Mass sterilisations and community engagement

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Mass sterilisation (also known as spayathons or sterilisation campaigns) as an intervention in communities where there is a perceived overpopulation of dogs, is a controversial matter. The main reasons for the controversy are as follows:

Firstly, the view that mass sterilisation has a long-term significant impact on the population of dogs is not conclusively supported by existing evidence. According to a demographic study conducted in India (Totton et al, 2010), the dog population in the study would remain stable if 31% of dogs were sterilised (implying ongoing sterilisation to maintain that rate). Leney & Remfry as reported by Totton et al (2010) report that ongoing sterilisation programmes can decrease the dog population with stabilisation occurring 5-7 years after implementation, while Totton et al’s (2010) model indicated 13-18 years to reach stabilisation. In the absence of epidemiological studies examining the population dynamics of dogs in various locations and contexts, it cannot be assumed that once-off or irregular mass sterilisation will indeed have the desired impact. For example, in areas where the life expectancy of dogs is low, sterilisation will have limited impact as the animals would not survive long enough to affect population numbers anyway. Since mass sterilisation projects are very costly, it begs the question whether the money spent on such projects could not be more efficiently spent on other programmes.

Secondly, mass sterilisations are usually performed as an imposed intervention rather than a participatory interaction. Participation requires that the community and the service provider (e.g. the animal welfare organisation), are equal partners and the community supports the initiative and actively participates in it. It is critical to promote collaborative engagement which equally
recognises the importance and the contributions of all partners (Israel et al 2001:182). Historically, most mass sterilisations only involved limited community participation and as a result have not always been adequately supported by the communities. The service provider typically identifies a dog overpopulation problem, arranges with some community members where and when to do the intervention and then implements the campaign. Consultation with the community is mostly limited to a few community leaders or so-called gatekeepers, and the plan (mass sterilisation) is decided upon regardless of the community’s inputs. Equal participation ensures a relationship built on mutual respect and trust between the community and the service provider. Partnerships may be difficult to maintain and unequal powers may complicate the situation (Moely et al 2009:76).

Thirdly, the community engagement approach has traditionally been a needs-based approach i.e. needs are identified and solutions formulated. An asset-based approach is likely to be more beneficial i.e. identifying assets within a community and developing innovative, contextually appropriate initiatives to benefit the community. Eloff and Ebersöhn (2001:149) affirm that the asset-based approach enhances capacity building as it utilises locally available resources to address challenges within a specific environment. This approach encourages the community to take ownership, promotes shared responsibility and contextualises the realistic solutions within their environment, thus enhances resilience given the adversity in many of the communities (Ebersöhn and Mbetse, 2003:323). In many instances this approach results in solutions found and implemented by the community for the community, with external roleplayers only playing a facilitatory role. Ebersöhn and Mbetse (2003:324) argue that “the role of the professional in an asset-based approach is that of helping the community to realise, appreciate and utilise their talents and assets.” A community that identifies its own resources and works out how these can be applied to address challenges is empowered and more likely to develop a sustainable solution to any challenges.

Lastly, mass sterilisations are often performed in isolation without any sustained form of community engagement linked with the intervention. Primary animal health care requires a holistic approach to animal health and sterilisation cannot stand alone. Vaccinations, deworming, nutritional advice, general management and behavioural advice and zoonoses (“one health”) are also important aspects of primary animal health care. It would for example be irresponsible to perform a mass sterilisation in a population that is exposed to a disease such as distemper but has not been vaccinated prior to the initiative, or where a prevalent zoonotic disease is not addressed at the same time.

Council therefore urges organisers of mass sterilisation events to carefully consider the broader and longer term implications of animal and human health when organising these events. Council supports an evidence-based approach to animal welfare and community engagement.
REFERENCES


