PMID:23019208
- Sundararaman T, Ved R, Gupta G. Determinants of functionality and effectiveness of community health workers: results from evaluation of ASHA programme in eight Indian states. *BMC Proc* 2012;6(Suppl 5):O30.
- Global Health Workforce Alliance [Internet]. Global experience of community health workers for delivery of health related Millennium Development Goals: a systematic review, country case studies, and recommendations for integration into national health systems. Geneva: World Health Organization; 2010. Available from: <http://www.who.int/workforcealliance/knowledge/themes/community/en/index.html> [accessed 14 July 2013].
- Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database Syst Rev* 2010;3:CD004015. PMID:20238326
- Corluka A, Walker DG, Lewin S, Glenton C, Scheel IB. Are vaccination programmes delivered by lay health workers cost-effective? A systematic review. *Hum Resour Health* 2009;7:81. doi: <http://dx.doi.org/10.1186/1478-4491-7-81> PMID:19887002
- Naimoli JF, Frymus DE, Quain EE, Roseman EL. *Community and formal health system support for enhanced community health worker performance: a US Government evidence summit, final report*. Washington: United States Agency for International Development; 2012.
- Regional Network on Equity in Health in Southern Africa [Internet]. Consultation on improving access to health worker at the frontline for better maternal and child survival: report. South Africa: EQUINET; 2012. Available from: <http://www.equinetafrica.org/bibl/docs/Consultation%20FrontlineHW%20Rep%20June%202012.pdf> [accessed 15 June 2013].
- CapacityPlus [Internet]. Professionalization of under-recognized health worker cadres. Washington: United States Agency for International Development & CapacityPlus; 2010. Available from: <http://www.capacityplus.org/files/resources/under-recognized-cadres-overview.pdf> [accessed 15 June 2013].
- Jaskiewicz W, Tulenko K. Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. *Hum Resour Health* 2012;10:38. doi: <http://dx.doi.org/10.1186/1478-4491-10-38> PMID:23017131