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Participatory approaches in animal healthcare: from practical applications to global-level policy reform

by **ANDY CATLEY**

For more than 15 years the use of participatory approaches and methods in animal healthcare and research has been growing and diversifying. In common with other sectors, early interest focused on participatory methods, and the adaptation of interviewing, ranking and visualisation methods to explore livestock-related issues¹. Over time, some methodological developments were grouped using the term 'participatory epidemiology' (PE) and PE is now recognised as a valuable approach to research and action on animal diseases (Box 1). Running parallel to the emergence of PE was the development of community-based approaches to animal healthcare and the increasing acceptance of community-based animal health workers (CAHWs) for the provision of primary-level veterinary services in rural areas². Important advances during the last five years or so include policy and legislative reform to enable CAHW systems and ensure appropriate levels of quality control. Changes at national level have been complemented by changes to the global standards on animal health. Also important has been progress towards the global eradication of rinderpest and the positive impact of community-based approaches in marginalized pastoralist communities of east Africa.

¹ See *RRA Notes 20* (1994) Livestock.

² See *PLA Notes 45* (2002) Community-based animal healthcare.

This article maps out some of the key experiences that have shaped the growing use of participatory approaches and CAHWs. It describes how negative attitudes among professionals and academics have changed during the process of policy reform, and explains how participatory impact assessment and other methods have contributed to the policy process. The article focuses on experiences in east Africa and the Horn of Africa, while also describing how events in these regions have influenced change in international bodies.

Community-level innovation meets professional barriers

The history of community-based animal healthcare starts with a period of innovation and testing in the late 1980s, largely by NGOs running small-scale projects. The common underlying philosophy was recognition of indigenous knowledge and skills, and the involvement of communities in the selection and support of CAHWs. Participatory methods were used during project design, often accompanied by ethnoveterinary surveys. These projects differed from earlier 'vetscout' or 'paravet' projects because of the focus on community involvement in project design and implementation, and the need to address community concerns rather than those of government. Also, CAHW projects used participative training techniques and training courses were often 10 to 14 days duration. The aim was to build on the existing know-how of livestock keepers, and use training methods which were suitable for both illiterate and literate trainees.

Box 1: Some uses of 'participatory epidemiology'**Participatory disease searching (PDS)**

PDS is an aid to locating the last cases of rinderpest during disease eradication. PDS practitioners are 'disease detectives', using livestock keeper's knowledge of the disease to find clinical cases in marginalized areas. Although often misunderstood by epidemiologists, PDS is now an accepted approach supported by the African Union/Interafrican Bureau for Animal Resources and the Food and Agriculture Organisation. PDS is currently in use in Sudan, Uganda, the Somali ecosystem of east Africa, and Pakistan.

Disease diagnosis and descriptive epidemiology

Information from participatory methods such as matrix scoring, mapping and seasonal calendars can be triangulated with conventional veterinary investigation methods to assist diagnosis of 'new' diseases. This approach was used to confirm the diagnosis of a chronic wasting disease in cattle in southern Sudan, which was prioritised by livestock herders. Proportional piling can be adapted and repeated to estimate age-specific disease incidence and mortality in livestock.

Disease modelling to understand options for disease control

Computer simulations of disease spread can assist epidemiologists to understand the pros and cons of different disease control strategies. 'Participatory modelling' combines livestock keeper's expert knowledge of disease dynamics within and between herds, with computer modelling techniques. The approach has been used to improve understanding of major epidemic diseases in pastoralist areas of Africa.

Impact assessment

Methods such as proportional piling can be used to assess the relative importance of livestock diseases against locally-defined indicators of disease impact. This approach is particularly useful for understanding the social benefits of livestock (such as dowry payments) relative to the more widely perceived benefits of food, income, draught power and hides and skins.

Assessing association: the mystery of the hairy panthers

For many years pastoralist communities in Africa have described sick cattle which develop long, woolly coats, avoid the sun and pant during the heat of the day. They explained that cattle with this strange disease had previously suffered from foot-and-mouth disease (FMD). In Tanzania, matrix scoring and proportional piling were adapted to explore possible association between these 'hairy panthers' and FMD. For more information and references, follow the 'Participatory Epidemiology' link at www.cape-ibar.org

As news spread about CAHW projects, the reaction of the veterinary establishment was often deeply negative. At an organisational level, there was resentment that NGOs were taking over the role of government and working independently to deliver animal health services. Although local government officers often worked alongside NGOs (and were paid for doing so) they did not always report this work to their superiors. At a technical level, there were concerns about the rapid and qualitative nature of the participatory assessment on which CAHW projects were based. Similarly,

Box 1: Community-based animal health workers and rinderpest control**Southern Sudan**

Between 1989 and 1992, the UNICEF livestock programme used conventional vaccination campaigns and vaccinated about 284,000 cattle against rinderpest per year. In 1992 the programme came to a virtual standstill as insecurity disrupted cold chains and vaccination teams; only 140,000 cattle were vaccinated that year. In 1993 CAHWs were introduced and supplied with heat-stable rinderpest vaccine. In 1993, 1994 and 1995 CAHWs in southern Sudan vaccinated 1,489,706, 1,743,033 and 1,070,927 cattle against rinderpest respectively. Confirmed outbreaks of rinderpest decreased from 11 outbreaks in 1993 to 1 outbreak in 1997. There were no confirmed outbreaks of rinderpest in southern Sudan after 1997.

Afar region, Ethiopia

For 15 years the Pan African Rinderpest campaign had been struggling to vaccinate cattle in Afar. In 1994, 20 CAHWs were trained and supplied with heat-stable rinderpest vaccine. Moving on foot they vaccinated 73,000 cattle in one season and achieved 84% vaccination efficiency (compared with 72% vaccination efficiency of Ethiopian government teams). There were no reports of rinderpest outbreaks in the region after November 1995.

there was often a knee-jerk reaction to the notion of the training livestock keepers for only two weeks or so, often exacerbated by the inclusion of illiterate people in CAHW projects. And at a professional level, there were fears that CAHWs would undermine the image of veterinarians and take over their jobs.

In the early years, a few courageous vets and NGO workers presented papers on CAHW experiences in national veterinary association meetings and other forums. The result was often uproar and highly personalised criticism of those few vets who were involved in 'non-professional' CAHW work. When projects were donor funded (as many of them were) there were also accusations that northern governments and donors were trying to maintain African veterinary services in a sub-standard state for their own interests. These various arguments and tensions created a slightly chaotic atmosphere which did not encourage open debate and learning about CAHWs. One outcome was that in many countries CAHWs were not recognised by the veterinary authorities or legislation.

Technological innovation meets community-based approaches

While the NGOs were either battling with or ignoring the veterinary establishment, the eradication of rinderpest from Africa was a major concern for the Organisation of African Unity/Interafrican Bureau for Animal Resources (OAU/IBAR)

**Community-based
animal health workers
achieved dramatic
results in places like the
Afar region of Ethiopia**



Photo: PARC Communications Unit

and the Food and Agriculture Organization. As a cause of massive cattle mortality, rinderpest was also a disease that was prioritised by livestock keepers³. In the Horn of Africa, attempts to control rinderpest through mass vaccination campaigns were frustrated by the limited capacity of government vaccination teams to access more remote pastoralist communities. Therefore, the disease persisted in pastoralist areas and there was a constant threat of disease spread to neighbouring countries.

A turning point was the introduction of CAHWs into rinderpest control programmes, assisted by the development of a new heat-stable rinderpest vaccine. The new vaccine meant that at field level, refrigeration equipment was no longer so important – the vaccine could be carried to remote communities for up to three months in a simple backpack by CAHWs. Selected by and trained within their communities, these CAHWs also provided preventive and curative services

for other animal health problems. The results in southern Sudan and the Afar region of Ethiopia were dramatic (Box 2). In 1997, the director of OAU/IBAR, Dr Walter Masiga, told me that initially he had been extremely sceptical about the CAHW approach. However, he also recalled his first trip to Afar to see the CAHWs in action and described it as 'a religious experience'.

Despite the apparently dramatic results from CAHW systems and support from international agencies such as OAU/IBAR and FAO, policy makers in many countries remained unconvinced. They quickly dismissed the experiences claiming that these areas were 'conflict zones' and not relevant to the stable situation in countries like Kenya, Uganda or Tanzania. At the same time, and with decreasing budgets and capacity of government services, they were unable to offer alternative solutions to providing basic animal health services in remote areas of their own countries. Their most common 'solution' was for government to employ and deploy

³ See the article by Jeff Mariner, Peter Roeder and Berhanu Admassu in *PLA Notes* 45.

This private store in north-east Kenya is run by a veterinary diploma holder who supplies and supervises CAHWs



Photo: Dave Hastings

more veterinarians and veterinary technicians. The fact that there was no money to do this was nearly always overlooked.

Privatisation meets participation

As experiences with CAHW systems were evolving, veterinary services throughout Africa were undergoing radical reform. Structural adjustment programmes and privatisation led to downsized government veterinary services, and numerous aid programmes were set up to encourage private veterinary practice through training and credit support. In many east African countries these programmes focused on vets in more urban and peri-urban areas, because it was assumed that rural areas were high-risk and poorer livestock keepers would not pay for services. Most NGOs (and donors) involved in CAHW systems made the same assumption, and ran projects based on either free provision of veterinary medicines or subsidised 'cost recovery' systems. Many of these projects and systems collapsed when the funding dried up and once again, communities were left without trained veterinary service providers.

Throughout the 1990s I worked for NGOs in the Horn of

Africa and was particularly interested in the financial sustainability of CAHW systems. I started to use participatory methods to understand local perceptions of wealth and poverty, and the apparent willingness of different wealth groups to pay for primary veterinary care. In remote parts of Somalia, Ethiopia, Eritrea and Uganda poor livestock keepers recognised the value of their animals and the logic of making relatively small investments in basic animal healthcare. People were also frustrated with projects that were not sustained. They didn't want free handouts or even subsidised systems if this meant that their CAHWs would only function for a short time.

For some NGOs, the idea that CAHWs might be 'privatised' was difficult to grasp and was perceived as contradictory to the benevolent, charitable nature of NGO work. There were also concerns about supporting multinational drug companies (although NGOs were already buying and distributing drugs) and the promotion of western medicine over traditional health systems. Suddenly, some NGOs which claimed to be 'participatory' seemed to stop listening to livestock keepers. A further dimension was that in NGO project budgets, veterinary drugs often accounted for a substantial

Table 1: Institutionalising participation and people-centred approaches: the spectrum of current practice in natural resource management

Information required for business plan	Participatory method	Secondary data sources
Definition of area(s) to be covered, including estimates of human and livestock populations, and infrastructure	Participatory mapping, key informant interviews	Official maps, human census, livestock census
Proportion (and number) of households owning livestock by livestock type	Proportional piling	
Relative importance of different livestock types, with reasons	Livestock species scoring	
Relative importance of different livestock diseases, with reasons	Livestock disease scoring	Government veterinary clinic reports
Prevalence estimates for important livestock diseases	Proportional piling	Laboratory reports, disease survey reports
Seasonal variations in important livestock diseases and disease vectors	Seasonal calendars	Government veterinary clinic reports analysed by month or season
Geographical variations in important livestock diseases and disease vectors; seasonal movement of herds	Participatory mapping	Disease or vector survey reports
Existing veterinary services (public, private, informal, indigenous)	Service maps	
Number of CAHWs required per target area	Participatory mapping	
'Demand' for veterinary services and capacity and willingness to pay	Wealth ranking, individual interviews, group interviews, problem plays, proportional piling.	Government veterinary clinic reports

proportion of the overall budget.

Within government veterinary services, the official position on privatisation was often welcoming as aid programmes channelled cheap credit to a relatively select group of vets. But behind closed doors, the unofficial policy was to maintain government delivery of clinical services through subsidised approaches even though these services had very poor coverage. Here also, the notion that rural livestock keepers might actually prefer to pay commercial prices for services was dismissed. A myriad of donor funding policies added to the confusion, with some donors pushing privatisation and others funding the revitalisation and expansion of post-colonial style government services.

In the mid 1990s a few NGOs began to support private sector involvement in CAHW projects. A key question was how to combine community participation in prioritising diseases and selecting people for training as CAHWs, with the profit-driven nature of private business. Although these

two approaches seemed to be very different, my experience of private practice suggested otherwise. A successful business responds to the needs of clients. It listens to them and provides a service which people want. In *Whose Reality Counts? Putting the Last First*, Robert Chambers noted how the bottom-up, people-centred aspects of PRA were strikingly similar to the concept of 'customerizing' in business development (page 197). Related to the concept of privatised CAHW networks, supervised and supported by private veterinary professionals, was the opportunity to use participatory methods to develop business plans (Table 1).

Focusing on policy and institutional change

Despite the innovation and progress of community-based approaches to animal healthcare, by the late 1990s CAHWs were still illegal in many countries. Although communities wanted CAHWs, the veterinary establishment either turned a blind eye or launched periodic 'anti-CAHW' campaigns in the

media. Lack of clear policies also hindered privatisation and the use of CAHWs by private vets or animal health technicians.

In December 2000, OAU/IBAR established the Community-based Animal Health and Participatory Epidemiology (CAPE) Unit to promote the creation of supportive policies and legislation for CAHWs, and institutionalise participatory approaches and methods in veterinary institutions. The CAPE Unit worked in east Africa and the Horn of Africa, and used a variety of learning, research and lobbying methods to engage national policy makers.

National-level participatory impact assessment

The personal experiences of CAPE staff indicated that veterinary policy makers tended to reject research that was conducted by 'outsiders'. Consultancy reports and studies conducted by foreign universities remained on the shelf while heated debate continued between 'pro-CAHW' field practitioners and 'anti-CAHW' veterinary associations, laboratory-based vets and academics. Policy makers also wanted evidence that a particular approach worked in their own country. To assist policy reform, the CAPE Unit invited agencies which made or influenced policy to join a 'National Impact Assessment Team'. The idea was to create a mixed group of CAHW supporters and sceptics, and facilitate community-level impact assessments to improve understanding of the pros and cons of the CAHW approach. It was realised that learning would arise not only from the interaction with communities (a novel experience for some policy makers), but also from conversations and debate between team members. At the time of writing, the CAPE Unit has supported participatory impact assessment in Ethiopia, Sudan and Uganda.

Peer-to-peer learning and engaging the international actors

In addition to prompting country-level impact assessments, CAPE staff also realised that the most senior veterinary policy makers – the Chief Veterinary Officers – were heavily influenced by international standards and norms, and each other. Under the Sanitary and Phytosanitary Agreement of the World Trade Organization, the *Office international des epizooties* (OIE) sets international standards in animal health. These standards are written, and regularly updated, as the OIE's Terrestrial Animal Health Code (the 'OIE Code'). The OIE is a membership organisation of states, and each state is represented by its Chief Veterinary Officer. Similarly, the Food and Agriculture Organization and the World Health Organization jointly produce international standards on food safety (called the *Codex Alimentarius*).

In October 2002 the CAPE Unit organised an international

conference to bring together the OIE, FAO and senior veterinary policy makers from around the world to discuss policy and institutional constraints to primary animal healthcare. A steering committee was set up with representatives from OAU/IBAR, FAO, OIE and NGOs. Although initially called a conference, the format was more of a workshop comprising a mix of formal presentations and working group discussions.

The conference was opened with a film produced by CAPE and showing interviews with livestock keepers in Mali, Kenya and Ethiopia. The key messages were the virtual non-existence of formal veterinary services, and the high impact but low recognition of CAHWs. For the conference presentations, the steering committee identified a small group of senior policy makers and researchers who had already made a difference in their own countries, and asked them to present their experiences. Consequently, senior government veterinarians, legal experts and researchers from Kenya, Ethiopia, Guinea, Uganda, Tanzania, Zimbabwe, Zambia, Senegal and Indonesia made presentations to their peers.

Throughout the workshop, a recurring theme was inappropriate policies and weak institutional arrangements at national and international levels for the private delivery of veterinary services and the use of CAHWs. The conference recommendations included a call to the OIE to clarify the roles of the private sector and veterinary para-professionals in the OIE Code (the global standards on veterinary services).

The OIE acted quickly on the recommendation and in February 2003 a committee of representatives from Africa (including OAU/IBAR), Asia, South America and Europe, plus the Chairman of the World Veterinary Association, met to brainstorm the topic of privatised vets and para-veterinary workers in relation to the OIE Code. It was during the meetings of this committee that the concept of CAHWs as one type of veterinary para-professional was accepted. The committee recommended changes to the OIE Code so that within each member country, a veterinary statutory body should be responsible for the licensing and registration of veterinarians and veterinary para-professionals (including CAHWs). In May 2004, member states at the OIE General Assembly endorsed this change to the code, thereby creating new global standards to support CAHWs.

Creating national capacity to support CAHWs

While the OIE was formulating new international standards to enable veterinary para-professionals, the CAPE Unit was working with governments and veterinary boards to produce national guidelines for CAHWs, including 'standardised' training curricula. The national guidelines included advice on

Figure 1: Summarised matrix scoring of animal health service providers, Dollo Bay and Dollo Ado districts, southern Ethiopia (source: National Impact Assessment Team, Ethiopia, 2003)

Indicator	Government veterinary service	Drug dealers (black market)	Traditional medicine	CAHWs	Others
'Service is near to us, so our animals are treated quickly'	••• •••• ••• 11	0	0	••••• ••••• ••••• 15	0
'Service always has medicines available'	•• 2	••• ••• •• 8	•• •• 4	••••• ••••• ••••• 14	• 1
'The quality of medicines is good'	•• ••• •• 7	•• •• 4	•• •• 4	•••• •••• •••• 12	0
'Our animals usually recover if we use this service'	• 1	••• •• 5	•• •• 4	•••••• ••••••• ••••••• 19	•• 2
'We get good advice from the service provider'	• 1	•• ••• •• 7	•• ••• •• 7	•••• •••• •••• 12	•• •• 4
'This service can treat all our animal health problems'	••• •• 5	•• •• 4	••• ••• ••• 9	••• ••••• ••• 11	0
'This service is affordable'	0	••• ••• 6	•• •• 4	•••••• ••••••• ••••••• 18	•• 2
'We trust this service provider'	0	•• ••• •• 7	•• •• 4	••••• •••••• •••••• 16	•• 2
'The community supports this service'	0	•• • 3	•• ••• •• 7	••••• •••••• •••••• 15	0

Notes for Figure 1

The Ethiopian National Impact Assessment Team comprised representatives from the Federal Veterinary Service Team, the Faculty of Veterinary Medicine of Addis Ababa University, the Ethiopia Veterinary Association, the National Animal Health Research Centre and NGOs⁴.

The matrix scoring was repeated in 10 communities where CAHWs were working; the median scores from the 10 communities are presented. Agreement between the 10 communities was assessed using the Kendal coefficient of concordance for each indicator. For all indicators, there was significant agreement between the 10 communities at the 1% significance level or higher.

⁴ See the article by Charles Hopkins and Alastair Short, *PLA Notes* 45.



Cartoon: Joseph Kariuki

community participation in CAHW systems and the need to address community concerns. The standardised training curricula included a set of fixed topics which all CAHWs needed to know, plus a set of flexible topics that depended on the main animal health problems in different communities. By 2004, the process of guideline and CAHW training course development was underway in Kenya, Tanzania, Uganda, Somalia and Ethiopia. Also, government veterinary services in four countries (Kenya, Ethiopia, Sudan and Uganda) had established new central units specifically for the promotion and quality control of CAHWs.

Complementary to the increasing national-level support to CAHWs was the development of AU/IBAR⁵ best practice guidelines for training and quality control of CAHWs. These guidelines included licensing of trainers who had themselves been trained in participative training techniques, and suggestions for good training and supervisory practice.

Future challenges

This article shows that much progress has been made to shift professional attitudes and policy makers towards more supportive policies for community-based animal healthcare.

In the CAPE project it was realised that policy change depended on attitudinal change and learning among professionals. Whenever possible, the project tried to create space for policy makers to consider the issues and find out for themselves what needed to be done. Of the various methods used by the project, simply putting policy makers face-to-face with livestock keepers was probably the most influential. In these interactions, senior professionals sometimes visited remote pastoralist communities for the first time and experienced the isolation, limited facilities and in some areas, insecurity. Impact assessment was an expansion of this process, giving more time for teams of policy makers from different agencies to examine specific issues. We encouraged these teams to identify and prioritise their own issues, but also pushed the idea that we needed to understand the links between improved animal health and people's livelihoods. The use of locally-derived impact indicators revealed the wide range of social, nutritional and economic benefits that livestock provide, and simple scoring methods showed changes during and attributable to CAHW activities.

Regarding international-level change, the Mombasa Primary Animal Healthcare workshop was an opportunity for senior vets to learn from each other and hear the views of international agencies. This was really an experiment for the project. We created a space, but controlled it in terms of the

⁵ Reflecting the change of the Organization for African Unity (OAU) to the African Union (AU).

Timeline for practice and policies related to participatory approaches and methods in animal healthcare in east Africa

- Late 1980s**
- Use of participatory methods such as wealth ranking and livestock disease ranking by NGOs for the design of integrated rural development and community-based animal health worker (CAHW) projects.
 - Experience with participative training techniques starts to emerge in relation to CAHWs.
 - Renewed interest in indigenous veterinary knowledge or 'ethnoveterinary knowledge'; comprehensive reviews published.
- 1992**
- Numerous papers on community-based animal health and participatory methods published from the 'Livestock Services for Smallholders' conference, Yogyakarta, Indonesia.
 - CAHW projects initiated in remote pastoralist areas of Africa through the Pan African Rinderpest Campaign of OAU/IBAR and Operation Life Sudan; CAHWs begin to use a new heat-stable rinderpest vaccine.
- 1994**
- Special issue of *RRA Notes* on livestock issues illustrates diverse applications of participatory methods to assess livestock health and husbandry issues.
- 1996**
- In the FAO Technical Consultation *The World Without Rinderpest*, international experts acknowledge the contribution of community-based approaches towards rinderpest eradication in Africa.
 - The PARC-VAC Project of OAU/IBAR begins to address policy constraints concerning privatised CAHWs in east Africa, partly in response to limited success of NGO-convened forums.
 - First peer-reviewed accounts of research using participatory methods appear in the veterinary literature.
- 1998**
- The Participatory Approaches to Veterinary Epidemiology (PAVE) Project of IIED and OAU/IBAR begins to assess the reliability and validity of participatory methods through research projects in southern Sudan, Kenya and Tanzania.
- 2000**
- The Community-based Animal Health and Participatory Epidemiology (CAPE) Unit is established in OAU/IBAR, focusing on policy and institutional constraints to CAHW services at national and international levels. The unit also supports reviews, training and practice of participatory epidemiology by government veterinary services, veterinary schools and research institutes in east Africa.
- 2002**
- Special issue of *PLA Notes* dedicated to community-based animal healthcare is published, highlighting progress towards pro-CAHW policies and the use of impact assessment to inform policy change.
 - The CAPE Unit of OAU/IBAR organises an international conference in Mombasa, Kenya, on policy and institutional constraints to primary animal healthcare. The meeting calls on the *Office international des epizooties* (OIE or World Animal Health Organization)¹ to clarify the roles of the private sector and veterinary para-professionals in service delivery.
 - The OIE establishes a committee to review the status of privatised para-veterinary professionals.
- 2003**
- The OIE committee recognises CAHWs as a cadre of veterinary para-professionals and proposes changes to the OIE Code to incorporate CAHWs into national veterinary services.
- 2004**
- Member states at the OIE General Assembly endorse changes to the OIE Code to recognise veterinary paraprofessionals, including CAHWs.
 - For the first time, Sudan, Kenya, Uganda and Ethiopia establish units in central government veterinary services for the quality control and harmonisation of CAHWs.

1. Under the Sanitary and Phytosanitary Agreement of the World Trade Organization, the OIE is tasked with setting the global standards on animal health, from the perspective of enabling international trade in livestock and livestock products. These standards are documented in the 'OIE Code', and include guidelines on the evaluation of veterinary services.

number and type of participants, the invited presentations and the topics for working group discussions. We felt that primarily, policy makers were influenced by each other and the international standard setting bodies, and then by researchers and NGOs. In terms of the workshop recommendations and the response of the OIE, the workshop helped to focus attention on the need for change at international and national levels. Within two years, the global

standards had changed to recognise community-based approaches. At national level, the workshop also highlighted the importance of a strong public sector and the need to reform policies on primary veterinary care within an overall process of re-organisation of government services.

While many vets may still feel uneasy about CAHWs, few are offering to move to rural areas and provide accessible and affordable services to livestock keepers. Among these

“Much progress has been made to shift professional attitudes and policy makers towards more supportive policies for community-based animal healthcare”

few are a group of entrepreneurial vets and animal health technicians who have set up small businesses in, or close to pastoralist communities, and who provide services via networks of CAHWs. This privatised and professionally-supervised approach appears to be a good option for ensuring financial sustainability and quality control. If national guidelines are followed, community involvement in CAHW selection and support will be part of the process and system.

But this is a big ‘if’. Government and veterinary boards, by their own admission, remain under-funded and questions remain over their capacity to implement activities related to CAHW supervision and regulation. Clearly, any new procedures have to be based on practical considerations, the need for flexibility and use of existing staff and resources. In general, government is still trying to directly control services which can be handled by others – the reorganisation of government veterinary services and regulatory bodies is still a major challenge in many countries. In addition to supporting CAHWs and private practitioners, government also needs to develop enabling policies and monitor and

evaluate policy change. There may be opportunities here to use participatory impact assessment as an ongoing learning methodology.

As privatised systems of community-based animal healthcare expand, there will also be questions of affordability for poorer users. More research is needed on these privatised systems to understand more about those who are excluded from CAHW services, and how to reach them. Not surprisingly perhaps, work in AU/IBAR shows strong linkages between the use of privatised CAHWs and active livestock marketing, indicating that better markets for animals and animal products support improved animal healthcare (and vice versa). The CAPE Unit now also supports a range of livestock marketing activities, varying from small-scale processing of animal products to further reform of international animal health standards.

As the CAPE project comes to an end, AU/IBAR is forming a new Institutional and Policy Support Team with an Africa-wide mandate. The team will continue to support governments on policy reform, implementation and monitoring in the area of community-based animal healthcare, while also working with Regional Economic Communities in Africa to harmonise policies at regional level. In terms of policy process, experiences from CAPE will be modified and applied to other policy areas. Encouraging direct communication between policy makers and communities will continue to be a key aspect of policy and institutional change.

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The IDL Group (2003). *Community-based Animal Health Workers – Threat or Opportunity?* The IDL Group, Crewekerne. www.theidgroup.com
Videos on Community-based Animal Healthcare
A series of three videos give ideas for setting up community-based animal healthcare systems and influencing policy makers. Visit www.cape-ibar.org for more information.