



COMMUNITY BASED ANIMAL HEALTH CARE

CHALLENGES IN COMMUNITY BASED ANIMAL HEALTH CARE EXPERIENCES OF PRACTICAL ACTION EAST AFRICA

Introduction

This technical brief describes some of the experiences in animal health care delivery in Eastern Africa by Practical Action East Africa (formally ITDG EA) and its partners as part of a food security and drought mitigation strategy among the pastoralists living in the arid and semi arid lands of East Africa. The pastoralists mainly keep cattle, camels, sheep, goats and donkeys and animal health care is a key factor affecting livestock production.

What is Community-based Animal Health Care (CBAHC)?

Community-based Animal Health Care (CBAHC) is an approach aimed at delivering services that are controlled by the community as opposed to the conventional government controlled or centralised service delivery approach. It is the delivery of animal health services by selected members of the community who are trained to handle basic animal health care issues at village level. These trainees are called community based animal health workers (CAHWs). For sustainability they are linked to a drug supply system as well as a referral system with veterinary professionals. This approach has also been used in the provision of animal health services in Nepal and India.

The historical development of Animal health services in Kenya

The veterinary department was established in Kenya in 1903 by the British government, which was more concerned with disease control and research, while European farmers in collaboration with private practitioners, took care of clinical services and breeding programs. This was the norm in the high potential areas where European farmers were located. The indigenous farmers were offered free disease control by the government so that their animals would remain free of disease to reduce the risk of infection to the European high-grade cattle.

Just before independence, the African farmers were allowed to keep grade cattle. Soon after independence in 1963, the European farms were sub divided into smaller units for allocation to small-scale African farmers along with the high-grade cattle in those farms.

The small-scale farmers had no experience in managing high-grade cattle that were less resistant to diseases, particularly tick borne diseases. The animals thus started dying in large numbers. The African farmers were also poor, with limited resources to invest in high-grade cattle. They therefore could not afford fees charged by the private veterinary practitioners. Consequently, the practitioners could not make a living and thus left the country. A vacuum in the provision of services was created and the government had to intervene to protect the high-grade national herd from risks of diseases. Clinical centres were built, artificial insemination services and bull schemes were opened, dipping programmes organized and where veterinary staff was inadequate expatriates were hired, and while manpower training was increased.

These types of services that were subsidized became a heavy budgetary burden and could not be sustained for long.

Why Community based Animal Health Care (CAHC)?

Over the years, the allocation for non-recurrent salary budgets has stated declining, resulting in inefficient delivery of services. It was also realized that the remote areas of Kenya were

technical brief

not being adequately served by the central government veterinary services for reasons, which included:

- The vastness and the remoteness of the areas and the sparse human population density;
- Poor infrastructure
- Poverty. Charges were unaffordable and / or the value of the animal was not worth investment.
- Insecurity
- Fewer veterinary staff due to non-recruitment by the government as a result of Structural Adjustment Programs (SAPs).
- Veterinarians unwilling to work in remote areas.
- Phasing out of the Junior Animal Health Assistants following the move by the government to give the livestock keepers greater control of their resources
- Poor distribution of veterinarians, many of whom lack the initial capital that is necessary for the establishment of private services
- Nomadism.

The absence of veterinary services led to the development of community-based animal health care.

The historical development of Community-based Animal Health Care (CAHC)

Community-based animal health care (CAHC) was introduced in Kenya in 1986. This was adopted from experiences in both Nepal and India.

Intermediate Technology Development Group Eastern Africa (ITDG- EA) in partnership with other development agencies initiated several CBAHC projects in the chronological order, as shown in table 1 below.

To date over 14 organizations have started CBHC projects in East Africa on the ITDG's experience and other development agencies.

Table 1: Chronological Development of some CBAHC projects and organization involved

YEAR	ORGANIZATION / PROGRAM	LOCATION	COUNTRY
1986	Catholic Diocese of Meru / ITDG EA	Meru District	Kenya
1987	Catholic Diocese of Kitale	Pokot District	Kenya
1989	Oxfam and ITDG EA	Baragoi division	Kenya
1992	ASAL program	Kajiado District	Kenya
1993	Trans Mara development program (TDP) funded by GTZ	Transmara District	Kenya
	Marsabit Development Program (MDP) funded by GTZ	Marsabit District	Kenya
1994	ITDG EA	Kathekani in Makueni	Kenya
1995	IFSP-E funded by GTZ	Mwingi District	Kenya
	IFSP-E funded by GTZ	Makindu in Makueni	Kenya
	Taita-Taveta ASAL Program	Taita-Taveta District	Kenya
1996	District Rural Development Program (DRDP)	Kahama, Biharamulo	Tanzania
1997	GoK and University of Nairobi	Kibwezi in Makueni	Kenya
	Vet Aid, Tanzania	Simanjaro Arusha	Tanzania
	ITDG EA	Tharaka in Tharaka-Nithi district	Kenya

1999 IFSP-E funded by GAA

Makueni district

Kenya

Source: Community-Based Animal Health Care in East Africa

Setting up a community based animal health care system

The main approach and procedure involved in setting up a CBHC System involved a process, which included the following;

- Conducting baseline surveys to get acquainted with the livestock health situation in the working area and create a better understanding between the communities and the implementing agency
- Holding a community dialogue workshop to discuss CBAHC concept where the roles of the participants are defined; selection of trainees is done by the community on the basis of set criteria such as interest in animal health welfare, honesty and literacy.
- Training the selected trainees
- Providing material support - after the completion of the training, CBAHWs are equipped with veterinary drug kits to take back to their respective communities where they start operating under supervision of veterinary technical staff
- Undertaking monitoring and evaluation – during the initial stages intensive monitoring should be carried out to assess whether the CBAHWs are following what they were taught and whether the objectives are being met.
- Conduct refresher courses at regular intervals based on the CBAHWs performance assessed during the monitoring. Retraining is devised based on the findings.



Photo of CBAHWs at work treating an animal in Marsabit. ©Practical Action

Challenges in the animal health care delivery systems

a) The veterinary legislation in relation to CBHC system.

The CBAHC provided an alternative animal health service in areas where no government veterinary services are available. It involves semi-trained personnel who are not eligible for licensing by the national veterinary boards in some countries. In addition, the Veterinary Surgeons Act in Kenya regulates several aspects of the veterinary profession, including who should practice and the code of ethics. The acts specify the minimum qualifications required for registration by the boards. As it stands today, Diploma and Certificate holders in animal health do not qualify for registration or licensing and can only practice under the supervision of registered/licensed veterinary surgeons.

Another act that affects the operations of veterinarians is the Pharmacy and Poisons Act. This act prohibits all veterinary surgeons from stocking large quantities of Part one poison (drugs) unless a registered pharmacist is in direct control of the premises where the drugs are stocked or sold. The requirement seriously curtails the profitability any veterinary practice in the area.

The overall effect of both acts on paraprofessionals and auxiliaries is that they are not recognized by the regulatory bodies, and that they may not stock and sell the drugs, despite these being the only persons available in ASALs. Consequently CBAHWs are providing the services illegally. It has been recommended in some countries such as Kenya that the Veterinary Surgeons Act be reviewed to accommodate “ semi professionals and other cadres of veterinary Practitioners” (Hubl et al., 1998). This move would lead to the improvement of the delivery of animal health services especially in ASAL.

Table2: The effect of the Veterinary Surgeons and Pharmacy and Poisons Acts on the veterinary services in high potential areas and Arids and Semi arid Lands

Legal Issue	Effect On Service Delivery In High Potential Areas	Effect On Service Delivery In Arid And Semi-Arid Areas
1. VETERINARY surgeons Act, Cap.366	-Trained vets available to establish vet practices and offer services -Government vets available and are providing services	-Number of vets trained is insignificant. No provision of services through private veterinary practices. - Few government vets; thin service on the ground
i) Only registered veterinary surgeons to establish veterinary services		
ii) Certificate and diploma holders in animal health not registered to establish vet practice.	-Certificate and Diploma holders trained, and are carrying out illegal practices (by providing services) -Certificate and diploma holders in Government services are providing services.	-A few certificate and Diploma holders trained but working with NGO's - Few certificate and Diploma holders in Government sector – provision of limited services
iii) Community based animal health workers not recognized.	-Number in high potential areas negligible. Insignificant effect on service delivery.	-Limited number available, but providing services illegally -Potential to train more exists if recognized by law.
2. The Pharmacy and Poisons Asct, Cap 224	- Operation of private practices limited and therefore services delivery is equally affected. -Sell of vet drugs monopolized by pharmacists who have little respect for ethical practices in dispensing these drugs.	-Supply and usage of veterinary drugs out of control. -Many vet drugs in the hands of pastoralists in poor and rudimentary services delivery.
i) Vets can not carry out business of veterinary drug stockists		
ii) Veterinary personnel not in drugs inspectorate service	-Inadequate control of drugs -Vet drugs in the hands of non professionals and hence poor services in many cases.	

Source; proceedings of the 8th DAH workshop, ITDG (1999)

b) Policy advocacy

Policy advocacy was necessary considering the serious need for vet services in the ASAL areas against the current veterinary legislation. The points to be considered were;

- Who to influence
- What evidence to defend

technical brief

- Who are the direct and indirect beneficiaries
- How each stakeholder will be affected.

Practical Action EA involved various stages in its advocacy strategy, which included;

- Proving a case on the ground
- Publishing and publicising the case
- Working with the government veterinarians
- Working with other partners like FARM Africa, GTZ, DANIDA and VET Aid
- Establishing contacts at policy levels.

c) Standardization of training in Community-Based Animal health Care.

At an animal Health stakeholders meeting held in Meru (Kenya) May 1999, It was reported that Community-based Animal Health workers (CBAHWs) training manuals although existing have the following shortcomings;

- Are not available to the public
- There is no common curriculum for CBAHC because of variation in;
 - a) Selection criteria
 - b) Training content training needs
 - c) Duration and frequency of training and recruiting
- The Kenya Veterinary Board has not officially recognized trained CBAHWs as a cadre of animal health service providers
- There is no agreement on who should examine the CBAHWs to ensure they have attained a minimum standard.
- The practices in other countries have not been adequately analysed and assessed.

A recommendation was made that all stakeholders who have an interest in sustainable delivery of community-based animal health services should form a committee to review these issues and make appropriate recommendations. At the same time a desire was expressed that Kenya Veterinary Board (KVB) and Department of Veterinary Services should officially recognize the other cadre involved in the delivery of animal health services which include CBAHWs, KVB to over see the training of the training of CBAHWs and the process of training CBAHWs be harmonized by formulating a common manual under the auspices of well trained professional educators. This would be followed by training a cadre of professionals, who in turn would train in different locations, using a common minimum curriculum and a varied component, which would emphasize the local breeds. It is only then that the Kenya Veterinary Board (KVB) will recognize those who pass.

d) Other challenges affecting the CAHC Systems were:

- Lack of support from the local leaders which affected performance of the CBAHWs
- Some CBAHWs exhaust their veterinary kits supplied by donors and fail to replenish them
- Areas covered by CBAHWs are so vast that they cannot meet the demand
- The legal aspects limit the amount at type of drugs these people are allowed to use
- Trained nomadic people may migrate to other places, thus reducing the overall objectives of the concept
- The drop out rate for the educated people is higher than for the un educated
- Record keeping has remained a set back in the day-to-day running of the CBAHC concept.