Follow-up of Discussions in Case Studies Course—Carl E. Taylor

Incentives for Community Health Workers (CHW's) was a question raised in the On-site course that I did not answer adequately. Because of my hearing deficit I apologize that I didn't understand the excellent questions being asked. Yes, this is an extremely important and chronic problem that is deeply polarized. Paul Farmer said in Haiti it was only "fair" to pay CHW's. But in most really poor situations, local complexities are influenced by laws, regulations, diversity of services, and economic potential. There are many forms of "compensation" for CHW's other than money such as training, family prestige, or other "perks that have most value locally. Community based partnerships can guide in defining the type and amount of work that can be expected. Henry thinks CHW's in the US tend to be paid if they work more than half time -- this obviously varies around the world.

I suggest that any CBPHC project which is not already locked into a firm position, and can choose a direction, should frankly face the following questions about incentives:

1. How much flexibility can the Outside-in partner expect to have in building three way partnerships? And then, what is the community role?
2. Donors are already imposing many constraints, should incentives be given higher priority and for what ethical or other reasons?
3. Donors and NGOs want quick results. Incentives certainly help initially, but do they create expectations which influence the long term sustainability of programs that depend on payments? What is the influence on other projects trying to promote community-based services? Does that lead to cooperation or competition? Do donors with abundant funding then pay but does it leave the services with little support who must rely on volunteers?
4. Do incentives and the idea of jobs create a tendency to bureaucratization rather than capacity building?
5. With scaling up, the numbers of CHW's may increase rapidly. In time, they may become among the most numerous of all health workers. In places with limited resources, even small wages can be a heavy burden on local financing?
6. At what stage might incentives cause CHW's to identify themselves primarily as part of the health system and only secondarily as community members? Should they be encouraged to get more health training? Would this flow cause the best community workers to bring greater community understanding into health care delivery? Or would they then just conform to health system practices for this to become a different level of brain drain?
7. Most importantly, if the ultimate purpose is Community Empowerment, how does the CHW role become part of building community capacity? What components are locally most important: training, prestige for the family from community service, increased access to leaders, increased access to facilities (such as priority health care for their own families, or the Welch Library for Maryland Health Officers), retirement benefits and access to income generation projects? At Jamkhed they became some of the richest people in their villages because of their leadership role in income generation.