Cross-border issues related to the provision of animal health services with reference to Kenya, Uganda, Ethiopia and Tanzania

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1. INTRODUCTION

The greater part of the cross-border areas of the four countries (Kenya, Tanzania, Uganda and Ethiopia) are arid and semi-arid and is inhabited by pastoral communities whose livelihood and incomes are derived mainly from livestock. In addition, animals are central to lifestyles and culture among those communities. Essentially, the importance of livestock to the cross-border communities goes beyond economic considerations and this explains the need to improve livestock production and productivity in these areas.

Animal health service provision is key to livestock production and productivity. Besides, it is a critical factor in cross-border trade in livestock and their products. This paper highlights various issues related to provision of animal health services in areas near national boundaries with reference to Kenya, Tanzania, Uganda and Ethiopia, and also suggests ways of improving service provision and delivery in these areas. Key issues highlighted include constraints in the provision of animal health services, problems related to disease surveillance and reporting, PACE interventions, role of community-based animal health service delivery, and the need for and progress towards regional harmonization of primary animal health care.

2. CONSTRAINTS IN THE PROVISION OF ANIMAL HEALTH SERVICES

The areas near national boundaries are characterized by poor infrastructure, communication difficulties, pastoralism, inaccessibility to services and insecurity menace. *The communities are trapped in a vicious cycle of poverty and insecurity due to persistent cattle rustling, counter raids, shortfall in services and infrastructure provision and absence of opportunities*. Specific constraints affecting provision of animal health services include:

- **Vast areas with minimal infrastructure, poor terrain and poor communication facilities**: Leading to unavailability of services to livestock keepers particularly the pastoralists.
- **Government veterinary services are thin on the ground with minimal technical staff, inadequate financial resources and working facilities, and low incentives**: Hence poor and inadequate provision of services.
- **Uncontrolled cross-border livestock movement with the accompanying risk of disease spread**: In all cases the boundary is too long to police and is porous to livestock keepers, animals as well as diseases. The porous nature of boundaries makes it difficult to enforce rules and regulations governing livestock movement.
- **Insecurity due to**:
    - Civil conflicts
    - Banditry menace
    - Cattle rustling/counter raids.
- **Inadequate and unreliable supply of veterinary drugs**
- **Inadequate information flow**: Due to lack of animal health service providers and poor infrastructure, disease information flow is slow, scanty, erratic and also unreliable.
- **Low cash economy among the pastoral communities**: This greatly affects viability of private animal health practices because of communities' inability to pay for services.
- **Poor marketing of livestock and livestock products**: Inadequate marketing infrastructure, high level of illiteracy/ignorance and insecurity are among the contributing factors.
- **Inadequate support for reliable, sustainable and effective animal health services.**

- **Drought**: Frequent droughts in some areas result in unavailability of pasture/water and therefore poor body condition of livestock and an upsurge of diseases.
- **Inadequate harmonization of animal health services**: Lack of harmonized approaches and strategies is a hindrance to effective control of transboundary diseases and disease surveillance. It is also a hindrance to better information sharing and dissemination.

2.1 Suggestions to improve provision of animal health services in cross-border areas:

1. Support livestock marketing through improvement of marketing infrastructure.
2. Harmonize animal health service delivery in the region to facilitate health certification. This will ease cross-border trade in livestock and products.
3. Improve provision of water supply for livestock.
4. Support and promote sustainable drugs supply to CAHWs and other animal health service providers.
5. Strengthen and support training, supervision and monitoring of CAHWs by Vets.
6. Promote peace initiatives and community dialogues in conflict prone areas e.g. among Karamajong cluster
7. Improve coordination of animal health service providers. Veterinary authorities to provide the lead role.
8. Establish effective drugs control system to minimize black markets for drugs and also to curb use of fake or expired drugs, e.g. establishment of drugs inspectorate service.
9. Sensitize communities on their role in disease control activities and animal health service delivery in general.
10. Improve infrastructure (e.g. road network, communication etc.)
11. Train and use more CAHWs, and provide incentives.
12. Institutional strengthening (e.g. State Veterinary Services). State Veterinary Services should have the capacity to provide sufficient coordination, and supervision and monitoring role.
13. Provision of adequate incentives (e.g. hardship allowance) that will attract vets in remote areas. Support development of subsidized private veterinary practices; at least as a starting point.
14. Regular cross-border meetings; and assist communities to establish community-based cross-border disease and livestock movement control mechanisms.
15. Promote pastoral education for development.

3. DISEASE SURVEILLANCE AND REPORTING

3.1 Approaches:

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PACE's approaches to disease surveillance and reporting are generally the same in all the four counties. The differences or variations are insignificant. The following approaches have been applied in all cases:

1. **An all inclusive approach:** participation of all relevant players including livestock keepers, CAHWs, paravets, private veterinary practices, NGOs, State Veterinary Services (field staff, administrators, laboratory services etc), community leadership and public in general.
2. **Awareness creation through sensitization**: to make all players understand the importance and benefits of disease surveillance and reporting, and more importantly their respective roles and responsibilities.
3. **Capacity building for disease surveillance and reporting through training**: Emphasis on relevant training so as to enhance skills and capacities..
4. **Coordination through a central unit**: Epidemiology Units established. Responsible for coordination of surveillance activities including data/information storage, analysis and dissemination.
5. **Communication component**: Establishment of communication component as an integral part of surveillance system. Through communication units, information is packaged in a simplified and clear manner for ease of presentation and dissemination to all players.
6. **Data and information collection**:

- *Passive surveillance*: Information or data collection through routine activity reports – e.g. monthly, quarterly or annual reports, specific case reports within routine work schedules etc. The reports from District veterinary officers and laboratories are commonly used. Reports from other players (e.g. private practices and NGOs) are also useful

- *Active surveillance*:

a. Specific case investigations, e.g. during an outbreak or reported disease threat.
b. Pro-active search for a disease/infection. This may be occasioned by rumor or suspicion of an outbreak or necessity to prove absence of diseases or infections.

3.2 **Constraints based on PACE experience include:**

- Inadequate resources – finances, transport, equipment etc.
- Insecurity – inaccessibility of some areas due to security problems.
- Insufficient experience and skills in surveillance work, e.g. participatory epidemiology.
- Inadequate professional/technical staff especially at the ground level, hence inadequate reports and information.
- Severe drought – forcing livestock to move far distances outside the reach of surveillance personnel. Livestock inaccessible because of constant movement.
- Laboratory capacity to handle samples limited, hence timely analysis of data curtailed.
- Inadequate technology for data analysis
- Lack of clear or tangible incentives especially on the part of private sector and community in general..
- Ignorance, illiteracy and insufficient awareness creation at the community level leading to inadequate community participation.
- Poor/lack of infrastructure (poor road network)
- Participation by CAHWs – limited knowledge on some diseases
- Long distance between livestock owners and district veterinary officers or nearest service providers – resulting in information gaps.
- Communication technology, equipment and facilities limited. Lack of communication network.
- Reports – lack of consistency, not entirely reliable and insufficient information.
- Decentralization of veterinary services to local authorities – no clear chain of command leading to inappropriate reporting channels.
- Delay in reporting and similar delay in feedback. Lack of information feedback de-motivates and leads to poor participation and occasionally direct lack of cooperation.

3.3 Suggestions for improvement:

- ✓ Lobby the Government to increase funding not only for PACE program but for livestock sector activities in general.
- ✓ More sensitization or awareness creation targeting all levels. More attention at the community level.
- ✓ More training based on specific needs.
- ✓ Provision of incentives, e.g. allowances.
- ✓ Lobby government to put in place veterinary structure that will allow smooth reporting and effective information flow from ground to top level. This will avoid inappropriate reporting channels.
- ✓ Intensify peace dialogue (inter-governmental level) – to secure peace, hence more conducive environment.
- ✓ An all inclusive rapid response system. This includes easy accessibility of funds as and when circumstances warrant.

4. PACE INTERVENTIONS

The Pan African Program for the control of Epizootics (PACE) was preceded by successful conclusion of the Rinderpest Control Program, PARC, which brought rinderpest under full control in the region, thus paving the way for eradication process. The PACE program is expected to build on the achievements of PARC and push forward the rinderpest eradication process in accordance with OIE pathways while at the same time addressing other trans-boundary diseases, with CBPP being the first priority. The core objective of the program is to strengthen animal disease surveillance and control capacities, support sub-regional and regional initiatives for the surveillance and control of priority epizootic diseases, promote and support privatization initiatives in animal health service provision and to spearhead adherence to OIE guidelines for the verification of freedom from rinderpest infection.

In all the four countries PACE is playing an important role in supporting and enhancing the provision and delivery of animal health services in border areas. Specific PACE interventions include:

- Disease surveillance and control, with particular attention to transboundary diseases.
- Capacity building in disease surveillance.
- Pursuing rinderpest eradication based on OIE pathway.
- Supporting community-based animal health service delivery system:
  - Training of CAHWs
  - Integrating CAHWs into disease surveillance and reporting network.
- Supporting review of current animal health legislation with a view to making it more supportive to animal health service delivery.
- Promoting / supporting harmonization of disease control policies and strategies.
- Supporting privatization initiatives in the provision of animal health services.
- Supporting cross-border peace initiatives.

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The interventions by PACE are important but not adequate to address all the identified problems/constraints. However, the program only plays a complementary role to other programs under National Veterinary Services and must not be seen as the only initiative through which the identified constraints and problems should be solved.

5. ROLE OF COMMUNITY-BASED ANIMAL HEALTH CARE SYSTEM (CAH)

Community based animal health care systems are in operation in nearly all the border areas of the four countries. In some of the areas it is perhaps the only available means of providing animal health services to livestock keepers. The role of CAH covers a wide range of activities including clinical service delivery, extension service, disease control and surveillance, and reporting among others.

Specific roles of CAH:

- Provision of simple clinical services (diagnosis and treatment).
- Simple surgical and manipulative operations (closed castration, wound treatment, occasional dehorning, simple cases of dystocia, hoof trimming etc).
- Provision of animal health and production extension services to livestock keepers.
- Assist in mobilizing communities during emergency interventions, vaccination campaigns or during active surveillance activities.
- Participate in actual vaccination, as was the case during rinderpest vaccination campaign under PARC.
- Part of disease surveillance and reporting network.
- Provide regular contact with livestock owners, thereby enhancing disease information and data collection and reporting. CAHWs make reports to veterinary authorities or supporting NGOs and such reports are useful in disease surveillance.
- Assist in sampling during surveillance work.
- CAHWs are key informants. They provide useful leads about livestock movement and some other intelligence information on diseases, weather patterns, community perceptions on various issues etc.

5.1 How can CAH be improved?

Suggestions:

- Establish effective monitoring and supervision linkages.
- Sustainable drugs supply system. For effective CAH service delivery, CAHWs must be linked to drugs supply lines and on a sustainable basis.

- More institutional support and enabling policy to CAH
  - Acceptance
  - Recognition.
- Stronger linkages between CAH and district veterinary authorities. Linking issues include:
  - Monitoring
  - Supervision
  - Technical guidance
  - Disease reporting
  - Feedback
- More training for CAHWs based on identified needs (refresher training).

- More sensitization: livestock owners and community in general to accept and support the payment for services concept. This is a cardinal point in CAH sustainability.
- Improved coordination of CAH programs.
- Harmonization of training curriculum – set minimum level of training.
- Provision of incentives to CAHWs – rewards, bonus, recognition, commendation, certificates etc..
- Improved participation of community during selection of individuals to be trained as CAHWs. Quite often, the "voice" of an influential individual overrides that of the community leading to selection of wrong people.
- Harmonization of approaches and methods applied by various agencies operating CAH programs.

6. REGIONAL HARMONIZATION OF PRIMARY ANIMAL HEALTH CARE:

6.1 Why harmonize primary animal health care?

1. Better control of transboundary diseases.
2. Enhanced exchange of information on livestock diseases in the region.
3. As a tool of promoting cross border trade in livestock and livestock products
4 To strengthen community-based animal health care system in border areas and hence improve service delivery

6.2 Progress towards regional harmonization of primary animal health care:

Notable initiatives taken towards regional harmonization of animal health care system:

- Under the umbrella of E.A.C, some progress has been made towards formulating a regional framework for disease control and related animal health services.
- The PACE programs in the region have incorporated community animal health care system in disease control, surveillance and reporting.
- Harmonization meetings facilitated by OAU/IBAR held
- Establishment of a regional (greater horn of Africa) community animal health network (CAHNET).

More groundwork is required to create enabling environment for harmonization of primary animal health care. More sensitization at both policy and community levels is needed. OAU/AIBAR should continue to play a lead role in the harmonization process.

7. KEY RECOMMENDATIONS:

1. Regional approach to disease control and surveillance to be promoted and supported.
2. Community peace initiatives and dialogue be supported so as to secure peace, hence an enabling environment for animal health service delivery.
3. More training/re-training of CAHWs be carried out and that sustainable supervision and monitoring systems be put in place. A closer linkage with district veterinary authorities is of critical importance in this direction.
4. All development agencies, institutions and organizations supporting and/or implementing CAH programs should now pay more attention to sustainability issues such as institutional support, drugs supply, economic viability etc.
5. Capacity building in disease surveillance, reporting and participatory epidemiology be given priority by veterinary authorities in the region. Further, more sensitization at the community level should be carried out, with clear message regarding the role of communities as well as CAHWs and the benefits to be derived from their participation.
6. Promote and support regional harmonization of primary animal health care (CAH).
7. AU/IBAR in collaboration with partners should support an impact assessment (including cost-benefit analysis) study of various CAH Programs in the region. The study will indicate justification, or otherwise, for investment in primary animal health care systems.
8. A comprehensive review of animal health service provision in all border districts be undertaken including identification of appropriate interventions.
9. Sustained awareness creation at all levels particularly for high level animal health Service policy makers.

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