COUNTDOWN
Calling time on Neglected Tropical Diseases

Case study: The Role of Community Norms, Relations and Power in Community Drug Distributor Selection and Experience

Community Drug Distributors are the key interface role between health systems and the community for the delivery of neglected tropical disease programmes, specifically mass drug administration. Mass drug administration involves a selected community drug distributor delivering medicines to community members house-to-house or through a fixed distribution point. In theory, as directed by the neglected tropical disease programme community directed intervention model, community drug distributors are selected by their communities using participatory approaches facilitated by the health facility. However, in practice, little is known about how existing power dynamics within communities shape these selection processes and impact on the reach of neglected tropical disease interventions.

This case study focuses on work of the COU**NTD**OWN consortium in Nigeria and Cameroon that sought to better understand how gendered roles and relations, as well as community power structures shape community drug distributor selection and experience. Both Nigeria and Cameroon have large neglected tropical disease burdens, as well as great geographical, ethnic and cultural diversity.

Study Design and Findings

- Conducted in Kaduna State within the two local government authorities of Igabi and Kachia
- Conducted in four regions in Cameroon - southwest, littoral, west and centre
- Methods included key informant interviews, semi-structured interviews and focus group discussions with community drug distributors and community members
- In Cameroon, additional direct and indirect observations were conducted within study communities

Community norms, power dynamics and gender

Across both contexts community drug distributor selection processes are frequently linked to gender norms, power and patriarchy within communities and households and needs to be negotiated carefully in programme design and delivery. Selection processes were also frequently non-standardised and were not described as participatory by community members.

In Cameroon, the methods of selection of community drug distributors varied normally according to each chief of centre, with no conscious consideration of gender, age or religion. Most community members thought the choice of the drug distributor was dependent strictly on the chief of centre. Tendencies showed a link with male supremacy or power where men who were upstanding or having “pronounced” positions in the village were easily selected. As a result, women were frequently not selected as community drug distributors. This was thought to be particularly pronounced in the western region of Cameroon, which is highly Islamic and women are not allowed to interact without a veil and in some cases, are not permitted to leave the house.

“Yes, it is the chief of post who selects those he wants…it looks like when each chief of post comes, its them who do their selection for distributors…”

Community member, female; Barombi Kotto

“My uncle was chief of post and so selected me to work for our village”

Male Community Drug Distributor, 10 years’ experience, village countil member, Christian; Barombi Mbo

In Nigeria, some female community drug distributors reported that the only reason they were selected into the role was as a replacement for male community drug distributors who were no longer available, as they were perceived to be a more stable substitute.

> ***"The women in the community suggested me to the village head when the male CDD left for the town you know how men are always looking for a better life"***
>
> Community Drug Distributor, Igabi

Community drug distributors also described that more men were perceived to be selected as community drug distributors as the selection processes tended to only involve men. Key informants described that despite sensitisation efforts, there is a perception that men are stronger than women and therefore they should be the ones to act as community drug distributors within communities. The role of a community drug distributor was also frequently cited to clash with women's reproductive roles. As a result, where female community drug distributors were selected, if they were absent from home for long distribution periods and unable to complete their reproductive roles, this often led to their attrition.

> ***"Well although we do a lot of mobilisation and sensitisation, you know the culture here and that means men are the ones who are perceived to be strong and not the women so this means in the selection of CDDs mostly it will be the men who would get selected and not women. Also, what time would the women have to be going around when she has to be in the house working and taking care of her family?"***
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> Local Government Area Health Staff, Igabi

Patriarchal power, household access, community experience

In both settings, the gender of community drug distributors shaped access to the household and ultimately who could or could not access medicines. Patriarchal control over medicine access and resources at the household and community level also shaped community drug distributors treatment and experience.

In Nigeria, some key informants and community members, especially in Igabi, reported limited or non-access to households by male community drug distributors even where the community drug distributors had been selected by the community and as such treatment may become inequitable. Community drug distributors also reported that in cases where it was a household head who has not seen benefits to the medicine, they sometimes, in addition to not taking the drugs themselves, prevented other household members from taking them.

> ***"It means that the men cannot enter the houses even though they are members of the community and were selected by the community most men would not want another man to see their women. This means that if the head of the household is not at home, those people won't get medicines"***
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> ***"I have an issue with a particular household. I was told that for the past two years, they have refused to accept the drugs. The head of the family says he has not seen any benefit for taking the drug and in turn has stopped the rest of his household from taking the drugs"***
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> Community Drug Distributor, Kachia




In Cameroon, psychological stress because of negative treatment by communities was identified as a reason for attrition of some community drug distributors. Female community drug distributors were more easily uncomfortable than men when being mocked or abused verbally by the community when seeking community-based remuneration for distribution activities (policy/expectation exists in Cameroon that households pay community drug distributors one hundred frs for drug distribution). This caused attrition, reduced attention where some homes are willingly skipped, and affected the gender distribution within the community drug distributors workforce and reduced productivity.

"Because of the way the people spoke bad, that was the main reason I decided to leave CDD work two years ago"

Former Female Community Drug Distributor, Christian; Barombi Kotto

Gender framework

Our findings indicate that policies and practice that guide community drug distribution selection and support are currently gender blind. At the community level selection and experience is highly influenced by existing patriarchal structures that are not currently recognised within health systems dialogues. Assumptions are made about the role that 'participatory' approaches for community drug distribution selection and support can play in ensuring that community drug distributions are representative, appropriate and acceptable for the whole community. The reality of many 'participatory' processes for community drug distribution selection or the way they are facilitated, currently act to reinforce existing gender and power hierarchies.

Many challenges exist in trying to move such processes along a continuum from gender blind to gender transformative, these include: a current lack of data regarding community drug distribution numbers, experience and programme outcomes that is disaggregated by gender, dis/ability, age etc; where data is available, numbers sometimes mask inequities that exist (for example the Nigerian component of this work was part of a mixed-methods study, quantitative results would suggest very little gender disparity in community drug distribution selection and support, but qualitative findings illuminated this); encouraging health systems actors who function within a patriarchal society to stop and reflect on how existing community norms affect health systems processes; policies currently do not recognise gender.

Small actions could be taken to make neglected tropical disease programmes more gender responsive when it comes to the selection and management of community drug distributors, for example, quotas regarding the ratio of male:female community drug distributors could be an initial step to instigate change and encourage active participation of both genders. The implementation of such policies would, however, need careful thought and attention.

For example, to move beyond numbers adequate supervision, mentorship and training during the selection process and for community drug distributors would be essential. Ultimately there is potential for community drug distributors (when selected appropriately) to be agents of change for gender transformation at the community level as they challenge and negotiate existing gender norms in their everyday activities.

Intersectionality Framework

An embryonic intersectional analysis allowed for the consideration of additional factors at the micro level such as religion and age, and how they too can shape and interact with gender power relations and influence programmatic decision making. It also allowed the research team to challenge assumptions about how existing known gender roles and relations would manifest at the community level. For example, in Cameroon, Islamic communities described more significant barriers for women in both being selected as a community drug distributor and in household interaction. However, in Nigeria this was a more pronounced issue in the Christian areas studied as opposed to the more Islamic contexts.

At the macro-level, the intersectionality wheel allows for the consideration of the political discourse that surrounds neglected tropical disease programming and how this shape the way in which community drug distributors are selected and supported/unsupported. For example, neglected tropical disease policies (including how community drug distributors should be selected and supported) are frequently shaped by international donors who control how programmes are designed and implemented, as such this makes adapting these processes for context more difficult. Funding restrictions frequently do not allow for adequate numbers of community drug distributors to be selected and trained, thus also shaping community drug distributor experience.

The intersectional analysis in these case studies was limited and could be strengthened through the consideration of other social factors such as dis/ability, sexuality etc. and how they shape various programme outcomes.

Key Recommendations

- ✓ Using gender and intersectional frameworks in collaboration/overlaid with existing health systems frameworks or intervention evaluation frameworks can allow for deeper interrogation of barriers and bottlenecks that can achieve gender and equity both within the health workforce and in the delivery of health systems interventions
- ✓ Adaptation of easy to use gender frameworks may be useful to health systems managers and implementers when thinking through these issues in programme planning and development
- ✓ Development of supportive structures that allow the health workforce to be recognised and respected within the health system, for example, building peer support mechanisms for solution sharing may be an approach that could be applied at all levels of the health system
- ✓ Considering women's reality and experience may be different from men with unique needs and interests, a redistribution of power and resources is required to ensure equitable access to health interventions at the community level

References and Further Reading

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