



The role of community participation for sustainable integrated neglected tropical diseases and water, sanitation and hygiene intervention programs: A pilot project in Tanzania

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ABSTRACT

Strategies aimed at reducing the prevalence of neglected tropical diseases (NTDs) in Tanzania including those attributed to water, sanitation and hygiene (WASH) problems have been largely top-down in nature. They have focused on strengthening the governance of NTD-WASH programs by integrating different vertical disease programs and improving the efficiency of report-generation. In this paper, we argue for community participation as an effective strategy for developing sustainable village health governance. We present the results of a pilot undertaken between November 2015 and April 2016 in which we adopted a mixed methods case study approach to implement an Enhanced Development Governance (EDG) model using existing village governance structures. Our results show that the EDG model was associated with a statistically significant reduction in the prevalence of schistosomiasis and diarrhoea, and has led to an increase in awareness of WASH interventions for sustaining gains in NTD control. We identify five key social processes enacted by the EDG model that have led to improved health benefits related to frequency of meetings and attendance, promotion of health and sanitation awareness, income-generating activities, self-organising capabilities, and interaction between village bodies. These findings hold important implications for conceptualising the role of community participation in sustaining NTD-WASH intervention programs and for sensitising institutional and policy reform.

1. Introduction

In Tanzania, the prevalence of neglected tropical diseases (NTDs) remains of major concern with over 40 million people in 2013 requiring mass drug administration (MDA) for onchocerciasis, lymphatic filariasis, soil-transmitted helminths, schistosomiasis and trachoma (Mwingira et al., 2016). While MDA is the primary strategy for controlling schistosomiasis and other NTDs, by not addressing the fundamental determinants of NTDs, continued re-exposure allows rapid re-infection implying the need for a high level of coverage for many years to achieve successful control and elimination. However, sustaining high coverage of the target population is challenging for control programs due to resource limitations, local resistance, non-compliance, and waning community and political support resulting in growing awareness of the need to improve the governance and delivery of NTD programs (Bardosh, 2014). In 2005, the introduction of an integrated NTD control program in Tanzania provided an opportunity to minimise

costs, streamline program activities and maximise the use of resources (Kabataraine et al., 2010). Efforts have also been made to define the role played by Community Health Workers (CHWs) in Tanzania and other Sub-Saharan African countries as these voluntary agents deliver relatively similar interventions across several programs to the same people (Marchal et al., 2011). From the mid-1990s, the introduction of a health management information system (HMIS) and more recently a mobile-phone based NTD HMIS piloted in Mkuranga district of Tanzania led to improvements in data-handling, although these systems have not resulted in increased local voice and participation in health planning and decision-making (Madon et al., 2014).

The NTD program governance strategies described above required considerable power to be vested with district-level agencies for strengthening the coordination of different programs, resources and information. A more recent strategy adopted by the Tanzanian government, the focus of this paper, has been to concentrate on improving governance and accountability of NTD control and WASH programs at

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the village level. There are several drivers for pursuing such an approach. First, NTDs are influenced by water, sanitation and hygiene conditions requiring joint implementation, management and evaluation of NTDs and WASH programs as part of an overall village development agenda (APPMG, 2015). Second, while the district holds substantial decision-making power with regards to NTD and WASH programs execution and coordination, the effectiveness of both programs has been impaired as their actual implementation occurs at the village level and requires active community participation (Maluka and Bukagile, 2016). Third, while recognising the important role played by CHWs in providing healthcare to the local community, the government needs to find locally-generated ways of providing income to these frontline workers. Non-financial incentives, such as improved working conditions or training and career path incentives, have been put in place in east and southern African countries (Dambisya, 2007) while in other cases local financial solutions have been sought; in India, for example, CHWs are paid through a fee-for-service system (Singh, 2013). The Tanzanian government's current village-level focus on NTD-WASH programs draws inspiration from the Mtwara Model launched in 2002 by the MoHSW¹ aimed at improving local health governance in the Mtwara region which was endemic for lymphatic filariasis. The model was implemented as a local government initiative with the Mtwara Regional Commissioner supporting each district in the region to allocate a budget to supplement central government funds for activities aimed at eliminating lymphatic filariasis. The Commissioner paid regular visits to each district to inspect the implementation of the program and was actively involved in raising awareness amongst villagers about the necessity of eliminating lymphatic filariasis. As a result of this local initiative, MDA coverage improved and the prevalence of lymphatic filariasis declined significantly over the years in that region (Malecela et al., 2013).

This paper evaluates the recent experience of resurrecting village governance structures in Tanzania based on an exploratory study undertaken between November 2015 and April 2016 in four villages in Rufiji District as part of a pilot project launched by the MoHSW. The aim was to create a platform for a broad, interactive discussion on NTDs and WASH programs and their joint implementation, management and evaluation at village level. The project involved the development of a model for sustainable village governance referred to as the Enhanced Development Governance (EDG) model to address the deficiencies in the existing NTD control program. The EDG model which was based on existing village structures such as the Social Services Committee (SSC) and village community bank (VICOBA)² was provided with resources to promote community awareness of NTD prevention and control by establishing new mechanisms for participation in village health.

There are two key objectives in this paper, namely (1) to describe the new mechanisms for community participation that emerged as a result of the EDG model, and (2) to test the hypothesis that the EDG model effectively improved health outcomes and program sustainability. In the next section, we draw from literature on community participation for health program sustainability as a relevant theoretical lens for studying the EDG intervention in Tanzania. Following a description of our methodological approach, we present the results from our evaluation exercise focusing on two key aspects. First, we demonstrate the extent to which the EDG model has increased the opportunities for local people to raise their voice and participate effectively in health planning. Second, we identify whether the enactment of this new

structure has resulted in the reduction of the prevalence of one selected NTD (schistosomiasis) as well as diarrhoea in our study villages and more broadly in improvements in health-related outcomes. Finally, we draw on our study findings to discuss theoretical and policy-related implications associated with supporting sustainable village governance structures for NTD-WASH control in a low-income country like Tanzania.

2. Conceptualising community participation in health program sustainability

The issue of health program sustainability has received attention over the past few decades as an important topic in both academic and policy literature. The concept is broadly accepted as referring to the continued use of program components and activities for the achievement of desirable or intended health outcomes beyond the initial funding period (Shediac-Rizkallah and Bone, 1998; Scheirer and Dearing, 2011). Within this discourse, the issue of what exactly is to be sustained has been a recurrent theme. From a medical or health systems perspective, of importance has been to track the long-term health effects of the program and for its institutionalisation within the pre-existing structures and processes of the health system (Pluye et al., 2004; Shigayeva and Coker, 2015). In their study of a community-based dengue control intervention in three health zones in Santiago de Cuba (Cuba), Toledo Romani et al. (2007) analysed the maintenance of health benefits and the level of institutionalisation of the intervention within the health system, for example in terms of earmarking funding on an ongoing basis for the execution of the new program.

Since Alma Ata,³ a growing strand of literature sees community participation as an essential driving force for health program sustainability based on the assumption that working with communities can help make interventions more relevant to local priorities (Rifkin, 1986, 2014; WHO, 2002; Draper et al., 2010). However, there remains lack of conceptual clarity about how exactly community participation leads to sustainable health outcomes (Hossain et al., 2004). An important debate in the literature has revolved around whether the aim of community participation should be to improve the efficiency of service delivery by increasing the uptake of interventions, or whether it should be linked to addressing broader structural issues of equity in healthcare (Rifkin, 2003; George et al., 2015a). Much effort has been dedicated towards understanding community participation as a process from low levels of participation to higher levels influenced by the socio-economic and political context within which it is embedded, as illustrated, for example, by Frumence et al. (2014) in their study of participation in health facility governing committees in Tanzania. The spidergram model developed by Rifkin et al. (1988) has been widely used to conceptualise community participation as a process influenced by different factors such as needs, leadership, program organisation, management and resource mobilisation, which taken together measure the uptake and sustainability of the health intervention. The model visualises each indicator separately as a continuum from narrow to wide participation, which is then linked to the rest of the indicators to arrive at an overall assessment of how community participation influences program sustainability.

There is increasing recognition in the literature that community participation by its very nature needs to address issues of power and control. For example, lessons from a study of community-directed treatment programs for onchocerciasis control across four African countries revealed the need for program implementers to improve communication strategies so that communities have greater control to plan the timing of treatment interventions and to take ownership of the intervention (Amaziqo et al., 2002). Health program sustainability may

¹ From 2016 this Ministry is called Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC).

² The SSC was established in 1982 as a village-level body re-elected every 5 years responsible for health, environment, water and community development including overseeing the functioning of NTD and WASH programs. In Tanzania, VICOBA started in 2009 and operates through self-selected groups of 25–30 members who organise themselves, undergo training in business management and entrepreneurship and are linked to a commercial bank for finance.

³ The Declaration emerged from the World Health Organization international conference on primary healthcare at Alma Ata in 1978.

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