External evaluation of ICRC Veterinary Vouchers system for emergency intervention in Turkana and West Pokot districts

An assessment report on the intervention, its impact on the target community, the privatized veterinary systems and lessons learnt with a view to perfecting future interventions

Kengen camp, Turkwell Gorge.
17th – 21st January 2005

By: Dr Paul Mbithi Mutungi
IPST/AU-IBAR
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<thead>
<tr>
<th>ACRONYMS</th>
<th>Description</th>
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<tr>
<td>AHS</td>
<td>Animal health service</td>
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<td>AHT</td>
<td>Animal health technician</td>
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<td>ASAL</td>
<td>Arid and semi arid lands</td>
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<td>CAHSD</td>
<td>Community animal health service delivery</td>
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<td>CBO</td>
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<td>District steering group</td>
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<td>DVO</td>
<td>District veterinary officer</td>
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<td>DVS</td>
<td>Director of vet services</td>
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<td>ECOSEC</td>
<td>Economic security</td>
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<td>FMD</td>
<td>Foot and mouth disease</td>
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<td>GOK</td>
<td>Government of Kenya</td>
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<td>ICRC</td>
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<td>KVB</td>
<td>Kenya veterinary board</td>
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<td>Livestock service providers</td>
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<td>M&amp;E</td>
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<td>MOU</td>
<td>Memorandum of understanding</td>
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<td>NGO</td>
<td>Non governmental organization</td>
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<td>PAVES</td>
<td>Pastoral veterinary systems</td>
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<td>TOT</td>
<td>Training of trainers</td>
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ACKNOWLEDGEMENTS

I would like to take this opportunity to pass my sincere regards to the head of IPST AU/IBAR Dr Tim Leyland and Dr Berhanu Admassu who through their support enabled me to carry out this evaluation for ICRC. This is not only an honour to me, but it justifies the confidence they bestowed on me in undertaking the evaluation.

Secondly I would like to thank Piers Simpkin of ICRC for his acceptance in my carrying out the evaluation and the great support he gave to me in all forms during the evaluation. Other thanks go to the ICRC field staff in Turkwell and Denge Tullu for sharing information on the intervention. The private practitioners (Vets and AHTS) thanks to them too for the vital information they shared and the cooperation they bestowed on me. Regards too to the DVO Turkana whose support, enthusiasm, participation, and encouragement was vital during the workshop and the entire evaluation process.

Lastly I will not forget the CAHWs I met, the community, and the provincial administrative staff in Kainuk for the information they volunteered to me.

Indeed this was a true learning experience, and hope that the knowledge gathered in this report will be shared widely to strengthen and raise awareness on the vet voucher system in emergency situations and how it can be used in support of the veterinary privatized systems in pastoral areas whilst taking care of the poor and conflict afflicted.

It is hoped that the lessons learnt in the pilot intervention and the recommendations given will go a long way in perfecting future interventions with an overall aim of improving livelihoods of the people.
EXECUTIVE SUMMARY AND RECOMMENDATIONS

This evaluation looks into the ICRCs Veterinary voucher pilot intervention in Turkana and west Pokot districts in the villages of Kaakong, Kainuk, and Lorogon in Turkana and the villages of Ritten, Orwa, and Sarmanch in West Pokot district.

The mentioned areas are conflict prone occasioned by livestock raids and senseless killings between the Pokot and Turkana communities. This chronic conflict in the area has seriously undermined the livelihoods of the communities and the occurrence of natural calamities such as drought/famine adds up to worsen the situation.

Emergency relief interventions often only provide temporary relief whilst undermining sustainable livelihood approaches and this in itself impacts negatively on development. The relief interventions only provide “cosmetic” short term solutions other than “radical” long term solutions that would go a long way in ensuring sustainable development.

With the above in mind ICRC assistance in its economic security programme (ECOSEC) designed the vet voucher programme alongside a private veterinarian and AHTs. The voucher programme (pilot basis) would see to it that households affected by conflict in the pilot area receive livelihood support assistance in terms of animal health whilst at the same time supporting and enhancing the privatized veterinary systems in the area.

In this light, the IPST of AU/IBAR was called upon to participate in the evaluation of the vet voucher pilot intervention with the overall objectives of giving advice based on experience and how future interventions could be improved based on the lessons learnt from the pilot intervention. The detailed terms of reference/objectives for the evaluation are as below.

1. Participate in the management and organization of the evaluation workshop.
2. Document all the recommendations and key issues emanating from the workshop.
3. Present experiences of other community based emergency animal health service interventions in the region.
4. Evaluate the methodology used in the intervention and how it fits into Kenya government policy and development thinking. Noting how the intervention was actually carried out on the ground in practice.
5. Identify the strengths and weaknesses of the intervention and make recommendations as to how it can be improved.
6. Make suggestions with guidelines for alternative emergency animal health interventions and alternative providers that link relief with development.
7. Provide an analysis of costs benefits and economic advantages or disadvantages of the intervention.
8. Review the costings involved in the implementation contracts and recommend acceptable rates.

The evaluation methodology for intervention was conducted through the following:
- Reports/literature review.
- Interview of the beneficiaries, non beneficiaries and local administration.
- Interview of key project staff.
- Interview of the private practitioners (Vet and AHTs)
- Questionnaire analysis (beneficiaries and non-beneficiaries)
- Cost benefit analysis information from the private vet and AHTs
- Workshop (Presentations, Experience sharing, brainstorming, question and answer sessions, discussions)
Key issues emanating from the vet voucher intervention

Weaknesses:
- CAHWs did more of drug distribution than actual treatments this led to more of self treatments by the beneficiaries.
- Some key stakeholders were not well identified and their presence was lacking in formulation and planning of the intervention.
- The AHTs at some point were sidelined by the system as their roles were not clarified, in real fact they walked away with profits that they worked little for.
- Networking and collaboration amongst some of the players was weak.
- There was too much responsibility high risk and lack of guarantee to the private vet
- Time frame was too short and hurried.
- Roles of actors were not clear and the linkages were weak, as a result of this government involvement was limited.
- Beneficiary and CAHW selection was open to abuse (Town based CAHWs were selected)
- Beneficiary selection could cause conflict.
- Some important drugs were missing while some locally unimportant drugs were included (voucher was generalized rather than area specific).
- Profit sharing amongst the AHTs and private vet caused disagreements.
- Reporting systems were weak or lacking.
- Drug residues in meat and milk could occur as withdrawal periods may not be adhered to by the livestock keepers.
- The intervention fell between relief and development.

Advantages/strengths
- The exercise did support and strengthen the private sector.
- The exercise reached and benefited the targeted beneficiaries.
- There was reduced disease incidence, improved health, higher milk production, and lower mortality. As one put it, “The abortion that was rampant in our goats is now a thing of the past”
- The community has trained CAHWs as animal health service providers.
- Quality drugs were distributed for use.
- There was minimal risk of drugs going out of the intervention area.
- The exercise fits into emergency situation since it incorporates the efficiency of the private sector. (Private sector moves faster than NGO systems and is free of bureaucratic processes)
- The CAHWs and AHTS got a free drug starter kit that will not only boost their drug stocks but also enhance their business.
Key recommendations:

- The donor and implementers should identify key stakeholders well, making sure their roles are well specified understood and documented.
- Joint planning in formulation of activities, networking/collaboration amongst stakeholders is essential towards the good success of future interventions. Time frames for the entire process should be realistic.
- Supervision and monitoring mechanisms for both business and financial accounting and quality control in AHSD should be put in place right from the planning stage.
- Organisations must follow/adhere to the right protocol before introducing projects/interventions in the districts. Passing through the right government channels district forums (LSP) and the DSG is of paramount importance.
- Government (vet dept) should provide policy guidelines for agencies to work within as regards CAHSD.
- Effective Community mobilization and SMART reporting is essential for good success.
- There is need to shift from a project mentality to a business mentality for the private practitioners as this improves their business acumen and enhances service delivery.
- Setting up of “campaign centres” where vouchers are exchanged for treatments and remaining drugs are left with livestock owner. Other drugs eg subsidised or normal priced drugs can be used alongside the exercise for non-beneficiaries. (NB Subsidised drugs only come in at times of severe natural calamities such as prolonged drought as this affects the community at large)
- Time between voucher and drug distribution should be as short as possible to avoid voucher losses or livestock migrations however distribution should not be “relief like”.
- If the relief style distribution is unavoidable, then voucher should be only for non-ethicals and the ethicals can go through the AHT and CAHW in a subsidised system setting. A combination (intermarrying) of the voucher and subsidised system is worth trying in future interventions.
- There is need for extra non-ethicals on the voucher eg wound powder and poultry drugs. The community is realizing the importance of deworming their animals.
- AHTs need to be subcontracted by the private vet in future interventions specifying their roles as this will help in the spread of risks. Donor can also contract the AHTs directly for interventions within their specific areas of operation.
- Price Tier system in real practice does not work, the AHTs therefore need to work extra hard and be aggressive in business to keep the CAHW allegiance.
- Reporting and follow up of community animal health services needs a standardised reporting format from the DVO this is in relation to the AHTs and the private vet.
- The private entrepreneurs (vet AHTs) should look at the intervention as a business holistically right from the start to finish. Profit margins between the different players are dictated by the prevailing business principles.
- There is need for a duplicate voucher to be left with the beneficiary and dully signed by the Vet/AHT in order to safeguard the vet in case of voucher losses thus minimizing risks.
- In the end the voucher system provides the services or drugs free to the beneficiaries, this in itself can become tricky and lead to dependency. There is need to fully sensitize the community on this, whilst letting them use their social structures and traditional methods to identify the poor and needy so as to avoid bias and complaints while they see the poor receiving free services.
INTRODUCTION

Background
More than 75 per cent of Kenya consists of arid and semi-arid lands (ASALS) that support approximately 25 per cent of the human population and slightly more than 50 per cent of the countries livestock population. The ability to derive maximum benefits from the livestock industry in ASALS has been hampered mainly by insecurity, cattle rustling/conflict, natural calamities such as drought and overstretching of the natural resource base. This situation is further worsened by the lack of appropriate policies, legal framework and implementation guidelines towards the support of the livestock industry.

Decentralised CAHS have been recognized as the only effective method of AHS delivery in the ASAL areas of Kenya, Ethiopia and Somalia and in the war-torn zones of southern Sudan. In partnership with governments or counterparts, a large number of CAHWS have been trained and provide quality AHS to pastoralist’s livestock. The major constraint to longterm sustainability of the system is finding a way for CAHWs to access quality drugs in a timely and affordable manner. The ASAL areas are characterized by a few private sector entrepreneurs whose drug supply system can easily be undermined due to the risk of subsidised or free drugs being provided by government or donor agencies. Other risks include insecurity, low rate of turnover, drug expiry, fake drugs, lack of start-up capital, lack of knowledge of market prices; unfair competition.

Due to the above, the ICRC in collaboration with a private veterinarian and AHTs designed and implemented a Pilot emergency veterinary voucher livestock health intervention exercise in the districts of Turkana and West Pokot. The pilot intervention was carried out in Orwa, Sarmanch, and Riting villages of West Pokot and Lorokon, Kainuk, and Kaakong villages of Turkana.

Objective of the intervention:
To design and pilot test an emergency veterinary voucher livestock health intervention by the use of existing privatized pastoral veterinary systems with an aim of strengthening them for long term sustainable development whilst offering quality and affordable service to the needy target community.

Problem statement / justification
Animal health service (AHS) delivery in pastoralist and ASAL areas is still very dependent on outside agencies. Attempts to introduce sustainable AHS delivery through the private sector have fared poorly due to provision and perceived risk of subsidised or free veterinary drugs provided by government or NGOs during emergencies. The concept of the use of veterinary vouchers addresses a pioneering attempt at ensuring emergency responses in the AH sector strengthen rather than undermine sustainable AHS delivery systems in both the private or public sector whilst ensuring the needy target groups continue to receive affordable or essential services.

Pastoralist areas are also prone to conflicts occasioned by cattle rustling and the competition for scarce resources. This often leads to displacement, loss of life, maiming and loss of livelihoods and the affected left in desperate hopeless situations. This combined with natural calamities such as drought and others compounds the situation further.

The following points justify the need for the intervention in the chosen area:
- Livestock are key to food production and survival in the area.
- There are no animal health services in the target area.
- No government or NGO plans to operate in the target area.
The training of CAHWs and use of vouchers will support the private sector and be sustainable beyond the 3 month of ICRC intervention.

- Treating livestock at end of dry season has shown to improve survival by 20%.
- If successful the system can be used much more widely at lower cost per unit.
- Low risk to ICRC staff as it is carried out by community and private sector contractor.
- High exposure of ICRC emblem and protection messages (Vouchers, training course materials)

With the above in mind, ICRC chose to work in the area as it was worthwhile and within the operational mandate and scope of ICRC. One of the pressing issue that needed attention was that of animal health, and the best way to go about this was through the existing vet private systems with an aim of strengthening them rather than undermining.

Pilot Veterinary Voucher plan for Turkana and Pokot districts

**Phase 1**
**Time:** September – December 2004

**Area:** Kainuk, Orwa, Ritten and Lorengon

**Beneficiaries:** 500 households (30,000 people) and 62,500 animals.

**Plan of Action/strategy and Costs:**
1. Contract Dr. Ririmpoi to sensitise community, train and refresher train and equip 12 CAHWs (6 Turkana and 6 Pokot) from target area. Training duration is 3 weeks during September. Cost: KShs 500,000/- (CHF 7,845)

2. Issue veterinary vouchers for specific drugs valued at KShs 1000/- (CHF 16) for 4 key vet drugs to 500 families (250 Turkana and 250 Pokot) during September/October (dry season). Cost: KShs 500,000/- (CHF 7,845)

3. Employment of 1 ICRC Ecosec Field officer for 4 months to sensitisie, help in selection of beneficiaries, supervise, monitor and evaluate the impact of the project. Cost: KShs 412,000/- (CHF 6465)

4. Private veterinarian and network of CAHWs collect vouchers from beneficiaries and treat animals. Vouchers sent by veterinarian to pharmaceutical company in Nairobi. ICRC refund pharmaceutical company based on signed delivery notes by veterinarian and ICRC Field supervisor. (This was changed and the private vet would collect the vouchers and be paid directly by ICRC)

5. Cost of preparing and distributing vouchers: CHF 200

6. Monitoring and evaluation of impact = CHF 2500

7. Total Costs of Intervention = CHF 24,852.

**Advantages of the strategy:**
The voucher approach will address many of the constraints faced by the private sector entrepreneur interested in working in ASAL areas and satisfy needs of poorer stakeholders, NGOs and donors:
1. The supply and process of trading in coupons reduces risks of carrying large quantities of cash.
2. Coupons are only provided to supply specific drugs that are beneficial to affected stock or immediate health emergency intervention ensuring quality drug supply.
3. Enables access by entrepreneur to professional advice and back-up.
4. Trader does not face subsidised competition.
5. NGO / donor confident that right target group is benefiting.
7. Links donors to private sector.
8. Known quantities / numbers of animals to be targeted – helps planning and lowers risk of oversupply and drug expiry.
9. Can create access to capital – Grameen bank style traders groups.
10. Private sector (large pharmaceuticals) can buy into community training costs.
11. Start as AHS programme, but phased in expansion into agriculture, human health, food aid etc.

**Expected impact / output:**
A successful implementation of an emergency CAHS intervention that supports sustainable CAHS delivery systems whilst improving livelihoods and consequently reducing conflict. Impact and methodology will be evaluated and results disseminated as best practices.

**Arrival and opening of workshop**
Twelve participants arrived for the workshop, the programme and workshop agenda was discussed and the theory and process of the voucher intervention was presented.

**The Timetable and Agenda**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Subject</th>
<th>Presenter / Facilitator</th>
<th>Output</th>
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<tr>
<td><strong>Monday</strong></td>
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<tr>
<td>17.1.05</td>
<td>12.30 pm</td>
<td>Arrival at Kengen camp, Turkwell Gorge. Lunch.</td>
<td>Isaac Waweru</td>
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<td></td>
<td>3.00 pm</td>
<td>Orientation and provision of background information.</td>
<td>Piers Simpkin</td>
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<td></td>
<td>3.30 pm</td>
<td>Aim and objective of voucher programme and the workshop.</td>
<td>Piers Simpkin</td>
<td>Focus on outputs and aims of workshop.</td>
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<td></td>
<td>4.00 pm</td>
<td>Planning workshop agenda.</td>
<td>Piers Simpkin / Dr. Paul Mutungi</td>
<td>Revised workshop agenda</td>
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<td></td>
<td>5.00 pm</td>
<td>Presentation of Voucher programme progress and achievements.</td>
<td>Denge Tullu</td>
<td>Progress to date</td>
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<tr>
<td><strong>Tuesday</strong></td>
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<tr>
<td>18.1.05</td>
<td>8.30 a.m</td>
<td>Meetings with voucher beneficiaries and CAHWs at Orwa and Kainuk.</td>
<td>Isaac Waweru and Denge Tullu</td>
<td>Participants split into two groups and talk to communities and CAHWs.</td>
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<td>3.00 p.m.</td>
<td>Presentation of findings of beneficiary view on the voucher programme.</td>
<td>Denge Tullu</td>
<td>DT Report and feedback from participants on a.m observations</td>
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<td></td>
<td>4.30 pm</td>
<td>Past emergency veterinary interventions in region</td>
<td>Dr. Paul Mutungi</td>
<td>Alternative systems to vouchers</td>
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<td><strong>Wednesday 19.01.05</strong></td>
<td><strong>Time</strong></td>
<td><strong>Event</strong></td>
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<td>8.30 a.m.</td>
<td>Presentation by Dr. Ririmpoi and PAVES on the voucher system as used in S. Turkana and Pokot – perspective from the private veterinarian</td>
<td>Dr. Ririmpoi.</td>
<td>Identify successes and failures</td>
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<td>9.30 am</td>
<td>Presentations by Willy Lolim and Wilson Chepkeruk on the voucher system from an AHA perspective.</td>
<td>Willy Lolim and Wilson Chepkeruk</td>
<td>Identify successes and failures</td>
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<tr>
<td>10.00 am</td>
<td>Presentation by CAHWs from Ritten and Lorengon on the vouchers system.</td>
<td>Isaiah Ronyet, James Chepkilim, Julius Ebenon Lobuin and Rebecca Eloto Lokenyi</td>
<td>Identify successes and failures</td>
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<tr>
<td>11.00</td>
<td>Presentation by DVO Turkana and Pokot on the voucher system within the GoK perspective.</td>
<td>DVOs</td>
<td>Identify successes and failures</td>
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<tr>
<td>11.30 am</td>
<td>Discussions on impact of voucher programme and how it fits into emergency livestock health interventions of other NGOs and GoK.</td>
<td>Dr. Irura, Oxfam and WV.</td>
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<td>2.30 p.m.</td>
<td>Identification of strengths and weaknesses; lessons learned in vouchers and other vet interventions and best practices. Are voucher systems worth continuing? If yes……..</td>
<td>Dr. Paul Mutungi</td>
<td>Lessons learned report</td>
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<td>4.00 p.m.</td>
<td>Group work</td>
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<td>Topic 1 and 2</td>
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<th><strong>Thursday 20.01.05</strong></th>
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<td>8.30 a.m.</td>
<td>Plenary – Recommendations for future vet voucher and other vet interventions, and Roles of Stakeholders.</td>
<td>Dr. Paul Mutungi</td>
<td>Blueprint proposal for future schemes</td>
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<td>10.00 a.m</td>
<td>Group work</td>
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<td>Topic 3 and 4</td>
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<td>2.30 p.m.</td>
<td>Plenary on Standardisation of vet kits and approaches (e.g Community contribution) in Turkana and Pokot and Selection and Targetting.</td>
<td>Dr. Paul Mutungi and DMOs / DVOs</td>
<td>Guidelines for agencies</td>
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<th><strong>Friday 21.01.05</strong></th>
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<tr>
<td>11.00 am</td>
<td>Evaluation, Summation and Closing and return to Lodwar / Kapenguria</td>
<td>Isaac Waweru</td>
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1. Village visits and feedback

The workshop participants were divided into two, with the group from Turkana visiting Orwa in West Pokot and the Pokot group visiting Kainuk in Turkana. The aims of the visits were to gather the views of the beneficiaries and non beneficiaries as pertains the veterinary voucher programme. The views are presented as follows.

1.1 Kainuk village

- Herders treated their own animals because they preferred to do so on their own. They said they had been treating animals on their own for a long time, due to this the CAHWs carried out very few treatments if any.
- The CAHWs did not follow the animals to the grazing areas citing long distances and lack of mobility.
- After the exercise, a few beneficiaries still had drug balances eg Adamycin and Diminaphen.
- The beneficiaries did benefit from the drugs in terms of reduced disease incidence, improved health, higher milk production, and lower mortality. As one put it, “The abortion that was rampant in our goats is now a thing of the past”
- The drugs are stored or kept in plastic bags or boxes.
- The beneficiary selection was fair with limited complaints.
- Majority of the beneficiaries were of the opinion that the exercise should be repeated.
- The intervention reduced conflict by 60% as there was better contact between neighbouring communities.
- Lobur and Dorcas were cited as active CAHWs but need to have incentives to improve their work.
- The community was aware that after the intervention CAHWs would offer their services on cash, however at the time the community did not know that the CAHWs had drugs to sell.
- There was no cross border borrowing of drugs.
- The community preferred to use trained CAHWs.

1.2 Kaakong village

- The herders treated their own animals with very little intervention by the CAHWs.
- The richer selected people finished their drugs whilst the poorer people still have some of the drugs remaining.
- The intervention was beneficial as disease was reduced, the dewormer treated 17 goats.
- The beneficiary selection was fair and there were no complaints.
- The drugs were too few in variety and hence no Ivomec (for Mange) and poultry drugs.

1.3 Non beneficiary views

- It was only the rich that benefited. People with less than 10 goats did not benefit. Traders, chiefs, businessmen and councillors all benefited is this fair?
- Selection was not good, there was need to have home to home visits to select people and ascertain the truth.
- If drugs provided at subsidised price they would strive to buy
- The exercise reduced conflict.
- The non beneficiaries did not know that CAHWs have drugs to sell.
- At time of vet kit distribution, it must be done as public event in order for information to be disseminated)
- Conflict was reduced, but there is no link between the intervention and conflict its just by chance that no conflict has occurred since.
1.4 Views from CAHWs in Kainuk:

- Low demand for drug sales in Kainuk as a lot of drugs were issued to people during the intervention and balances are still available and animals in good health. However, there is a high demand in Kaakong and Katilu from the pastoralists.
- Kainuk animals have not moved and do not move far hence have not been followed since they are within the vicinity.
- Need a refresher course.
- Elders preferred to treat directly on their own not through CAHWs. The CAHWs were called upon by the elders (120) in a one day barasa to teach/advice them on how to treat.
- A total of 113 goats were treated by the CAHWs for the following conditions pneumonia, helminths, ticks, and tryps.
- The CAHWs did not report their work although they had the disease reporting formats.
- Beneficiary selection was not fair, but chief explained that they put everyone together so that they all benefit and claimed that very poor people have too few animals, so drugs on voucher may well expire.
- On selection of the beneficiaries, the CAHWs suggested that a wealth ranking survey should be carried out to determine the needy and only faithful people should be chosen to write the names of the beneficiaries not chiefs or village elders. If this is not possible all to be included and subsidised drugs provided.
- The CAHWs have already formed a group to collect drugs together for economy of scale they hope to open a local pharmacy in future.
- The CAHWs understood well their relationship with DVO, AHT, private vet, etc.
- Hope to network with other CAHWs for encouraging each other, information sharing, or formation of a working group to ease the purchase of drugs.
- Not clear on drug pricing.

1.5 Orwa village

- The community got the right drugs, and the acaracides and injectables were very useful. The community however needed spray pumps for the acaricide application.
- The drugs were too few in number and variety, the antibiotic was used to help combat the effects of FMD.
- The beneficiaries shared drugs with non-beneficiaries.
- The CAHWs treated animals but only to a small extent as many herders preferred to do treatments on their own.
- The CAHWs who carried out treatments were not paid in cash but were given a token of appreciation in terms of tea or food.
- The CAHWs followed the livestock into the grazing areas.
- All the drugs were used no left overs.
- Many people were left out as the number of beneficiaries was few.
- The drugs are kept in locked boxes, wooden honey containers and in caves. They are aware drugs are dangerous and keep them away from children.
- Main diseases common in area are Tryps, pneumonia, mange, worms, FMD, and blackquarter.
- The beneficiary selection was fair.
- The exercise should be repeated.
- They have no idea on how the community could contribute for the next exercise.
- Conflict reduced, but not directly due to intervention. Conflict will only end when everyone has full stomachs (Food relief) and when children from the two communities are educated together.
Other problems not covered by the intervention include donkey and chicken drugs and the need for human health intervention. The community was informed that drug and equipment kits for CAHWs would be distributed on Monday 24th Jan, and drugs would be sold to them. Chief suggested that a livestock production CBO be formed to link community and CAHWs. Community requested Vet dept to vaccinate against FMD, but they were not willing to contribute directly. On sustainability there is need for credit for the CAHWs but misuse of money from Miraa, busaa and other leisures could contribute to a problem.

1.6 Discussions on Village presentations

50 ml bottles of 30% Alamycin were distributed as part of the profits to CAHWs. They were difficult to sell as they were expensive and the bottle is small. Pastoralists tend to look at the size of the drug bottle versus cost and with the influx of cheap drugs 30% Alamycin could prove difficult to sell. There is need to continue the campaign on the use of 20% Tetracycline time is not yet ripe for the use of 30% Tetracycline.

There is also the need to provide the drugs according to district requirements, for example Diminaphene was supplied to Turkana and its not popular Novidium is more preferred. This led to very little use of the drug in Turkana while in Pokot there were no balances remaining. Mange is a problem in Turkana and the drug was not provided for, acaricide was used instead but Ivomec would have been more preferable. Poultry drugs were not provided for yet poultry exist in the villages.

Before the intervention there was a lot of abortion experienced in goats, probably due to stress caused by disease. The reduction or absence of the abortions after the intervention is a clear sign that the cause had been addressed by the use of voucher drugs.

2. Perspective from the private veterinarian on the voucher system, as used in S. Turkana and Pokot- by Dr Benson Ririmpoi (PAVES).

2.1 PROJECT FORMULATION:
Private system did provide some input into the design of the intervention, but the vet department was not satisfactorily included from the beginning in order to incorporate their inputs.

2.2 PROCESS:

2.2.1 CAHW selection
Private sector was involved with the community in selection of CAHWs. But there was insufficient awareness raising and mobilization occasioned by the short time frame. There wasn’t enough information from ICRC and the community did not clearly know the full agenda of ICRC. Selection was done transparently and fairly.

2.2.2 CAHW training
Training was done according to the KVB standardized curriculum ensuring quality. GoK facilitated but did not do the training. Hiccups occured in the training due to contract being only between Ririmpoi and ICRC. Details of the training package were not clear to the participants (AHTs and CAHWs). There were complaints on the training venue, food quality, allowances, and the absence of the vet etc. AHTs did most the training as the private vet
was too involved in the logistics to participate in the training. The training however was conducted well.

2.2.3 Drug distribution
Drug distribution was 1 week after voucher distribution. ICRC approved the drugs to be bought and they were purchased by the vet in Nairobi and couried to Kapenguria for distribution.

Distribution was witnessed and verified by ICRC staff. In distribution, the private vet was the principle person involved in terms of capital investment and delivery to site. In this case the vet bore all the risks attributed to purchase, transport and delivery to site.

AHTs were not involved in the distribution satisfactorily (their role was limited) due to volume of drugs. Distances to the target areas, transport costs and the base of operation of AHTs.

Trust in CAHWs was lacking especially in the distribution of drugs to the beneficiaries. There was no guarantee that CAHWs would not sell the drugs before vouchers came in and this is an area that needs to be looked into further. The CAHWs lacked security, guarantee, storage, and trust hence the compromise to store drugs in ICRC office until distribution.

The exercise may also prove costly while distributing to beneficiaries who missed out during the appointed dates of the first distribution as this calls for repeat visits.

2.2.4 Profit sharing:
Profit sharing was implemented as 40% for vet, 31% for AHT and 29% for CAHW. This still was not agreed to by the AHTS. In itself this margin was agreeable to the vet as the lowest possible share he could accept was 20% of capital investment, this is because the total logistical cost was Ksh 22,000 and this lowers the percent share further. The vet was not willing to compromise below the 20% as he had use a bank overdraft to procure drugs whose cost would be reimbursed over a period of time.

76 vouchers for Sarmanch and Nasolot got lost these were valued at Ksh 76,000. The vet expected a profit of Ksh 61,335 from the drugs but when the logistical costs and the loss of vouchers are included, he ended up with a net loss of Ksh 36,665.

2.2.5 Quality assurance:
Observations:
- Used ICRC approved drugs.
- ICRC verified drugs at distribution sites.
- Trained CAHWs to improve quality of service.
- Advice given to livestock owners at time of distribution.
- Vet made 1 follow-up visit to CAHWs. One CAHW Isaiah made a visit to PAVES to purchase drugs and received advice from the vet.
- DVOs and AHTs have not done any follow-up supervisory visits.
- CAHWS did very little treatment thus lack of quality in treatment, their low knowledge on animal health also impacts on quality.
- Drug residues in meat and milk possible due to livestock owners doing their own treatments and not heeding the withdrawal periods. It is possible CAHWs may not advice on withdrawal periods.
- Lack of reporting to DVO.

2.3 Strengths of the vet voucher system:
- Voucher system does strengthen the private sector system rather than undermining it.
- Quality drugs are distributed for use.
- Products and services reach the intended beneficiaries.
• There is minimal risk of drugs going out of the intervention area.
• Fits into emergency situation since it incorporates the efficiency of the private sector. (Private sector moves faster than NGO systems and is free of bureaucratic processes)

2.4 Weaknesses of the vet voucher system:
• Too quick an implementation that can easily cause confusion and false expectations.
• Vet carries too much of the risk and responsibility (professional, financial input, logistical input, risk of losses etc) and this is not reflected in the profit sharing which is comparable to other micro-entrepreneurs.
• Vet department was not involved sufficiently from the beginning of the formulation of the intervention. There was no official recognition of the programme by the vet department they kind of ignored the project.
• The linkage of the AHT was weak at some stages of the intervention. The distance of the AHT from the project area and the capacity to serve added to the weak links.
• Insufficient or lack of supervision mechanisms of the CAHWs by the DVO, private vet and AHTs.
• Lack of reporting systems and structures on the intervention by the CAHWs to the AHTs who would further report to the private vet and DVO.

2.5 Recommendations:
• Consult with DVS to get legal standing on vouchers and CAHWs. ICRC to consult DVO with regards to signing an MOU (This serves as a protection to the DVO, from the authorities and KVB)
• Voucher and drug distribution must be as close to each other as possible to avoid loss and destruction of vouchers and the migrations of the pastoralists.
• Good sensitization of the beneficiaries on drug distribution days/times must be done to avoid beneficiaries missing out and hence repeat of the exercise.
• The programme should be expanded in coverage area and numbers of beneficiaries, number of activities as well as the size/value of voucher.
• The AHTs should come out strongly in linkage strengthening. Where the AHTs fail to link with the vet, CAHWs can do so directly.
• The CAHW incentives be tied to performance.

2.6 Issues and Comments:
There is need to make a clear difference between business and project. The intervention process was business, but not all players were clear on this especially the AHTs. There is need for a business team spirit to enhance the process and ensure equal participation and benefits. The intervention process should be viewed as a business in a holistic manner right from the formulation stage to the final steps of implementation. Gains should not be seen from the drugs point of view only as this is a narrow scope. Gains should be seen as coming from the entire process from beginning to end.

ICRC needs to collaborate with the DVOs and seek advice on the need of an MOU with the DVS. There is also need for good collaboration with the LSP and DSG in the respective districts.

Too much responsibility was vested on the private vets (Ririmpoi's) shoulders, re-permissions and risks and this in itself can jeopardise business.
Proposals and progress reports should be sent to DVOs.
3. Perspective from the private AHT Turkana on the voucher system, as used in S. Turkana by – Willy Lolim.

3.1 Successes:
The voucher system was successful as the AHT benefited financially from the CAHW training fee as well as the drug profits. The intervention exercise put him in recognition as a private AHT working in south Turkana. The linkages in terms of collaboration, joint planning and process formulation between the donor, private vet and AHT need to be strengthened in future.

3.2 Weaknesses:
Selection of CAHWs in Kainuk was not perfect, there was the influence by politicians and local leaders. The illiterate but village elected CAHWs (Lorinyoki & Kaagete) were deselected at Kainuk by local leaders due to the fact that they were not literate. Others were put in their place. (ICRC insisted on the selection of literate people std 7 and above) Illiterates are allowed to be CAHWs according to the DVO and CAPE and this is in line with KVB guidelines.

Communication was not good between AHTs the private vet and ICRC. Dates of distributions etc were changed without the concerned parties being informed.

3.3 Recommendations (From AHT Turkana)
In future beneficiary selection should be done by whole team (ICRC, AHT, CAHWs village elders and chiefs) but councillors and politicians need not be included.

In order to encourage actual treatments of livestock as well as improve on reporting by the CAHWs after voucher issue, the drugs should be kept in a store and beneficiaries come on a daily basis for drugs and receive them and are escorted by the AHT and CAHW to treat the animals. (Or CAHWs and AHTs inform the communities he will visit each centre or village / area on certain days to collect vouchers and do the treatments)

The drugs should not be distributed like famine relief food as they can be subject to abuse.

Direct drug purchases by CAHWs from PAVEs should be discouraged so that the AHT model of privatization is not undermined.

There is need for bringing all stakeholders on board for the planning process to ensure that opinions of all are captured and activities flow according to time frame without anyone being left out.

Community dialogue before selection of CAHWs and beneficiaries is a crucial step towards the success of projects and interventions in pastoral systems and should not be underestimated as it creates a sense of ownership.

There is need for pricelist to show the charges at the various levels to avoid confusion and exploitation.

In the past, VSF-B and other partners delivered free drugs to AHTs during emergencies. The AHTs sold the drugs to CAHWs at subsidised cost and the CAHWs further advanced the subsidy cost to stockowners. The system generated a lot of money for AHTs and CAHWs and benefited many as it was not specific. Although the system had its shortcomings it could still be perfected for future interventions.

3.4 Constraints
The private vet was not involved in the CAHW training and yet the AHTs needed his support in terms of technical advice, giving direction, logistics and other matters accruing from the training since he was the lead person. Due to this logistics was a problem leading to meal delays, vegetable shortages, lack of transport for practicals and purchase of commodities, and complaints from the participants. The AHTs played the role of logistics and training and the burden was heavy. The training venue was poor and needed improvements. Communication/information sharing between the AHT and the private vet was poor.

4. Perspective from the private AHT West Pokot on the voucher system, as used in Pokot – By Wilson Chekeruk

4.1 Successes
There was cooperation from the stakeholders involved in the exercise. Voucher distribution was successful and 250 households benefited on the Pokot side. The 12 CAHWs were trained successfully. The area for the intervention was chosen correctly as no other NGOs operate within the area. Quality drugs were delivered to livestock owners.

4.2 Weaknesses
Original profit margins for the drugs were low even in the training the CAHWs complained it was too low (44%, 34%, 22%).

Voucher system did not recognise role of AHAs who do all aspects including selection of CAHWs, CAHW training, community mobilization, selection, disease reporting, CAHW supervision, and advisory services. Somewhere along the line AHTs were sidelined especially in the handling of drugs and safe passage and supervision to CAHWs. The vet voucher lacked some drugs eg Ivomec and poultry drugs.

The value of vouchers in terms of drugs is small compared to the number and needs of the beneficiaries.

The intervention process was rushed more time needed at all stages ie (selection of CAHWs and beneficiaries, and the distribution of vouchers and drugs.

Selection of CAHWs and beneficiaries needs more time to ascertain the right candidates, most of the selected CAHWs were town-based.

Communication and linkages between Vet-AHT-CAHW-other stakeholders need to be improved.

4.3 Recommendations (From AHT Pokot)
- The different implementation stages require sufficient time.
- Period between voucher and drug distribution has to be close to avoid losses.
- Future interventions should target more beneficiaries
- Need to strengthen communication and linkages amongst the different stakeholders.
- There is need for refresher course.
- AHAs need incentives e.g. more drugs, especially those relevant to their area.
- Motorbikes are needed for AHTs to improve their transport.
- More vet equipment needed.
- Need storage facility, including cold chain for vaccines.
• The subsidized form of intervention can prove useful where vouchers should be aimed at the poorest members of the community and subsidised drugs for the others this will ensure all are targeted.
• Profit margins need standardisation / fine tuning.
• Red Cross should store and transport the drugs.

5. Matters arising from AHT presentations:
The AHTs did not negotiate with the private vet and had no contracts with the private vet and ICRC. The AHTs only negotiated for the facilitation of the CAHW training. There was need for them to set up invoices and rates before hand but this was complicated by the fast process.

The linkages between the AHTs and the private vet were negative and this created bad feelings between them.

There is need for sub-contracting of activities/roles between partners and implementers.

A lot was learnt of the intervention process due to its quick and rushed nature, in future there is need to set up a realistic timeframe of activities.

Pricing of drugs for the different cadres must be clear on drug kits, right from manufacturer to vet, AHT, CAHW and livestock owner. Prices between different localities in the field do obviously vary and in this case rates between vet and AHTs should be standard and Vet should not sell drugs to CAHWs at same rate as he sells to AHTs.

Distribution of drugs to beneficiaries should not be like food relief. Either beneficiaries come with their livestock and voucher for treatment, or CAHW goes out to single manyattas each day. This however is easier if fewer drugs are prescribed on the voucher.

The other option is a “campaign style” form of intervention whereby beneficiaries bring their animals for treatment at specific sites. In this case the CAHWs, AHTs are present for treatments and if possible the vet department for supervision purposes. This kind of process can have the element of subsidised drugs to cater for those who were missed out in the vouchers and are capable of paying for the drugs.
If subsidised approach is to be used, then intervention time and duration must be well clarified to the beneficiaries ie the beginning and end.

The AHTs complained about low profits from the drug sales yet their participation in the drug distribution and administration was low or lacking, there really was no logic in them reaping the profits from where they didn’t sow.

Its difficult for agencies to set profit margins for the private sector, as it is not within their mandate to do so, rather it is up to prevailing business principles. Openness in negotiations between the different actors is essential, and competitive business principles must apply “more work more earnings”.

Private Vet can supply drugs strictly at wholesale price to AHTs but they must then take on all the transport and overheads from there. It is difficult for the vet to carry out supervision and M&E without higher profit.
Need to reduce the risk away from the vet alone is essential and this is worth pondering about for future interventions. (Having duplicates of vouchers was floated and a double entry system but was too complicated logistically for it to succeed).
6. CAHWs perspectives

6.1 Lorogon CAHWS

6.1.1 The benefits

- They have profited from start (training) to finish (profit from vouchers).
- Animal health has improved in those areas that received vouchers.
- Milk yields have increased due to the good health of animals and this has contributed to the good health of people.
- Livestock owners are benefiting from CAHWs through getting advice on treatments and better management of stock. There were no reports of bad effects on animals in any of the drugs used.
- Livestock owners are getting an alternative to the poor quality drugs that are present through the supply by quacks.
- Animal health services are closer to the livestock owner through high quality drugs.
- The intervention had quick results.

6.1.2 Problems:

Very few livestock owners are willing to pay for services they believe the CAHWs are paid by ICRC.
There is need for mobility in terms of motorcycles since the area is prone to insecurity and wild animals (one motor cycle can be used by two people)
Training venue was not safe and sleeping facilities were of poor quality.
There has been a breakdown in communication between CAHWs, PAVEs, DVO and AHAs and this made it difficult for the CAHWs to express their problems and successes. Due to insecurity in the area service provision is at times difficult.

People still like cheap drugs of poor quality and this makes it difficult to sell good quality drugs of high prices.

6.2 Ritten CAHWs

- Vouchers have helped animals to recover good health.
- Livestock owners have local qualified CAHWs close to their vicinity.
- People do not understand the difference between 10% and 20% because the bottles are of the same size but prices are different.
- Some people think that Red Cross drugs are free, and so they should not be charged for them.
- Some people do not want to pay until the animals have already been treated and recovered, thereafter follow-up on payments is difficult.

6.3 Matters arising from CAHW presentations (Questions and issues to CAHWs)

The men CAHWs go out to treat animals for up to 3 days while the women CAHWs cover the village animals.
The CAHWs have agreed to join hands in each village and sell at same prices.
The CAHWs benefitted through earning money, got respect in the community and have also exchanged drugs for goats.
The CAHWs expect the AHTs to bring drugs closer to them while helping them solve problems eg difficult cases.
There are other drug sellers in the area, quacks selling poor quality drugs in the market. Oxytetracyline 10% does not sell fast because of other cheaper (10% & 5%) drugs in the market, Novidium also in some areas (Ritten). Ivomec and 20% LA is required but its movement is slow.
Only a few CAHWs attempted to keep treatment report records.
The CAHWs know whom to get drugs from. They know Ririmpoi has good stock and always available; as for Lolim he is too far from them while Wilson at times is not available and may not have the required drugs. The CAHWs plan to join together for the purchase of drugs in order to reduce overheads.

7. The DVO Turkana district views on the intervention (includes DVO Pokot’s comments) Dr Omori

Voucher program was a good idea for emergency intervention of conflict afflicted and drought stricken families though the private vet carried a lot of risks. The system should be encouraged as it identifies and targets the needy (poor) this is the first line of focus in emergencies. The LSP in Turkana supports emergency interventions and there is no need for MOU since DSG can handle. CAHWs are important in Turkana and Pokot districts as they compliment the services of the vet department and the CAHW approach is acceptable.

7.1 Weaknesses:

- Preparation of the process was too hurried and various issues were not taken into consideration.
- There wasn’t enough consultation on the design formulation, and planning through the involvement of important stakeholders.
- The roles of the different stakeholders in the process were not clearly defined.
- Emergencies are tackled through the local DSG – LSPF (Livestock Service Providers Forum), not from National level. In this case the intervention came from Nairobi without sufficient local consultation and planning.

7.2 Selection

Selection of beneficiaries was well done and this is the community and organisations role to do, however it is good to involve the vet department in CAHW selection.

7.3 Training

IPST is in the final stages of producing the CAHW trainers guide in collaboration with CLIP and this is pending the approval of the DVS. The trainers guide is in line with the KVB standardized guidelines which are acceptable.

Training should be done with the vet department providing one trainer as this would have minimized the problems faced during the training.

7.4 Drug distribution:

Much of the exercise was done as a food relief distribution and is not acceptable. It should have been done slowly with the CAHW involvement in treatment and other technical people eg DVO and AHTs.

The exercise could also have been done in a “campaign style” where voucher beneficiaries bring livestock on a certain day for treatment, and vets, AHTs are present to sell drugs to those who can afford it. The drugs could be normal price or subsidised form.

7.5 Reporting:

Reporting is needed, there were no reports sent to the DVO on CAHW selection, training, and results of the intervention outlining the livestock diseases treated. Reports keep the DVO informed of what is happening on the ground and his awareness offers protection for the implementing agency and other partners.
7.6 **Supervision:**
Supervisory support from the veterinary department is required in future interventions.

There is need to make use of the CAHWs by the DVO for reporting purposes, in this light the DVO has recruited one CAHW in an intervention activity for reporting purposes.

7.7 **Handing over the CAHWs:**
Handing over the CAHWs is a transition process from emergency to development and the DVO should have been alerted on this. The CAHW kit is the biggest ever witnessed in Turkana district.

The programme can be expanded but in future it needs to be done with more collaboration from the Vet department.

7.8 **Points arising out of DVOs presentation:**
There is a need for a ToT course for equipping vets with skills to train CAHWs.
Technically the intervention is illegal, as no MoU exists with the DVS but since this is a short term intervention the LSP through the GSG can handle.

The private sector is part of the LSP forum and they are invited to attend.
Inclusion of a vet starter kit was not part of the original ICRC plan, and is part of a new programme. This should have been discussed in more detail with relevant stakeholders before it was implemented.

8. **World Vision, Lodwar – By Cecilia Mutanu**
World vision are mainly involved in education, health and food security (agro and livestock), HIV / AIDS and religion (Christian impact) as cross cutting issues that all affect children.

Team work is vital in AHSD network, strengthening the linkages is important.

There is need to note areas of operation and what organizations are doing to avoid duplication this calls for collaboration, coordination and networking amongst the different development organizations.

In relief WV does little in vet, but does restocking. World vision is soon opening up an office in Kainuk and should use those empowered by the voucher system in its activities.

The vet voucher exercise was not only an emergency it was also an empowerment exercise to the affected people.
9. Comparisons between different Emergency Vet Interventions
(The voucher system vs the subsidised drugs system)

9.1 Strengths and weaknesses of Vouchers system

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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</thead>
<tbody>
<tr>
<td>- Supports the private sector.</td>
<td>- Too much responsibility on one person (Vet)</td>
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<tr>
<td>- Targets the poorest of the poor in livestock</td>
<td>- Time frame too short.</td>
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<tr>
<td>communities.</td>
<td>- Roles / linkages were not clearly defined.</td>
</tr>
<tr>
<td>- Empowers community through the trained</td>
<td>- Beneficiary selection open to abuse.</td>
</tr>
<tr>
<td>CAHWs.</td>
<td>- Beneficiary selection could cause conflict.</td>
</tr>
<tr>
<td>- No diversion of drugs – direct to target</td>
<td>- Too specific.</td>
</tr>
<tr>
<td>beneficiary, thus improving transparency.</td>
<td>- Open to misuse of drugs as self-treatment instead of treatment by CAHWs.</td>
</tr>
<tr>
<td>- Ensures quality drugs at community level.</td>
<td>- Some important drugs missing and some locally unimportant drugs included.</td>
</tr>
<tr>
<td>- Encourages teamwork, networking and</td>
<td>- Created business jealousies in terms of profit.</td>
</tr>
<tr>
<td>collaboration.</td>
<td>- Risky for certain parts of the chain - Lack of guarantee to vet.</td>
</tr>
<tr>
<td>- Encourages livestock owners to seek for</td>
<td>- Reporting was weak.</td>
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<tr>
<td>services.</td>
<td>- Too oriented to distribution methodology than quality services.</td>
</tr>
<tr>
<td>- Fits into the emergency response situation</td>
<td>- Cost of voucher production.</td>
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<tr>
<td>framework.</td>
<td>- The end product is free.</td>
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Organogram Of Vet Voucher Scheme
9.2 Strengths and Weaknesses of Subsidised drug distribution system

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Everybody benefits in pastoral system.</td>
<td>Diversion of drugs out of district</td>
</tr>
<tr>
<td>Activates everybody to make maximum profit.</td>
<td>Can be difficult to supervise needs good planning.</td>
</tr>
<tr>
<td>Turnover can be very high.</td>
<td>Lack of incentive for vet to take part in implementation after day 1.</td>
</tr>
<tr>
<td>Supports private sector.</td>
<td>Requires a lot of trust - AHT could disappear with bulk drugs.</td>
</tr>
<tr>
<td>Stakeholder linkages were good.</td>
<td>Needs storage in the field for easy and prompt distribution</td>
</tr>
<tr>
<td>Is not selective in targeting serves everybody in need.</td>
<td>No specific targeting</td>
</tr>
<tr>
<td>Reporting and supervision systems are in place.</td>
<td>- Does not guarantee that CAHWs treat and donot engage in selling drugs to stockowners</td>
</tr>
<tr>
<td>There is involvement of the DSG, LSP and other stakeholders in AHSD.</td>
<td>- Process can be cumbersome and needs good planning.</td>
</tr>
<tr>
<td>Drugs are not availed free to the end user.</td>
<td>- High profits lead to high drop-out rate of CAHWs.</td>
</tr>
<tr>
<td></td>
<td>- High risk of temptation to divert funds accrued from the sale of drugs</td>
</tr>
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</table>

The subsidised system embended in a privatized network (See diagram next page)

In this scenario, the donor links directly with the private vet or engages a lead agency to manage the whole process. Note that in the end the drugs reach the user at a subsidised cost and are not free. The subsidised system makes sure that the relief or “emergency effect” of the intervention is not lost whilst ensuring that development is not undermined.

The private vet purchases drugs and charges donor or the lead agency the retail price. The drugs then pass via a system of AHTs and CAHWs to the stock owner at subsidised cost. The AHTs and CAHWs make their profits from the agreed subsidised they charge to their clients.

The subsidised costs to be charged by the AHTS and CAHWs have to be agreed upon through the DSG or the LSP. The lead agency plans, coordinates and makes decisions on M&E through the DSG or LSP.

In the case where some areas are not covered by CAHWs, the government veterinary staff can be involved in the process, and the funds accrued from the sale of subsidised drugs are deposited in a revolving fund. The deposited funds are important in assisting the department carry out important emergency interventions within the district in the absence of government departmental fund allocations.
VERDICT: IT WAS AGREED THAT THE VOUCHERS SYSTEM IS WORTH CONTINUING BUT NEEDS TO HAVE THE WEAKNESSES ADDRESSED AND THE SYSTEM IMPROVED.
9. Plenary and Group discussions/recommendations

GROUP A. ROLES

- Roles of different stakeholders in the voucher intervention exercise.
- Role of Govt vets in training and M&E.
- The role of other players in AHSD in supporting refresher courses.
- How can linkages between the different players in AHSD be strengthened for effective service delivery.
- What are the best means of improving awareness raising in order to achieve maximum community participation.

Group responses on the roles of the different stakeholders

**Roles of CAHWS:**
- Treat animals
- Advisory service to livestock owners
- Referral of difficult cases to AHTs
- Outbreak and notifiable disease reporting
- Routine monthly standard reporting
- Witness voucher distribution
- Safe storage of drugs
- Identification of beneficiaries
- Distribution of drugs in exchange for voucher
- Collection of voucher and handover to AHTs
- Regular replenishment of drug kits
- Following animals during migrations
- Vaccination campaigns and emergency interventions
- Mobilisation of community, and awareness raising.

**Roles of Stock owners:**
- Mobilisation and community organisation
- Identification/selection of CAHWS and beneficiaries
- Receive vouchers and drugs
- Monitor CAHW activities to keep them active
- Proper storage of drugs
- Report disease to CAHWS, AHTs and vet dept
- Call for services
- Paying for services rendered by CAHWs
- Bring livestock for vaccinations
- Accept branding in vaccinations
- M&E

**Roles of AHTs:**
- Planning interventions with/alongside other stakeholders
- Mobilisation and awareness creation
- Selection of CAHWs and beneficiaries
- Training of CAHWs
- Collection of vouchers
- Supervision of CAHW activities
- Drug supply to CAHWs
- Routine reporting
- Involvement in vaccination campaigns
- Refresher courses for CAHWs
- M&E
- Delivering drugs to distribution sites


Ensure transparency and accountability during interventions

**Role of Private vet:**
- Sign contract of implementation with donor
- Planning and implementation
- Awareness creation
- Selection of CAHWs and beneficiaries
- Training of CAHWs
- Procurement of drugs
- Collection of vouchers from AHTs and submission to ICRC
- Supervision of AHTS and CAHWs
- Technical advice to all
- Sufficient drug supply for purchase
- Files monthly reports to DVO
- Gets contracts for vaccinations from GK and NGOs
- Refresher training with Vet dept
- M&E
- Ensures transparency and accountability

**Roles of donor / NGO:**
- Provide funds
- Sign contract with vet
- Selection of beneficiaries and CAHWs
- Printing and distributing vouchers
- Supervising drug distribution
- Post-distribution monitoring
- Receive and file field reports
- M&E

**Vet Dept:**
- Provide policy guidelines
- Quality control
- Sign MoU with donors
- Involved in planning
- Involved in selection of CAHWs
- Training of CAHWs
- Supervise project/intervention at district level
- Receive reports from field for DSG
- Vaccination campaign organisation
- M&E

2. Group responses on the role of GoK in Training M&E
- Plan the training alongside other stakeholders
- Provide trainer or facilitator (if trained in TOT)
- DVO attend training sessions
- Quality assurance of the training, be involved in the final evaluation of the trained CAHWs
- Be involved in monitoring and supervision of CAHW activities.

3. Group responses on the role of other players in refresher training

**Pharmaceutical companies:**
- Support by partly or fully financing refresher courses.
- Sponsor or pay for the voucher with inscriptions of their products.
Private vet:
Partly sponsor CAHW refresher courses.
Organize field days alongside pharmaceuticals, as part time refreshers for new products and technologies.
Provide technical inputs during the training.

GOK vet dept:
Provide inputs in form of facilitating during refreshers.

4. Group responses on strengthening linkages for better service delivery.
Networking and information sharing
Collaboration and joint planning
Business contractual obligations between vet, AHTs, and CAHWs are necessary.

5. Group responses on improving awareness raising
Community dialogue (As workshops, barazas, or on site)
Identify the right community entry points.
Small group meetings
Individual explanation.

Recommendations

- Stakeholders should be well identified making sure none is left out.
- Stakeholder roles should be well-specified, documented and understood by all stakeholders.
- Joint planning in formulation of activities, networking / collaboration amongst stakeholders should not be underestimated.
- Continuous learning, (technical, operational and financial) is essential in order to enhance the quality of service delivery.
- Proper supervision and monitoring mechanisms for both business and financial accounting and quality control in AHSD should be put in place in the planning stage.
- Organisations must follow/adhere to the right protocol before introducing the project in the districts.
- Government should provide policy guidelines for agencies to work within depending on the type of intervention.
- Realistic time-frames should be planned for the intervention cycle.
- Community dialogue is essential for effective community mobilization however its success depends on the identification of the right community entry points.
- Need to include pharmaceuticals, GoK, private vet, and other donors to contribute towards refresher training and voucher printing.
- Need SMART Reporting against contractual details with good documentation of activities and meetings.
- There is need to shift from a project mentality to a business mentality – and link to “company / organisation approach”. “This is business, we are in business”
- In order to strengthen linkages and smooth running of the process, business contractual obligations are necessary between the private vet, AHTs AND cahwS.
GROUP B. IMPROVING THE VOUCHER SYSTEM

- How can CAHWs be controlled from just issuing out drugs without administering?
- How can it be ensured that CAHWs do not use fake or adulterated drugs?
- How can the misuse of vouchers be avoided?
- If an organisation distributes vouchers and there is a time lag between supply to CAHWs, voucher distribution and voucher redemption, how can it be ensured that CAHWs have sufficient drugs in stock to carry out all treatments?
- What happens if not all items are in stock is there a likelihood of CAHWs saying they do not have one drug, and not delivering 1 item, but ticks the box before he delivers it to vet for refunding. Is there need of vouchers for each specific drug / treatment?
- Should vouchers be for individual livestock owners or for adakars and communities e.g 1 voucher covers 500 shoats and 50 cattle. – what conditions would the voucher treat and who is it to be given to to ensure poorer households benefit?
- How can it be ensured that AHTS are fully involved in the system through:
  - Special interventions?
  - Two-tier drug pricing system?
- How best can reporting and follow-up systems be improved?
- How can the issue of profit sharing between the various cadres in the drug supply chain be handled in order to satisfy all. What are the considerations and mechanisms of handling the profit sharing issue?

Group responses

1. **How can CAHWs be controlled from just issuing out drugs without administering?**
   - Setting up campaign centres where the target group animals are brought for treatment under close technical supervision. The remaining drugs are left with livestock owner.
   - More extension is necessary to improve the CAHWs work.
   - Monthly monitoring sessions to check whether CAHWs are doing work correctly.

2. **How can it be ensured that CAHWs do not use fake or adulterated drugs?**
   - Random checking by GoK vet department.
   - Strengthen supervision by AHT and private vet.
   - CAHWs should keep good records
   - Check with beneficiaries whether animals are recovering or not and the reputation of the CAHW.

3. **How can the misuse of vouchers be avoided?**
   - Time frame between voucher and drug distribution should be short
   - Home visits
   - Animals should be presented at time of drug and voucher exchange.
4. If an organisation distributes vouchers and there is a time lag between supply to CAHWs, voucher distribution and voucher redemption, how can it be ensured that CAHWs have sufficient drugs in stock to carry out all treatments?
   - CAHW must have good linkages with private vet and AHT.

5. What happens if not all items are in stock is there a likelihood of CAHWs saying they do not have one drug, and not delivering 1 item, but ticks the box before he delivers it to vet for refunding. Is there need of vouchers for each specific drug / treatment?
   - Voucher should be returned until all drugs are available (this question was not well addressed)

6. Should vouchers be for individual livestock owners or for adakars and communities e.g 1 voucher covers 500 shoats and 50 cattle. – what conditions would the voucher treat and who is it to be given to ensure poorer households benefit?
   - Voucher should remain aimed at individual owners, as adakar leaders may not be honest.

7. How can it be ensured that AHTS are fully involved in the system through:-
   - Special interventions
   - Two-tier drug pricing system
   - Need to strengthen AHT agrovet stores
   - AHTs need motorbikes as an incentive
   - Provision of subsidised drugs to the AHTs
   - AHTs need recognition by vet department and NGOs and contracted to implement
   - AHTs should be involved in planning
   - Give AHTs ToT course
   - Strengthen communication between the partners
   - Strengthen linkages at all levels
   - Create trust between partners
   - Have a 3 tier pricing system

8. How best can reporting and follow-up systems be improved?
   - This is important and is encouraged at all levels.

9. How can the issue of profit sharing between the various cadres in the drug supply chain be handled in order to satisfy all. What are the considerations and mechanisms of handling the profit sharing?
   - Encourage normal business ethics to set up the profit sharing system.
Recommendations:

1. Setting up of campaign centres where vouchers are exchanged for treatments and remaining drugs are left with livestock owner. Other drugs eg subsidised or normal price drugs can be used alongside the exercise for non-beneficiaries. The exercise needs good awareness creation, mobilization and clear dates for the specified centres extension and supervision are done alongside the exercise.

2a. Distribute vouchers but the exchange has to be staggered and AHT has to be present (debatable) with CAHWs to treat over a more longer period. (Good idea but difficult to implement and worries on credit duration before vouchers get back to the private vet, unless credit is with the AHT and not the vet)

2b. Supervision by all parties is essential to avoid misuse and mismanagement of drugs. The DVOs office spot checks and ICRC field staff involvement is important. There is need for longer-term ICRC Livestock officer to do this work.

3. Time between voucher and drug distribution should be as short as possible to avoid voucher losses or livestock migrations.

4. The distribution should not be “relief like” to avoid drug misuse through own treatments.

5. If the relief style distribution is unavoidable, then voucher should be only for non-ethicals and the ethicals can go through the AHT and CAHW through a subsidised system. (But debate was to keep ethicals on the voucher but increase amount of non-ethicals)

6. There is need for extra non-ethicals on the voucher eg wound powder and poultry drugs.

7. Syringes and needles need not be included in voucher as they encourage self treatment.

8. Drug voucher should reflect disease challenge/situation in the district not just general for all areas (eg drugs for trypanosomiasis and mange)

10. Seasonal calendar of diseases is not so dependable for planning for interventions as diseases vary each year. There is need for quick disease assessments before interventions.

11. Voucher should remain for individuals and not for adakar leaders or communities.

12. AHTs should be subcontracted, by the private vet specifying their roles as this will help in the spread of risks.

13. Donor can also contract the AHTs for interventions within their areas of operation.

14. Vet should sell drugs to CAHWS at higher price than to AHTs so that it encourages CAHWS to go via nearer AHT to resupply as it is cheaper. (It is competition from other pharmacies that encourages Ririmpoi to sell to CAHWs – looking for sales volume – as otherwise he will lose his network of CAHWs to other cheaper suppliers. If a CAHW turnover is bigger than an AHTs why should he not go direct to the vet?)

15. Price Tier system in real practice does not work, the AHTs therefore need to work hard and be aggressive in business to keep the CAHW allegiance.

16. Reporting and follow up of community animal health services needS a standardised reporting format from the DVO. (This is in relation to the AHTs and the private vet. The CAHWs have reporting formats to use)

17. The private entrepreneours (vet AHTs) should look at the intervention as a business holistically right from the start to finish.

18. Agencies cannot set profit margins for the private sector rather the prevailing business principles should dictate.
GROUP C. SELECTION AND TARGETTING ISSUES

1. What are the criteria and guidelines for selection of beneficiaries and how can favouritisim and nepotism be avoided in beneficiary selection?

2. What are the criteria and guidelines for selection of CAHWs?
   - How do the CAHWs reach the remote livestock owners?
   - How can rural CAHWs be selected and not town based CAHWs?

Responses

Criteria for selecting voucher beneficiaries
-Carry out baseline survey and wealth ranking in the community this should take 2-3 weeks.
-Identify existing social structures/entry points that can be used for selecting beneficiaries.

The target groups should be as follows:

In rural areas:
Target vulnerable widows (not all widows), single mothers and vulnerable men who are disabled or aged.
Beneficiaries should have less than 5 large stock and 20 small stock (actual figures will depend on baseline survey).

In Urban centres:
Those displaced by conflict / disaster with a maximum of 15 small stock.
Other vulnerable group with animals.

NB: It is important to share findings of the baseline with community and discuss the selection criteria and verify whether they agree with the selection criteria.
The community then is given time to identify the beneficiaries using the criteria. A period of maximum 2 weeks and a minimum of 1 week is sufficient. All parties need to be present to verify the beneficiaries in an open meeting.

Criteria for CAHW selection
Agency and key stakeholders identify selection criteria and guidelines through discussion with the community and leaders. Appropriate entry points must be identified.
The community then selects CAHWs based on final criteria agreed upon, a period of 2 weeks is sufficient for the community to select. After the selection approval must be conducted at a public baraza.

CAHW selection criteria include the following:
Should own livestock
Should have a livelihood based on livestock
Not a drunkard
Be a member of the community and well known to them.
Be willing and interested to be a CAHW
Hard working and self motivated
Be physically fit to handle livestock
Be willing to follow animals to the grazing areas.
Be well behaved and trusted.
Be a good communicator.
Be respectful and respected.
Be knowledgeable of local conditions.
Knowledgeable on traditional livestock management.
Be willing to be supervised by community and veterinarians.
Basic academic knowledge is an advantage (NB illiteracy should not disqualify candidates who are otherwise suitable to being trained KVB standard guidelines)
How to reach remote livestock owners
Process must start from the village level in the presence of the implementing agency. To avoid selecting town-based CAHWS, the above criteria must be followed with emphasis on the selection criteria. (Agencies "must get out of towns and off the roads" into rural areas.)

GROUP D. DRUG KIT STANDARDISATION AND COMMUNITY CONTRIBUTION
1. What equipment and quantities of drugs should be included in the veterinary starter kits?
2. What incentives should be offered?
3. How can Community contribution be ensured to the CAHW system – e.g an initial contribution to the vet kit - how and when? How much?

Responses on the ICRC kit:

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>QTY</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxytetracycline 20% 100 ml</td>
<td>12</td>
<td>OK</td>
</tr>
<tr>
<td>Albendazole 10% 1 litre</td>
<td>3</td>
<td>Need 5 litres</td>
</tr>
<tr>
<td>Ivomectin 1% 50 ml</td>
<td>5</td>
<td>Not in all areas, but quantity is right</td>
</tr>
<tr>
<td>Trypanocidal tablets (Novidium)</td>
<td>100</td>
<td>Should be 100 Novidium/Diminaphen or Tryquin (to same value as Novidium total e.g 20 units)</td>
</tr>
<tr>
<td>Acaracide - Amitraz 100ml</td>
<td>24</td>
<td>OK</td>
</tr>
<tr>
<td>Healing oil</td>
<td>1</td>
<td>Need to make 5 tins</td>
</tr>
<tr>
<td>Wound powder</td>
<td>3</td>
<td>OK</td>
</tr>
<tr>
<td>Oxytet spray</td>
<td>3</td>
<td>OK</td>
</tr>
<tr>
<td>White Spirit (0.5 .litre)</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Footpump sprayer</td>
<td>1</td>
<td>Knapsack sprayers may be better as easier to adjust or even flower sprayers for poor people. But presently all are poor quality.</td>
</tr>
<tr>
<td>Metal bucket 20litre</td>
<td>1</td>
<td>Consider plastic bucket – not agreed by all.</td>
</tr>
<tr>
<td>Burdizzo Size 12 (smallstock)</td>
<td>1</td>
<td>OK – but make sure good quality – German 14&quot;</td>
</tr>
<tr>
<td>Burdizzo Size 16 (largestock)</td>
<td>1</td>
<td>Not necessary or share between 2 CAHWs</td>
</tr>
<tr>
<td>Automatic vaccinating syringe (30ml)</td>
<td>1</td>
<td>Not necessary</td>
</tr>
<tr>
<td>Reusable syringes (20 ml)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Reusable syringes (10 ml)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>60 ml plastic syringe</td>
<td>1</td>
<td>Prefer 30 ml</td>
</tr>
<tr>
<td>Disposable syringes (20ml)</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>Disposable syringes (10ml)</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Disposable syringes (5ml)</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Disposable needles (18g)</td>
<td>100</td>
<td>OK</td>
</tr>
<tr>
<td>Re-usable needles 16x1 (pack 12)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>1m dehorning wire</td>
<td>1</td>
<td>Not necessary</td>
</tr>
<tr>
<td>Cotton wool (400gm)</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Clinical Thermometer</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Tin trunk for storage Heavy guage 28</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Padlock (Tricircle No 265)</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Drenchgun (manual)</td>
<td>1</td>
<td>Not necessary</td>
</tr>
<tr>
<td>Hoofknife (double edged)</td>
<td>1</td>
<td>Not necessary</td>
</tr>
<tr>
<td>Overalls</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Boots</td>
<td>1</td>
<td>Not gumboots, possibly tyre shoes but not necessary</td>
</tr>
<tr>
<td>Canvas bag or rucksack</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Responses on incentives

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bicycle</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Tarpaulin</td>
<td>1</td>
<td>OK</td>
</tr>
<tr>
<td>Tyre Repair kit</td>
<td>1</td>
<td>OK</td>
</tr>
</tbody>
</table>

CAHWS should be involved in vet interventions and incentives are welcome. They should also get refresher courses, be supervised and advised.

Community contribution
Community should provide 5-10% of the initial kit cost, although it has been found to be difficult and slow (takes time). Some community members believe if they contribute before, then drugs should be free and not paid for. Therefore it is better if the individual CAHWs should contribute 20% of the cost of drugs in the kit before they receive it. This ensures ownership of the kit to the CAHW and avoids the problem of the community asking for free drugs.

Community or CAHW can be asked to contribute to CAHW training and refresher costs in the future. (This could be in the form of Goats both for food and practical purposes or part contribution of the training expenses this however needs consent and blessing of the community)
11. ANALYSIS OF COST BENEFITS OF THE PRIVATE VET AHTs AND THE INTERVENTION PROCESS

Dr Ririmpoi’s income versus expenditure

<table>
<thead>
<tr>
<th>Processes</th>
<th>Activity</th>
<th>Expenses Ksh</th>
<th>Income Ksh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vet advance for training</td>
<td>500,000</td>
<td></td>
</tr>
<tr>
<td>TRAINING</td>
<td>Pre- training expenses (food, accom, transport to NBI)</td>
<td>16,520</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mobilization expenses (transport lunches)</td>
<td>21,370</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training expenses (transport to station of facilitators, participants and foodstuffs)</td>
<td>25,200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost of foodstufs</td>
<td>78,750</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cost of training venue and cooks</td>
<td>84,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training materials aids and bags</td>
<td>30,735</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication – tel and postage</td>
<td>2,800</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DVOs payments Pokot and Turkana</td>
<td>12,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participants allowances</td>
<td>6,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitators allowances (AHTs)</td>
<td>84,000</td>
<td></td>
</tr>
<tr>
<td>VOUCHERS</td>
<td>TOTAL income/expenditure</td>
<td>361,375</td>
<td>138,625 (gained as facilitation allowance)</td>
</tr>
<tr>
<td>VET DRUG KIT</td>
<td>Total capital investment on vouchers (drugs)</td>
<td>316,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total retail pricing of voucher drugs</td>
<td>500,000 (Gross profit vouchers is 183,500 to be shared bw vet AHTs and CAHWs at 40% 31% &amp; 29%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Profit of vouchers to 12 CAHWs</td>
<td>53,105</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Profit of voucher to 2 AHTs</td>
<td>56,274</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport charges for drugs to Kapenguria</td>
<td>8,820</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food, accom, transport to NBI and field</td>
<td>11,610</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport of drugs to field and accommodation</td>
<td>7,620</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Packaging, postage, tel and photos</td>
<td>3,600</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss of 76 drug vouchers</td>
<td>76,000</td>
<td></td>
</tr>
<tr>
<td>VET DRUG KIT</td>
<td>TOTAL income/expenditure</td>
<td>533,529</td>
<td>Minus 33,529</td>
</tr>
<tr>
<td>VET DRUG KIT</td>
<td>Total capital investment on drug/equipment kits</td>
<td>460,300</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total retail pricing of drug/equipment kits</td>
<td>643,700</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Freight of kits</td>
<td>9,606</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport to field by securicor (bicycles)</td>
<td>5,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transport and distribution of drug and equip kits</td>
<td>8,800</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Food and accom in field</td>
<td>3,600</td>
<td></td>
</tr>
<tr>
<td>VET DRUG KIT</td>
<td>TOTAL income/expenditure</td>
<td>507,306</td>
<td>136,394</td>
</tr>
</tbody>
</table>

Comments:
From the above table, the vet made a net profit of Ksh 241,490 which translates to 55% nett gain on initial investment. The net gain would have been higher at Ksh 317,490 had the vet not lost Ksh 76,000 worth of vouchers.
The total gross profit of the vouchers was Ksh 183,500 and was shared between the vet (72,500), AHTs (56,274) and CAHWs (53,105) at 40%, 31% and 29%.

The nett profit of the vet after deduction of the vouchers was Ksh 40,850 which is actually 22% of the gross profit a loss of 18%. This was lowered even further to minus Ksh 35,150 due to the loss of 76 vouchers valued at Ksh 76,000. As can be seen from the table above, the vet made a loss of Ksh 33,529 in the process of vouchers.

There was an oversite on the vet and he took too much load and hence did not put into consideration expenses for voucher distribution costs to the field.

The vet also made a profit of Ksh 138,625 as facilitation fees for the CAHW training was more than double the expected payment of Ksh 63,000, a further additional Ksh 75,625. The payment of Ksh 138,625 is not justified as the second vet was not present in the training and neither was the private vet whose appearance was technical.

Perhaps the extra money earned by the vet in this case could be well justified in the use of transportation of vouchers, materials and CAHW kits to the field and man hour time spent by the vet in organizing the intervention processes.

On the part of the vet drug kits, the vet had minimal expenses and here he made his catch by bagging a gain of Ksh 136,394.

Assuming that the vets nett income/salary is Ksh 20,000 per month and he made Ksh 241,490 in four months this translates to Ksh 60,373 per month. This is 200% increase in his monthly wages and indeed its good business (salary approximated from civil service rates)

In comparison with NGOs salaries the income of Ksh 60,000 is just about what many would expect as a starting point before taxes are recovered.

### 11.1 AHT West Pokot income versus expenditure

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expenses</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilization process</td>
<td>Fuel – 3,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b/fast – 900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lunch – 1,800</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supper – 2,400</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accom – 3,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total 11,100</strong></td>
<td></td>
</tr>
<tr>
<td>CAHW selection</td>
<td>B/fast – 450</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lunch – 900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supper – 1,200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accom – 1,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total 4,050</strong></td>
<td></td>
</tr>
<tr>
<td>Drug distribution</td>
<td>b/fast – 450</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lunch – 900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>supper – 1,200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>accom – 1,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total 4,050</strong></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>Transport – 550</td>
<td>Allowances 42,000</td>
</tr>
<tr>
<td>Transport</td>
<td>m/bike repairs - 3,380</td>
<td></td>
</tr>
<tr>
<td>Report writing</td>
<td>3,500</td>
<td></td>
</tr>
<tr>
<td>Voucher profit</td>
<td>28,442</td>
<td></td>
</tr>
<tr>
<td>Value of vet drug kit received</td>
<td>40,000</td>
<td></td>
</tr>
<tr>
<td>CAHW selection fee</td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total expenditure Ksh 26,630</strong></td>
<td><strong>Total income ksh 112,442</strong></td>
</tr>
</tbody>
</table>

Nett Gain = Ksh 45,812 cash and vet drug kit valued at Ksh 40,000
Comments:
From the above figures the AHT made a net profit of Ksh 85,812 (ie Ksh 45,812 in cash and a drug kit worth Ksh 40,000)
Noting from the AHTs expenses on meals over the period of mobilization, selection and distribution are a bit on the higher side considering the local circumstances and could impact negatively on his profits. The rates though are within the recommended margins. The report writing expenditure is not well justified as it is not known who it was being written to and who was bearing the cost.

The cost benefits report of the AHT was written as if he was expecting refunds by ICRC from his expenses. This was a true reflection of project rather than business mentality and needs improvement. The AHT was not focussed on the business gains from the intervention but rather on what ICRC would refund on his expenses. This raises the question as to whether he understood the process clearly in business terms.

The cadre of an AHT receives about Ksh 10,000 per month in government, and from the figures over a period of four months the AHT earned Ksh 11,453 per month which is within the limits. NGOs can offer up to Ksh 20,000 per month. Considering the vet drug kit, the AHT gained in kind as they would approximately make another Ksh 30,000 bringing them closer to the NGO scale, but in essence it was good business a gain after all.

### 11.2 AHT Turkana income versus expenditure

<table>
<thead>
<tr>
<th>Activity</th>
<th>Expenses</th>
<th>Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobilization CAHW selection and training</td>
<td>Fuel m/cycle- 11,960</td>
<td>28,442</td>
</tr>
<tr>
<td></td>
<td>Cycle repairs – 2,560</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Accom &amp; meals – 2,000</td>
<td></td>
</tr>
<tr>
<td>Kit distribution</td>
<td>Cycle repair – 3,800</td>
<td>42,000</td>
</tr>
<tr>
<td></td>
<td>Fuel/ accom – 5,560</td>
<td></td>
</tr>
<tr>
<td>Voucher profit</td>
<td></td>
<td>40,000</td>
</tr>
<tr>
<td>Training allowances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>1,200</td>
<td></td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>Ksh 26,080</strong></td>
<td><strong>Total income Ksh 110,442</strong></td>
</tr>
</tbody>
</table>

**Nett Gain = Ksh 44,362 in cash and a vet drug kit worth Ksh 40,000**

Comments:
From the above figures the AHT made a profit of Ksh 84, 362 (Ksh 44,362, in cash and a vet drug kit worth Ksh 40,000)
The expenditures are quite realistic considering the AHT was operating from Turkana and had to use his own transport and maintain it.

The cadre of an AHT receives about Ksh 10,000 per month in government, and from the figures over a period of four months the AHT earned Ksh 11,090 per month which is within the limits. NGOs can offer up to Ksh 20,000 per month. Considering the vet drug kit, the AHT gained in kind as he would approximately make another Ksh 30,000 bringing him closer to the NGO scale, but in essence it was good business a gain after all.
11.3 The benefits and impact of the intervention
According to the proposal, 500 households (30,000 people) were to gain from basic animal health support for 62,500 livestock hence improving livestock production and livelihoods. The total livestock population per species in the intervention area is as follows:

- 30,000 heads of cattle
- 35,700 sheep,
- 77,850 goats,
- 4,133 camels
- 1,000 Donkeys

The table below looks at the possible approximate figures of animals that could be covered by the voucher intervention in Pokot and Turkana as per the estimated figure of 62,500. It is also assumed that 70% of the covered livestock are sheep and goats while the remaining 30% are cattle. This translates into 43,750 sheep and goats and 18,750 cattle. Camels and donkeys were not covered during the intervention.

It is worthy to note that it is difficult to know for certain which conditions were treated specially with regards to the antibiotic. It is also assumed all 500 households got the vouchers.

### Table of number of treatments per species and age categories

<table>
<thead>
<tr>
<th>Drug /condition</th>
<th>Sheep and goats</th>
<th>Cattle</th>
<th>Camels</th>
<th>Donkeys</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albendazole</strong> (Helminthiasis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>12,000 (27%)</td>
<td>Large 3,000</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Medium</td>
<td>20,000 (46%)</td>
<td>Medium 6,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small</td>
<td>60,000 (137%)</td>
<td>Small 12,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(16%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(32%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(64%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Amitraz</strong> (mange/ticks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large</td>
<td>25,000 (57%)</td>
<td>Large 10,000</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Medium</td>
<td>50,000 (114%)</td>
<td>Medium 15,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small</td>
<td>100,000 (228%)</td>
<td>Small 25,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(53%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(80%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(133%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diminaphen</strong> (tryps)</td>
<td>n/a</td>
<td>Large 1,250</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medium 2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(14%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small 4,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(21%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tetracycline</strong> (infections)</td>
<td></td>
<td>Large 1,500</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medium 2,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(14%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Small 5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(28%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NB:
- Figures based on 43,750 sheep/goats & 18,750 cattle.
- Percentage mean treatments for sheep and goats is 70% (30,625 sheep & goats)
- Percentage mean treatments for cattle is 35% (6,563 cattle)
11.3.1 Introduction:
The table tends to outline the possible number of animals per species and age group that could have been covered by the voucher intervention for 500 households. Camels and donkeys did not feature in the treatments and the drug Diminaphene for tryps was not used much in Turkana.

11.3.2 Impact:
From the above observations it can be seen that the drug that covered the most animals in both cattle and shoats was Amitraz. Considering that it is the medium and the large animals that mostly get treated the percentage combined treatments for shoats and cattle was 77%. As for the other drugs, their percentage treatments were low averaging at 34% for sheep and goats and 18% for cattle. 
As for the small category of animals, the drugs were sufficient, only in goats but not for cattle (the only drug sufficient for the small category in cattle was Amitraz)

This clearly shows that the drug quantities were not calculated well to fit the projected livestock populations of the needy. This is supported further by the fact that the targeted number of animals is 62,500 but it is not broken down into numbers for the different species.

The mean percentage treatment for the large and medium animals is 30% for cattle whilst that for sheep and goats is 51%. The overall mean percentage treatments/impact on all categories (large, medium & small) is 70% for sheep and goats (30,625) and 35% for cattle (6,563)

These results show that it is important to conduct a proper wealth ranking and populations of the different species of animals prior to interventions in order to avoid over or undercoverage.

11.3.3 Treatments and diseases:
The table also shows the diseases treated per species and age category, it can only be assumed that the tetracyclines treated more of pneumonia in goats and other bacterial infections in cattle. Other directly identified conditions treated are helminthiasis, tryps and ectoparasites. Lessons from past interventions show that treatments in goats/sheep approximate to about 70% of the total treatments. Pokot has more cattle than Turkana and the coverage in cattle could have been higher there.

11.3.4 Economic impact:
Assuming that 70% of the sheep and goats (30,625) and 35% of cattle (6,563) were treated to avert a mortality between 10% and 20% that would have occurred the community would have saved as follows:

1. At 10% mortality 3,063 sheep and goats valued at Ksh 3,063,000 would have been lost.
2. At 20% mortality 6,126 sheep and goats valued at 6,126,000 would have been lost.
3. At 10% mortality 656 cattle worth 3,936,000 would have been lost.
4. At 20% mortality 1,312 cattle worth 7,872,000 would have been lost.

NB:
- Average cost of sheep/goats = Ksh 1,000
- Average cost of cattle = Ksh 6,000
Economically the community has gained in that the losses that could have occurred due to deaths from disease are now averted. The gains may not be felt immediately by the community but they contribute well to the long term well being and livelihoods of the community. The combined effects of both cattle and shoats in terms of avoiding losses economically, show just how viable the intervention was.

The economic input per household for the intervention process was Ksh 1,000 totaling to Ksh 500,000 for five hundred households while the cost of the intervention is Ksh 2,182,227. The economic gains for the community definitely outweigh the project inputs as per the realization supported by the facts above.

11.3.5 Conclusion:
The cost of the intervention was definitely viable as the cost of the donor input is outweighed by the community economic gain in terms of avoiding loss of livestock through disease. This in itself is an empowerment to the community, an improvement of livelihoods and food security especially for those that had been affected by conflict as well as drought. The disadvantage though is that low percentages of animals were covered it was satisfactory in goats and sheep but low in cattle. This was occasioned by the poor estimates of livestock populations according to species and age and this led to a poor calculation of drug quantities for the targeted livestock.

All in all the exercise and its impact is satisfactory considering the fact that pastoralists rely more on small stock for their daily needs and the economic gains to the community over a long term outweigh the project inputs.
12. Guidelines/alternatives for emergency animal health interventions

<table>
<thead>
<tr>
<th>ACTIVITY/PROCESS</th>
<th>ALTERNATIVE INTERVENTIONS</th>
<th>CONCERNED PARTIES</th>
<th>COMMENTS/IMPORTANT CONSIDERATIONS</th>
</tr>
</thead>
</table>
| 1. Introduction of the Donor and intentions in the districts | - Free drugs  
- Free drugs in support of private systems  
- Subsidised drugs in support of privatized systems  
- Subsidised drugs + voucher in support of privatized systems. | Donor, NGOs in AHSD, DVO, Private vet/AHTs | - Introduction into district through the right protocol.  
- Problem statement.  
- Introducing intervention concept  
- Introduction to district livestock fora (LSP) and the DSG  
- Introduction to other partners  
- understanding the vet depts policy guidelines as pertains CBAH.  
- Receiving of blessings to go ahead. |
| 2. Identification of intervention type and its location | - Vet voucher system  
- Subsidised drugs system  
- Subsidised + Vet voucher system | Donor, private vet, AHTs, DVO, other partner NGOs  
Donor, private vet, AHTs, DVO, NGOs in AHSD, private vet, AHTs  
Donor, Lead agency, NGOs in AHSD, private vet, AHTs | - Problem statement.  
- Meeting to discuss the options of intervention and agree on which to use.  
- Discuss options and their suitability (Voucher system, Drug subsidy, Voucher + drug subsidy)  
- Identify location of operation.  
- Make sure no other organizations are doing the same thing in identified location. |
| 3. Collect baseline data of identified location. | - Vet voucher system  
- Subsidised drug system  
- Subsidised + vet voucher system | Private vet, AHTs, DVO, Donor, Other agencies  
Lead agency, NGOs in AHSD, private vet, AHTs  
Donor, lead agency, NGOs in AHSD, private vet, AHTs | - Baseline data should capture all aspects required for the intervention it should not be generalized but area specific.  
- In the case of voucher system conduct a wealth ranking to set criteria for beneficiary selection.  
- Meeting to present baseline data information to donor or lead agency presenting baseline info to donor. |
| 4. Formulation of intervention and presentation to donor. | - Vet voucher system | Private vet, AHTs, DVO, Donor | - Formulation of the intervention by options agreed upon. - Use of baseline data and justification - Identify other stakeholders and partners - Clear spelling of roles of the different actors - Joint planning |
| - Subsidised drug system | Lead agency, Donor, NGOs in AHSD, private vet, AHTs |
| - Subsidised + vet voucher system | Donor, lead agency, NGOs in AHSD, private vet, AHTs |

| 5. Donor scrutiny of intervention formulation and responses. | - Vet voucher system | Donor, private vet, DVO, AHTs |
| - Subsidised drug system | Donor, Lead agency |
| - Subsidised + vet voucher system | Donor, Lead agency |
| | - Meeting to discuss formulation and suggest/ make corrections. - Stake holders/partners meeting to make corrections on suggestions and finalizing the formulation. |

<p>| 6. Donor acceptance of intervention formulation and contractual obligations | - Vet voucher system | Donor, Private vet, AHTs, Pharmaceuticals, publishers etc. |
| - Subsidised drug system | Donor, lead agency |
| - Subsidised + vet voucher system | Donor, lead agency |
| | - Contract signed between donor and vet. - Contract signed between donor and AHT - Contract between donor pharmaceuticals or publishers/printers - Contract between donor and lead agency and vet - Contract between lead agency and AHT - Direct contract of donor and private vet or AHT. - Contract between donor and lead agency. - Contract between lead agency and vet - Contract between lead agency and AHT - Direct contract between donor private vet or AHT. |
| 7. Introduction of the concept process in the identified locations. | - Vet voucher system | Donor field staff, Private vet, AHTs, community. |
| - Subsidised drug system | Lead agency, NGOs in AHSD, private vet, AHTs DVO, community. |
| - Subsidised + vet voucher system | Lead agency, private vet, AHTs, NGOs in AHSD, community. |
| | - Make use of the right entry points to introduce the process and maximize awareness raising on what is intended to be done. |
| | - Community dialogue is very essential |
| | - Clearly introduce everyone and the specific roles they are going to carry out. |
| | - Explain the nature of the intervention well and specify the time frame. |
| | - Listen to the views of the community for change of strategy if need be. |</p>
<table>
<thead>
<tr>
<th>8. Beneficiary/ CAHW selection mobilization</th>
<th>an awareness creation</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Vet voucher system</td>
<td>Community, Private vet &amp; AHTs, donor staff</td>
</tr>
<tr>
<td>- Subsidised drug system</td>
<td>Community, private vet, AHTs, DVO, NGOs in AHSD</td>
</tr>
<tr>
<td>- subsidised + vet voucher system</td>
<td>Community, private vet, AHT, DVO, NGOs in AHSD</td>
</tr>
<tr>
<td></td>
<td>- Community dialogues for awareness raising (Max 2 wks for beneficiary selection and 2 wks CAHW selection but this varies on size of area)</td>
</tr>
<tr>
<td></td>
<td>- Agree and set criteria for selection of CAHWs and beneficiaries</td>
</tr>
<tr>
<td></td>
<td>- Coordination/networking</td>
</tr>
<tr>
<td></td>
<td>- If CAHWs present in area no need to select but conduct a 1 wk refresher.</td>
</tr>
<tr>
<td></td>
<td>- Not specific targets all affected.</td>
</tr>
<tr>
<td></td>
<td>- No need for CAHW training as GOK can intervene in area without CAHWs.</td>
</tr>
<tr>
<td></td>
<td>- Coordination/networking</td>
</tr>
<tr>
<td></td>
<td>- Existing CAHWs need to be informed of the process.</td>
</tr>
<tr>
<td></td>
<td>- Take stock of cattle camps and areas to be served.</td>
</tr>
<tr>
<td></td>
<td>- Inform community the prices of the subsidised products</td>
</tr>
<tr>
<td></td>
<td>- Targets the poor as well as the others who are affected.</td>
</tr>
<tr>
<td></td>
<td>- Community dialogues for awareness raising (Max 2 wks for beneficiary selection)</td>
</tr>
<tr>
<td></td>
<td>- Agree and set criteria for beneficiary selection</td>
</tr>
<tr>
<td></td>
<td>- No need for CAHW training as GOK can intervene if area has no CAHWs.</td>
</tr>
<tr>
<td></td>
<td>- If CAHWs present in area there is no need to select but conduct a 1 wk refresher</td>
</tr>
<tr>
<td></td>
<td>- Inform community the prices of the subsidised products</td>
</tr>
<tr>
<td></td>
<td>- Coordination/networking</td>
</tr>
</tbody>
</table>
| 9. CAHW/Beneficiary certification | - Vet voucher system  
- Subsidised + vet voucher system | AHTs, Donor, Private vet, community  
AHTs, private vet, community, Donor | - Activity to be conducted in a public barasa  
- Ensure selection criteria adhered to.  
- Agreement on beneficiary and CAHW selection  
(Applicable only in the voucher system and the subsidy + voucher system and not the subsidy system alone) |
|---|---|---|---|
| 10. CAHW training/refresher course | - Vet voucher system  
- subsidised drug system  
- Subsidised + voucher system | Certified trainer, 2 AHTs, logistician, Vet personnel | - 21 days training for new CAHWs  
- 7 days refresher course for existing CAHWs  
- Private vet can sub contract AHTs and trainer.  
(NB in all the three systems, existing CAHWS need to be refreshed and explained more on the mode of the intervention) |
| 11. Drugs and CAHW kits purchase. | - vet voucher system  
- subsidised drug system  
- Subsidised + voucher system | Private vet, Private AHT | - Private vet purchases drugs and CAHW kits from pharmaceuticals.  
- Private vet delivers subsidised drugs to lead agency or awaits collection by AHT and vet dept.  
- Private AHT only purchases drugs from private vet for use in his locality. |
<table>
<thead>
<tr>
<th>12. Voucher distribution for beneficiaries</th>
<th>- Vet voucher system</th>
<th>Private vet, donor staff, AHTs, CAHWs</th>
<th>- Distribute vouchers to all beneficiaries - Announce date of bringing the drugs - Time between voucher distribution and drugs be short - Announce there will be subsidised drugs for non-beneficiaries - Private vet can sub contract voucher distribution to AHT in his locality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Subsidized + voucher system</td>
<td>Private vet, donor staff, AHTs, CAHWs, DVO</td>
<td></td>
</tr>
<tr>
<td>13. Actual intervention (Drug and CAHW kit distribution, purchases, and treatments)</td>
<td>- Vet voucher system</td>
<td>- AHTs, Private vet, DVOs, CAHWs, community, Donor representative</td>
<td>- Set up campaign centres where beneficiaries bring their animals and exchange vouchers for treatments by CAHWs and AHTs - Vet can sub contract the AHT for drug and CAHW kit distribution in his locality</td>
</tr>
<tr>
<td></td>
<td>- Subsidised drug system</td>
<td>AHTs, NGOs in AHSD, Lead agency Private vet, CAHWs, GOK vet dept, community.</td>
<td>- AHTs and DVO collects controlled amount of drugs from lead agency or private vet - AHT sells to CAHW at subsidised cost then CAHW treats or sells to stockowner - DVOs staff do direct sales and treatments in areas not covered by privatized systems or involved in supervision - Proceeds from the sale of drugs are direct profits to AHTs and CAHWs and DVOs staff or revolving funds</td>
</tr>
<tr>
<td></td>
<td>- Subsidised + voucher system</td>
<td>AHTs, CAHWs, DVO, Donor/lead agency, community</td>
<td>- Subsidised drugs provided by private vet to AHT and DVOs. - Set up campaign centres for beneficiaries to bring their animals for treatments while exchanging vouchers. - AHTs and CAHWs serve the non beneficiaries through subsidised drugs - The vet dept serves areas that are not privatized at district level or are involved in supervision. - AHTs and CAHWs gain from voucher profits and direct sales of subsidised drugs</td>
</tr>
<tr>
<td>14. Supervision</td>
<td>All systems</td>
<td>DVO, Private vet, AHT, donor Lead agency</td>
<td>- Supervision mechanisms in place and roles of actors specified. Time frame planned.</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 15. Reporting   | All systems | DVO, Private vet and AHTs, CAHWs, Lead agency | - Regular progress reports to DVO who reports to DSG.  
- Regular progress reports to lead agency.  
- Regular progress reports to donor.  
- CAHW monitoring format report for the intervention to AHT.  
- AHT report to private vet or DVO  
- Private vet technical report to DVO.  
- Private vet or AHT report to donor.  
- Technical report of the intervention citing species of animals treated, their numbers, the diseases, and drug quantities used.  
- Final report of lead agency to donor. |
| 16. Evaluation  | All systems | All players | -Literature review  
- Field visits  
- Interviews  
- Reports etc |

The table above gives guidelines required for the success of emergency animal health interventions giving room and suggestions for two alternative approaches. The alternative providers that are vital in linking relief to development are those dealing with AHSD in the concerned districts and are geared towards privatization. The table shows a step by step process right from the beginning to the end. It is worth to note that collaboration, networking, joint planning and information sharing cut across all the processes. The role of the DSG and other livestock oriented fora in districts should not be underestimated. The subcontracting of some roles by the private vet to other players will reduce burden and risk from him. The guidelines cannot be said to be totally perfect but pave the way to better improving future emergency interventions especially those that are geared to supporting the private sector.
13. Review of costings (recommendations)
The table below looks at costings for the various processes of the intervention involving the private system (private vet as main contractor) and his relationship and linkages with other stakeholders. The table tries to bring into light the approximate costs of the processes from start to finish. In totality the table does not come out with real total figures of all the processes. In some cases real figures are given but in other cases real costs have to be calculated following given standard rates.

It is worth to note that costs of transport, materials, foodstuffs, and labour change from one area to another and therefore the recommended rates are just guidelines. The cost of bulk drugs and equipment for example is more to do with the vet and this can only be qualified by competitive bidding. However the cost of drugs for training purposes can easily be approximated. The rates have been put on the higher side to cater for contingencies and are calculated for the use by the private practitioner as he is the main contractor. The costing of issues to do with ICRC within the process have not been taken into consideration as they are more to do with the organization.

<table>
<thead>
<tr>
<th>Process/stage</th>
<th>Activities</th>
<th>Players</th>
<th>Expenses for</th>
<th>Cost estimates Ksh</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preparation</td>
<td>Meeting with donor</td>
<td>Private vet, &amp; 2AHTs</td>
<td>Transport/accom/food</td>
<td>10,500 (1day)</td>
<td>Ksh 3,500/day per person</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>Introducing donor to district</td>
<td>DVO, private vet, AHTs</td>
<td>Transport</td>
<td>1,000 (1day)</td>
<td>Flat rate 1 day</td>
</tr>
<tr>
<td>3. Intervention option</td>
<td>Meeting with donor to specify intervention option and location</td>
<td>Private vet, 2 AHTs, 2DVO, NGOs.</td>
<td>Transport/accom/food</td>
<td>17,500 (1day)</td>
<td>Ksh 3,500/day per person</td>
</tr>
<tr>
<td>4. Baseline data</td>
<td>Gathering of baseline data and present to donor</td>
<td>Private vet, 2 AHTs, 2DVO, NGOs.</td>
<td>Transport/accom/food</td>
<td>17,500 (1day)</td>
<td>Ksh 3,500/day per person</td>
</tr>
<tr>
<td>5. Formulation</td>
<td>Formulation of activities for the intervention. identification of key stakeholders and specifying roles.</td>
<td>Private vet, 2 DVOs, NGOs, 2AHTs</td>
<td>Sitting allowance/accom/food/transport</td>
<td>14,000</td>
<td>2 day meeting for formulation</td>
</tr>
<tr>
<td>6. Presentation</td>
<td>Presentation of formulated activities to donor</td>
<td>Private vet, 2 DVOs, NGOs, 2AHTs</td>
<td>Trans/accom/food</td>
<td>17,500 (1 day)</td>
<td>Ksh 3,500/day per person</td>
</tr>
<tr>
<td>7. Scrutiny</td>
<td>Donor scrutiny of formulated activities responses and corrections.</td>
<td>Private vet, 2 DVOs, NGOs, 2AHTs</td>
<td>Trans/accom/food</td>
<td>17,500 (1day)</td>
<td>Activity 6 and 7 can be combined to make 2 days</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>8. Acceptance</td>
<td>Donor acceptance of revised formulation of activities and contract signing.</td>
<td>Private vet, or AHT</td>
<td>Transport/accom/food</td>
<td>3,500 (1 day)</td>
<td>If signing is both for AHT and vet then rate doubles.</td>
</tr>
<tr>
<td>9. Community introduction</td>
<td>Introduction of concept to community through awareness raising dialogues</td>
<td>Private vet, AHTS</td>
<td>Transport</td>
<td>Ksh 20 per km for car &amp; 8 Ksh per km for Mcycle</td>
<td>Distance estimates will determine cost of fuel.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Food/accom</td>
<td>18,000 (5 days)</td>
<td>Ksh 1,200/day per person</td>
</tr>
<tr>
<td>10. Mobi/Selection</td>
<td>CAHW and beneficiary selection by community, specifying criteria</td>
<td>Private vet, AHTs</td>
<td>Transport</td>
<td>Ksh 20 per km for car and 8 Ksh per km for Mcycle</td>
<td>Distance will determine the cost of fuel. NB the vet can sub contract this activity to AHTs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Food/accom</td>
<td>18,000 (5 days)</td>
<td>Ksh 1,200/day per person</td>
</tr>
<tr>
<td>11. Certification</td>
<td>CAHWs and beneficiaries certified</td>
<td>Private vet, AHTs</td>
<td>Transport</td>
<td>Ksh 20 per km for car and 8 Ksh per km for Mcycle</td>
<td>Distance will determine the cost of fuel. NB the vet can sub contract this activity to AHTs</td>
</tr>
<tr>
<td>12. Training</td>
<td>CAHW training or refresher if CAHWs exist</td>
<td>Certified trainer, 2 AHTs, Logistician 12 CAHWs</td>
<td>- Trainer allowances - AHT allowances - logistician - Venue cost &amp; cooks - Foodstuffs - Training materials - Transport (materials to venue, participants mobilization, practicals, transport refunds other transport contingencies etc) - Open &amp; close DVOs</td>
<td>63,000 (21,000) 84,000 (28,000) 10,500 (3,500) 60,000 (20,000) 80,000 (27,000) 15,000 (5,000) 42,000 (14,000) 12,000 (12,000) 366,000 (130,500)</td>
<td>The bracketed figures are for refresher training. NB if vet not available he can sub contact a certified trainer advice can be sought from the DVOs</td>
</tr>
<tr>
<td>13. Purchase of inputs</td>
<td>Drugs and CAHW kits purchase</td>
<td>Private vet or AHTs</td>
<td>Trans/postage/tel/accom</td>
<td>This is the obligation of the Vet/AHT and it is his responsibility if he has won the tender.</td>
<td></td>
</tr>
<tr>
<td>14. Drug Vouchers</td>
<td>Distribution of vouchers to beneficiaries</td>
<td>Private vet, AHTs</td>
<td>Transport</td>
<td>Ksh 20 per km for car and 8 Ksh per km for Mcycle</td>
<td>Distances will determine the cost of fuel. NB vet can sub contract this activity to AHTs. Ksh 18,000 (5 dys)</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------</td>
<td>------------------</td>
<td>-----------</td>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15. Intervention</td>
<td>Distribution of drugs to beneficiaries and treatments. Distribution of CAHW kits</td>
<td>Private vet, AHTs, CAHWs</td>
<td>Transport</td>
<td>Ksh 20 per km for car and 8 Ksh per km for Mcycle.</td>
<td>Car hire can be arranged at local rates. If AHT is capable of doing this in his locality Vet can sub contract</td>
</tr>
<tr>
<td>16. Supervision</td>
<td>Monitoring of the activities of the intervention</td>
<td>Private vet, DVOs, AHTs</td>
<td>Transport</td>
<td>Ksh 20 per km for car and 8 Ksh per km for Mcycle.</td>
<td>Ksh 36,000 (5 dys)</td>
</tr>
<tr>
<td>17. Reporting</td>
<td>Writing reports to Donor, DVO, lead agency etc.</td>
<td>Private vet, AHT</td>
<td>Transport</td>
<td>8 Ksh per km for AHTs while picking reports from CAHWs and returning to DVO or private vet.</td>
<td>NB The transport and accommodation costs are for the AHTS only for report collection signifying end of exercise.</td>
</tr>
</tbody>
</table>

**TOTALS**

| Ksh 600,800 |
13.1 Comments on review of costings:
The total costs shown in the table are the known, the field transport has not been calculated since this has to be verified by the participating parties. Payment for the field transport is calculated at Ksh 20 per Km for a vehicle and Ksh 8 per Km for motor cycles. While presenting the formulated concept proposal, the vets and AHTs should be aware of the distances they expect to cover in order that they are budgeted for.

As can be seen from the table, the training costs as per the vets proposal were high, the realistic costs of the whole process are Ksh 366,000. The expenses for the second vet as per Ririmpois proposal are not justified since this vet was not available. According to payments for facilitation Dr Ririmpoi was to gain Ksh 63,000 from the facilitation of the training but he ended up with more than double that (Ksh 138,625). While the Ksh 63,000 is not justified due to his absence from the training the double profit of Ksh 138,625 complicates the justification even further and this needs justification.

The CAHW bags in the proposal of the training should have been included in the starter kits and the cost is on the higher side. As earlier stated, the above table for costings is a guideline and the total costs stated are not the final since some transport components are not calculated as they depend on the distances which cannot be verified as per now.

14. CONCLUSION:
The intervention was carried out well but it was rushed, the mobilization and awareness raising was too quick and insufficient, more needs to be done in this aspect. Though it must be understood that emergency interventions are generally quick in nature, the important thing is to ensure good organization, planning, collaboration, sensitization, clear time frame, precise execution, good feedback mechanisms and reporting.

The key players ICRC, and the private vet underplayed the role of the vet department in the exercise and the right protocol for introduction of the exercise in the districts was not given the seriousness it deserves.

The DSG and LSP were not fully aware of the voucher intervention. In the planning and formulation stage, notable absence of key stakeholders was noticed, this needs improvement in the future.

Reporting and supervision systems were missing in the exercise. There is need for the AHTs to supervise the CAHWs and encourage them to use the reporting formats. Networking, coordination, communication and information sharing especially between the private vet and the AHTs was poor and needs improvement.

The exercise was taken as a project especially by the AHTs and in future they need to look at the process in business terms.

The veterinary drug voucher was too general and in future it should be area specific to avoid important drugs for specific areas being missed out. The selection of beneficiaries needs to be improved through baseline survey and wealth ranking a set criteria for selection of beneficiaries should be adhered to.
The absence of the private vet from the training cannot be underestimated as this could impact negatively on the quality of CAHWs trained. In future there is need for the vet to avail himself in full for the training and if he is too busy then he can sub-contract the work to a qualified accredited trainer in line with KVB guidelines.

There is need to ensure that logistics as pertains to food, training aids, practical materials and transport to practical sites is well arranged for the smooth running of the exercise. The use of two AHT trainers acting both as trainers and logisticians is not in line with the KVB guidelines which require the presence of a vet and at least two AHTs.

The part of class demonstrations and field practicals for CAHWs needs to be taken seriously in future. Reports of inadequate class demonstrations and field practicals were evident due to logistics problems. CAHW training should be taken seriously right from day one to the end and all important apparatus put in place to ensure its smooth running.

There was no link between the intervention and conflict reduction it was just by chance that no conflict occurred during the time.

There is need for a duplicate voucher to be left with the beneficiary and dully signed by the Vet/AHT in order to safeguard the vet in case of voucher losses thus minimizing his risks.

In the end the voucher system provides the services or drugs free to the beneficiaries, this in itself can become tricky and lead to dependency. There is need to fully sensitize the community on this, whilst letting them use their social structures and traditional methods to identify the poor and needy so as to avoid bias and complaints while they see the poor receiving free services.

The CAHW drug starter kit was too generous and there is need for standardization, it is suggested that the equipment part of the kit is reduced and add more of the drugs to improve the capital base for the CAHW to do business.

Incentives are good but in future they should be linked to performance. Part contributions of incentives like the bicycle improve the sense of ownership, care and responsibility of the equipment.

Despite its shortcomings, the vet voucher system is worth trying in other areas bearing in mind the recommendations given in this report. The intervention impacted positively on the privatized systems, pastoral livelihoods as well as the animal health status in the intervention area.

It goes without say that improved livelihoods in terms of food security can contribute positively towards conflict reduction. ICRCs intervention in conflict prone areas through the voucher system in itself is a way of conflict reduction through improved livelihoods. The effects may not be immediate but can be realized in the long term.
14.1 General Issues emanating from the workshop:

- Some livestock owners are not aware of the value of the drugs.
- Need drug use and treatment reporting by CAHWs.
- Need to be flexible and control kit contents – e.g. no point in distributing too many trypanocidals in non-tsetse areas or where cattle populations are low. The drug component should be higher to enhance privatization by the CAHW because it increases capital base. Supply equipment based on performance of CAHW.
- Need to consider Triquin in Turkana rather than Diminaphen. But even in Turkana, Triquin does not sell. Only recently is Triquin moving in big quantities in Turkana. Sells at 250/- per bottle. Novidium has good market.
- In Pokot, Diminaphen sachets are cheaper than Novidium tablets, thus preferred on price difference alone.
- Livestock owners do not like trying new drugs. Prefer what they know or to see others experiment with new drugs and assess results.
- Investigate possibilities if using district revolving funds for start-up capital for AHA or private system linked to voucher system.
- AHTs have insufficient capital to invest in activities hence the need to source credit facilities as this will strengthen their privatized systems.
- Time-frames need to be realistic (enough time to deal with "pastoralist factors")
- Profit sharing ratios are controlled by business principles.
- Big need to have an ICRC Livestock Field Officer in Turkana to liaise with Gok etc.
- Identify areas not covered by other NGOs for voucher intervention.
- Need to reduce risk to vet and spread it more widely.
- If campaign style treatment on vouchers, there is need to specify what drugs should be used.
- Need CAHWS and AHT to contribute to risk by sub-contracting AHTs or giving them special contracts in their areas would help spread the risk.
- Need list of registered trainers in each district for quality training.
- Need policies and guidelines from government as pertains CAHSD.

NB: 30% oxytetracycline was provided by the vet to the CAHWs as part payment of their profits earned. It was not part of the vouchers or the kits provided by ICRC. Time though is note right yet to use 30% oxytet, and the use of 20% oxytet should be encouraged through extension, community field trainings, and pastoral field days sponsored by pharmaceuticals.
## Annexes

### Annex 1. List of Participants:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DESIGNATION /INSTITUTION</th>
<th>CONTACT ADDRESS</th>
<th>Email / Tel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Omori G N</td>
<td>DVO vet dept Turkana</td>
<td>Box 52 Lodwar</td>
<td>054-21443</td>
</tr>
<tr>
<td>Dr Kisa Toroitich</td>
<td>DVO vet dept W/Pokot</td>
<td>Box 225 Kapenguria</td>
<td>054-62279</td>
</tr>
<tr>
<td>Cecilia Mutanu</td>
<td>World Vision Turkana</td>
<td>Box 264 Lodwar</td>
<td>054-21458</td>
</tr>
<tr>
<td>Wilson Chekeruk</td>
<td>Private AHT Psigor W/Pokot</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Benson Ririmpoi</td>
<td>Private vet PAVES W/Pokot</td>
<td>Box 434 Kapenguria</td>
<td>054-62298 / 0733-403034</td>
</tr>
<tr>
<td>Willy Lolim</td>
<td>Private AHT Turkana south</td>
<td></td>
<td>0735-732362</td>
</tr>
<tr>
<td>David Kimama</td>
<td>KRCS volunteer</td>
<td>ICRC Turkwell</td>
<td></td>
</tr>
<tr>
<td>Dominic Ekeno</td>
<td>KRCS volunteer</td>
<td>ICRC Turkwell</td>
<td></td>
</tr>
<tr>
<td>Denge Tullu</td>
<td>ICRC ECOSEC field officer</td>
<td>ICRC Turkwell</td>
<td>0735-332368</td>
</tr>
<tr>
<td>Isaac Waweru</td>
<td>ICRC field officer</td>
<td>Box 73226 Nairobi</td>
<td><a href="mailto:Wathab.nai@icrc.org">Wathab.nai@icrc.org</a> 020-2723963 / 0735-640533</td>
</tr>
<tr>
<td>Piers Simpkin</td>
<td>ICRC regional livestock specialist</td>
<td>Box 73226 Nairobi</td>
<td><a href="mailto:Ecosec.nai@icrc.org">Ecosec.nai@icrc.org</a> 020-2723963 / 0733-735951</td>
</tr>
<tr>
<td>Paul Mutungi</td>
<td>IPST external consultant</td>
<td>Box 30786 Nairobi</td>
<td><a href="mailto:Paul_mutungi@yahoo.com">Paul_mutungi@yahoo.com</a> 0734-751635 / 020-253680 054-62455</td>
</tr>
</tbody>
</table>
**Annexe 2. Evaluation of the Evaluation**

Feelings of the 9 participants who replied to the questionnaire and question to "Please provide your comments on the ICRC Voucher Evaluation workshop 17-21st January 2005".

<table>
<thead>
<tr>
<th></th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Comment for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length / Duration</td>
<td>6</td>
<td>3</td>
<td></td>
<td>3 days enough, Other suggested 10 days needed</td>
</tr>
<tr>
<td>Organisation of workshop</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contents of workshop</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Timing, Timeframe and punctuality</td>
<td>4</td>
<td>5</td>
<td></td>
<td>Busy time of year, thus fewer participants than expected.</td>
</tr>
<tr>
<td>Participation by participants</td>
<td>5</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venue</td>
<td>6</td>
<td>3</td>
<td></td>
<td>Excellent – no diversions or interruptions</td>
</tr>
<tr>
<td>Accommodation</td>
<td>5</td>
<td>3</td>
<td></td>
<td>Water shortage</td>
</tr>
<tr>
<td>Food</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>No choice, no variety, too oily</td>
</tr>
<tr>
<td>Transportation</td>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitation</td>
<td>8</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Should voucher system be repeated? 9/9 said yes, but with the necessary recommendations implemented.

Other Comments:

More interventions required in the area.
Need involvement of all key players in the intervention.
Other NGOs could take it on as lead agency.
Should expand the area and increase the drugs on the voucher. i.e. Ivomec.
Needs more time – not so hurried with good baseline surveys.
Annexe 3. Results of ICRC Vet Voucher Evaluation Question Sheet – Non-beneficiaries

In January 2005, a total of 25 Pokot who did not receive ICRC vet vouchers were interviewed in Rittin, Orwa and Surmach/Nasolot and 25 Turkana who did not receive ICRC vet vouchers in Loregon and Kainuk. Their views and answers to the evaluation questions are listed below:

1. Did you receive a veterinary voucher from ICRC? 100% of these interviwees did not receive vouchers.

2. Did you hear about the ICRC Veterinary voucher scheme? YES NO
   If yes, What? (Was it positive or negative?)
   All of those interviewed had heard of the voucher intervention and the feedback to them was all positive.

3. Did you benefit in any way from the veterinary voucher scheme? YES
   If yes, How?
   76% of Pokot non-beneficiaries and 64% of Turkana non-beneficiaries said they had benefitted from the voucher intervention as they were given some drugs by their beneficiary friends.

4. Do you think the scheme was good for addressing emergency animal health situations? YES NO
   100% of the respondents said yes it was good for addressing emergency animal health situations.

5. Was the beneficiary selection done in a fair and open manner? YES NO
   If No, How should beneficiary selection be done?
   Everybody said yes, even though they were not beneficiaries.

6. Do you know the names of the CAHWs in your location? YES NO
   96% of Pokot non-beneficiaries and 80% of the Turkana non-beneficiaries knew their CAHWs.

7. Have you used the services of the CAHWs in your location? YES NO
   If No, why not?
   80% of Pokot and 40% of the Turkana non-beneficiaries had made use of the CAHWs.

8. What sort of services do you need from the CAHWs?
   Assistance with difficult births.
   Need provision of drugs.
   Advice on dose rates, route of administration, diagnosis, etc.
**Annexe 4. Results of ICRC Vet Voucher Evaluation Question Sheet – Voucher Beneficiaries**

Also in January 2005, a total of 25 Pokot who received ICRC vet vouchers were interviewed in Rittin, Orwa and Surmach/Nasolot and 25 Turkana who received vouchers in Loregon and Kainuk.

9. Do you think the scheme was good for addressing emergency animal health situations?  
   YES  NO  
   If NO, Why not?  
   *All said it was good.*

10. Was the beneficiary selection done in a fair and open manner?  
    YES  NO  
    If No, How should beneficiary selection be done?  
    *All said beneficiary selection was good.*

11. Who should the beneficiaries be (in terms of Livestock holdings?)  
    *Those with few livestock and are needy and cannot afford to buy drugs.*

12. Was the timing and scheduling of the voucher intervention good?  
    YES  NO  
    If NO, how can it be improved in future?  
    *All said timing was good.*

13. What did you do with the drugs you received?  
   Treated your own animals?  
   □ 16% Pokot and 36% of Turkana  
   Shared with family and friends?  
   □ 84% Pokot and 64% of Turkana  
   Sold the drugs?  
   □  
   Other………………  
   □  

14. Of the different drugs you received do you still have?  

<table>
<thead>
<tr>
<th></th>
<th>Albendazole</th>
<th>Amitraz</th>
<th>Tetracycline</th>
<th>Diminaphen</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>0% P, 8% T</td>
<td>0% P, 4% T</td>
<td>0% P, 36% T</td>
<td></td>
</tr>
<tr>
<td>Most</td>
<td>0% P, 4% T</td>
<td>0% P, 36% T</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very little</td>
<td>12% P, 24% T</td>
<td>20% P, 56% T</td>
<td>4% P, 44% T</td>
<td>12% P, 36% T</td>
</tr>
<tr>
<td>None</td>
<td>88% P, 68% T</td>
<td>80% P, 36% T</td>
<td>96% P, 56% T</td>
<td>88% P, 20% T</td>
</tr>
</tbody>
</table>

*i.e. 12% P = 12% of Pokots have very little Albendazole remaining, whilst 24% of Turkanas interviewed claim the same.*
15 Which drug was most important to you and why?

72% Pokots and 68% of Turkans claimed the Antibiotic to be most important.
24% Pokots and 28% of Turkans found Anthelminthic the most useful drug to them.
12% Pokots and 24% of Turkans found Acaricide was the most useful drug to them.
12% of Pokots and 05 of Turkana said the diminaphen was the most useful drug to them.

16 What can you say about the quality and quantity of the drugs given?

<table>
<thead>
<tr>
<th>Quality</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Too much</td>
</tr>
<tr>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enough</td>
</tr>
<tr>
<td></td>
<td>20% Pokot and 28% of Turkana</td>
</tr>
<tr>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Too little</td>
</tr>
<tr>
<td></td>
<td>80% Pokot and 72% of Turkana</td>
</tr>
</tbody>
</table>

17 How many animals did you treat with the drugs received, and what were the results?

<table>
<thead>
<tr>
<th>Albendazole</th>
<th>Amitraz</th>
<th>Tetracycline</th>
<th>Diminaphen</th>
<th>Results*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camels</td>
<td>0</td>
<td>7 P, 0 T</td>
<td>1 P, 0 T</td>
<td>0</td>
</tr>
<tr>
<td>Cows</td>
<td>0 T 129 P</td>
<td>85 P, 0 T</td>
<td>156 P, 0 T</td>
<td>185 P, 36 T</td>
</tr>
<tr>
<td>Chickens</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donkeys</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18 Who actually treated the animals?

- Self                  | 32% P, 24% T
- CAHW                  | 36% P, 48% T
- AHA                   | 32% P, 0% T
- Vet                   |   
- Other (who? friend/relative) |   

19 What constraints / problems did you have during the period and what could be the solution?

<table>
<thead>
<tr>
<th>Problems</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>None had any problems with</td>
</tr>
</tbody>
</table>
20 What issues or problems emerged in your community as a result of this project (and what could be the solutions)?

None

21 Do you know the names of the CAHWs in your location? YES NO

All said yes.

22 How often have you used the services of the CAHWs in your location?

- Often □ 56% P, 44% T
- Sometimes □ 20% P, 40% T
- Never □ 24% P, 16% T

If Never, why not? □ CAHWs are too far away, or owners themselves have enough knowledge.

23 Do you think the CAHWs are active and helpful to the community? YES NO

All said yes.

24 What do you think of their services?

All said their work is good.

25 What sort of services do you need from the CAHWs?

Assistance in treating, advice, as per non-beneficiaries.

26 How can the community contribute to the CAHW system to make it sustainable and motivated?
Fundraise; support CAHWs by purchasing their drugs; reward them for services; recognise them as important community members.

27 What are the lessons learned / experience? how should system be improved in future?

They have now discovered "quality drugs"; realise that many of the previous drugs were fake or poor quality. "Niwele na badalika". They better understand dose rates and that routes of injection are important.

28 Any other comments / requests:

52% of Pokots and 68% of Turkanas say they need more drugs.
32% of Pokots and 24% of Turkanas say it should be expanded programme and increase number of beneficiaries.
12% Pokots and 32% of Turkana say that more CAHWs should be trained
4% of Pokot and 12% of Turkana say that poultry drugs should be included.
Annexe 6. Final report on the subsidised drug system in Turkana

Project title: Turkana Drought Mitigation Intervention – Livestock Sector Support
Project Number: CDTF-EDP/3TNA/AS/003/2000
District: Turkana
Divisions: Turkwell, Loima, Lokichoggio, Kakuma, Oropoi, Katilu, Lokichar, and Kainuk
Project Budget: 7,362,820 Ksh
Project Period: 6 months
Reporting Period: Final report LS

1. Project Objectives
   o Provision of subsidized veterinary drugs:
     • To improve the health status of drought-stricken livestock. This will enhance their changes of
       survival and thus their continued contribution to food security in the area, and the speed of
       recovery of the herds when the rains return.
   o Vaccination of goats
     • Increasing the chances of survival of goats, in particular at the onset of the rains.
   o Experimental supplementary feeding of the reproductive stock.
     • To test applicability of supplementary feeding as a drought coping strategy, and whether the
       animal feed are a suitable intervention in times of drought and pasture scarcity. The logic of
       this intervention is the need to keep the reproductive stock alive so that they can be the take-
       off point after the drought.

2. List of Project Targets
   o Provision of subsidized veterinary drugs:
     • Hold 8 Community Dialogues
     • Hold 40 follow-up dialogues [these have been replaced by on-going monitoring by the AHAs in
       the field]
     • Monitoring sheets collected
     • Re-supplying of the CAHWs
     • Treat 108,000 Animals
   o Vaccination of goats
     • Facilitate 40 CAHWs to carry out the vaccinations
     • Vaccinate 200,000 goats
     • Organize 3 supervision visits from GoK
   o Experimental supplementary feeding of the reproductive stock.
     • Distribute 140 bags of Animal Feed to the Adakar leaders

Activities undertaken

Introduction:

The TDMI was a worthy intervention in Turkana district considering the long-standing drought that had
been felt since the beginning of 1999. This was called “Kirimirk” by the Turkana meaning extremely
prolonged drought. The drought cycles in the district usually take 10 years but the period is becoming
shorter over the years.

During the beginning of 2000, the effects of the drought were beginning to be felt and several animals
perished in the NW part of the district while others elsewhere were in poor health. The exact number of
animals lost to the drought cannot be ascertained but definitely quite a number was lost, some pastoralists said they had lost all they had while others talked of losing more than a half of their herds approximately 50% of the small stock were lost. Water and pasture were becoming scarce commodities and all the reserve grazing grounds seemed to have been utilized.

As a means of coping, the pastoralists moved their cattle across the international boundaries but the threat of raiding was looming. As for the pastoralists who remained with the small stock, the situation was pathetic as the health of the stock continued to deteriorate due to poor nutrition.

At this point, something had to be done, the LSP NGO members were asked to draw proposals to donors with the hope that they may fund to avert the catastrophe in the livestock sector.

The first proposal was funded by CORDAID to ITDG who worked together with the DVO to treat animals in Lokitaung and the Kerio areas of the district. The second proposal was funded by USAID and this mainly targeted the NW area of Lokichoggio and Kakuma divisions. Following shortly was the proposal funded by CDTF which was covering Turkwell, Loima, Lokichar, Katiliu, Kainuk, Lokichoggio, Oropoi, and Kakuma divisions.

This report describes the activities undertaken in the livestock sector support which include, CCPP vaccinations in goats, and the supply of subsidized veterinary drugs to CAHWs for the treatment of animals of the stock owners. The actual implementation of the livestock sector support was initiated in the month of October 2000. The proposal initially had been tailored to cover project areas only, but this was modified through suggestions in the LSP that the entire district needs to be covered. Due to this fact a proposal was presented to CDTF suggesting that the non-project areas be covered by the GOK, CDTF accepted the proposal but this was not implemented until May 2001.

- **Community dialogue workshops:**

Community dialogue workshops were held in the project locations to signify the start of provision of subsidized drugs by CAHWs as well as the CCPP vaccination. Other workshops were also held to signify the end of the drug subsidy. The workshops were attended by pastoralists in the various project locations as below:

- 4 starting community dialogue workshops in Lokichar, Kakuma, Lorugum and Lokichoggio.
- 4 stopping subsidized drugs workshops in Lokichar, Kakuma, Lorugum, and Lokichoggio.
- AHAs field monitoring replaced the 40 follow up dialogues at the tree of men.

During the initializing workshops, the elders commended the move to supply subsidized drugs as well as the CCPP vaccinations. They said that this move would go a long way in saving their livestock from drought related ailments. The subsidized drugs would also enable those with a low purchasing power to be able to procure drugs for their sick stock. The CAHWs would also benefit from the profits accruing from the high turnover of the drugs they sell to livestock owners or the treatments they perform.

The workshops for the stoppage of the subsidized drug delivery however were not received with much enthusiasm and the stockowners had the following to say.

The following were main points picked from the exit dialogues.

- The stockowners appreciated the exercise and emphasized it was the right thing to do at a crucial time.
- The period of the subsidy was short.
- The services did not benefit some stockowners especially in the NW and some parts of central.
- Some stockowners were not aware of the intervention.
- Extension of the exercise.
- The abrupt stoppage brought in confusion to the CAHWs and some elders.
- Some difficulties in adjustment to normal prices that were there originally may be expected.

The average attendance of elders from the various Adakars to each workshop was approximately 70.
• **Provision of subsidized veterinary drugs:**
  - The monitoring sheets for the various disease conditions were filled and collected as required.

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<table>
<thead>
<tr>
<th>General overview of the period from the field</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rainfall:</strong> During the period of the project implementation, the district experienced moderate to heavy showers of rainfall. The rain was mainly confined to the NW and western areas as well as some southern parts of the district. The northern area of the district as well as the central and other parts of the south especially the eastern zone were not well endowed with rain.</td>
</tr>
<tr>
<td><strong>Pasture availability:</strong> Browse was readily available in the areas that received good rains. The good browse was more evident in some parts of south Turkana and others in the NW and the central area of Turkwell and Lorgum. The rest of the areas remained with moderate amounts of browse due to the scarce rains. The pasture was not very adequate in most areas because rainfall was not sufficient.</td>
</tr>
<tr>
<td><strong>Livestock body condition:</strong> The browsers continued showing good and improved body condition owing to the improvement in browse availability. The cattle in the south benefited from the riverine vegetation along the Turkwell river while the cattle in other areas migrated beyond the international boundaries into Uganda and the Sudan. An outbreak of CCPP reported in Lorengippi and Lokiriamaa slowly subsided due to the vaccination and the subsidized animal health delivery services offered by the CAHWs. To conclude, livestock health was fair, but there needs to be more rain so that the situation can improve. Already in some areas in the north central and parts of the south browse is becoming a scarcity and this is affecting the health of the small stock.</td>
</tr>
<tr>
<td><strong>Livestock movement / security:</strong> The livestock movement occurred across the international boundaries of Uganda and Sudan occasioned by the search for pasture that was scarce in the country. Livestock movement was also due to search for water, and secure grazing grounds safe from raiders. Within the country, the cattle were mainly concentrated along the riverine vegetation of the Turkwell river. Cattle raiding occurred between the Turkana and the Pokot and the Ngijie and Dodoth of Uganda as well as the Toposa in Sudan. This kind of scenario forced the Turkana to migrare into difficult areas that had either limited pasture or water for the safety of their stock.</td>
</tr>
</tbody>
</table>

---

• **Treatment of animals**

The subsidized animal health services continued in all the project areas as well as the non-project areas served by the GOK. The livestock owners acknowledged the services that were offered to them by the CAHWs and the GOK as well. The good thing about the subsidized drug delivery was that majority of the stockowners were able to purchase save for a few that were unable. Some livestock owners were not able to benefit from the intervention due to the distances separating them from the CAHWs, this was noted in the central area as well as the NW. In the northern part the GOK personnel were not able to reach the stockowners due to poor terrain.

Outlined below is the way in which the subsidized drugs were issued / sold to the CAHWs and stockowners during the month under review.
Central (VSF-B)
Drugs issued during the period & amount to be cost recovered.

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Number of units issued</th>
<th>Number returned</th>
<th>Number sold</th>
<th>To be cost recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC LA</td>
<td>996</td>
<td>95</td>
<td>901</td>
<td>144,160</td>
</tr>
<tr>
<td>EYE WOUND POWDER</td>
<td>146</td>
<td>39</td>
<td>107</td>
<td>5,885</td>
</tr>
<tr>
<td>DEWORMER</td>
<td>203</td>
<td>7</td>
<td>196</td>
<td>9,800</td>
</tr>
<tr>
<td>ETHIDIUM</td>
<td>8,150</td>
<td>312</td>
<td>7,838</td>
<td>70,838</td>
</tr>
<tr>
<td>TRIQUIN</td>
<td>474</td>
<td>30</td>
<td>444</td>
<td>17,760</td>
</tr>
<tr>
<td>TRIATIX</td>
<td>148</td>
<td>19</td>
<td>129</td>
<td>1,395</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>249,838</strong></td>
<td></td>
<td></td>
<td><strong>249,838</strong></td>
</tr>
</tbody>
</table>

Out of the above there still is an outstanding balance of ksh 33,245 to be cleared by VSF-B.

NW (SNV):
Drugs issued during the period & amount to be cost recovered.

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Number of units issued</th>
<th>Number returned</th>
<th>Number sold</th>
<th>To be cost recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC LA</td>
<td>240</td>
<td>9</td>
<td>231</td>
<td>36,960</td>
</tr>
<tr>
<td>EYE WOUND POWDER</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DEWORMER</td>
<td>24</td>
<td>24</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ETHIDIUM</td>
<td>3,240</td>
<td>0</td>
<td>3,240</td>
<td>32,400</td>
</tr>
<tr>
<td>TRIQUIN</td>
<td>50</td>
<td>45</td>
<td>5</td>
<td>200</td>
</tr>
<tr>
<td>TRIATIX</td>
<td>160</td>
<td>0</td>
<td>160</td>
<td>2,400</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>71,960</strong></td>
<td></td>
<td></td>
<td><strong>71,960</strong></td>
</tr>
</tbody>
</table>

Out of the above, there is still an outstanding balance of ksh 43,885 to be cleared by SNV (Willy Lolim).

South (SNV)
Drugs issued during the period & amount to be cost recovered.

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Number of units issued</th>
<th>Number returned</th>
<th>Number sold</th>
<th>To be cost recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC LA</td>
<td>420</td>
<td>0</td>
<td>420</td>
<td>67,200</td>
</tr>
<tr>
<td>EYE WOUND POWDER</td>
<td>60</td>
<td>17</td>
<td>43</td>
<td>2,365</td>
</tr>
<tr>
<td>DEWORMER</td>
<td>87</td>
<td>0</td>
<td>87</td>
<td>4,350</td>
</tr>
<tr>
<td>ETHIDIUM</td>
<td>3,200</td>
<td>0</td>
<td>3,200</td>
<td>32,000</td>
</tr>
<tr>
<td>TRIQUIN</td>
<td>257</td>
<td>7</td>
<td>250</td>
<td>10,000</td>
</tr>
<tr>
<td>TRIATIX</td>
<td>294</td>
<td>0</td>
<td>294</td>
<td>4,410</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>120,325</strong></td>
<td></td>
<td></td>
<td><strong>120,325</strong></td>
</tr>
</tbody>
</table>

There is no balance as per the above as all the money has been paid by the concerned (Michael Kapolon).

GOK (DVO TURKANA)
Drugs issued during the period & amount to be cost recovered.

<table>
<thead>
<tr>
<th>DRUG TYPE</th>
<th>Number of units issued</th>
<th>Number returned</th>
<th>Number sold</th>
<th>To be cost recovered</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC LA</td>
<td>310</td>
<td>160</td>
<td>150</td>
<td>24,000</td>
</tr>
<tr>
<td>EYE WOUND POWDER</td>
<td>60</td>
<td>10</td>
<td>50</td>
<td>2,750</td>
</tr>
<tr>
<td>DEWORMER</td>
<td>142</td>
<td>22</td>
<td>120</td>
<td>6,000</td>
</tr>
<tr>
<td>ETHIDIUM</td>
<td>1,000</td>
<td>0</td>
<td>1,000</td>
<td>10,000</td>
</tr>
<tr>
<td>TRIQUIN</td>
<td>494</td>
<td>94</td>
<td>400</td>
<td>16,000</td>
</tr>
<tr>
<td>TRIATIX</td>
<td>639</td>
<td>139</td>
<td>500</td>
<td>7,500</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>66,250</strong></td>
<td></td>
<td></td>
<td><strong>66,250</strong></td>
</tr>
</tbody>
</table>

The balance payment from the above is ksh 6,450 to be paid by the DVO Turkana.
Total cost recovery:

- The total cost recovery as per the above tables is supposed to be **Ksh 508,373**.
- Less outstanding balance of **Ksh 83,580** the cash at hand is **Ksh 424,793**.

It is strongly believed that the outstanding balances will be cleared to bring the cost recovery to **Ksh 508,373**.

**Drug balances in VSF-B & SNV stores**

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Balance</th>
<th>To purchase</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTC</td>
<td>179</td>
<td>28,640</td>
<td></td>
</tr>
<tr>
<td>ETHIDIOUM</td>
<td>0</td>
<td>471*</td>
<td>21,195*</td>
</tr>
<tr>
<td>EYE WOUND</td>
<td>107</td>
<td></td>
<td>5,885</td>
</tr>
<tr>
<td>TRIATIX</td>
<td>0</td>
<td>209*</td>
<td>38,665*</td>
</tr>
<tr>
<td>TRIQUIN</td>
<td>1,455</td>
<td>58,200</td>
<td></td>
</tr>
<tr>
<td>DEWORMER</td>
<td>245</td>
<td>12,250</td>
<td></td>
</tr>
</tbody>
</table>

The drugs marked in asterix are to be purchased and returned to VSF-B as they had been borrowed for the intervention therefore their cost is at buying price from pharmacies. The rest remain at subsidized costs.

- **Vaccination of goats**
  The vaccination of goats was initiated in the months of November and December in the project areas of central (VSF-B) and the NW (SNV). The exercise went on well but was cut short due to the poor supply of the CCPP vaccine. The second phase of the vaccination occurred in the south of the district where the GOK covered non-project areas and SNV covered their area of operation. This exercise was also cut short due to the erratic and poor supply of the CCPP vaccine despite the high demand by the pastoralists.

  The total number of goats vaccinated during the exercise in all areas was **96,929** representing almost 50% of the expected target.

  The total number of vaccines sent to the field was **108,100** which means that **11,171** doses were spilt or spoilt. It is worthy to mention that ITDG, and the UNICEF provided the initial vaccines. Itdg was free while those of UNICEF were to be refunded this process is complete by now.

- **Experimental supplementary feeding of the reproductive stock**
  This activity could not take place as there was problems with suppliers of the feeds, (not reliable) as well as logistics and the modes of delivery to the pastoralists.

3. **Results achieved.**

- **Provision of subsidized veterinary drugs:**
  - **120,342** animals were treated during the period out of the targeted **108,000** representing an increase of 10%.

  - **Vaccination of goats**
    - Total number of goats vaccinated was **96,929** out of the targeted **200,000** this represents approximately 50%.

- **Experimental supplementary feeding of the reproductive stock.**
  - This activity did not take off or was not implemented.
  - **Community dialogue workshops.**
  - 8 workshops were conducted.
### DISEASE SURVEILLANCE SUMMARY (ALL AREAS)

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>SPECIES</th>
<th>LARGE</th>
<th>MEDIUM</th>
<th>SMALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBPP</td>
<td>Bovine</td>
<td>638</td>
<td>506</td>
<td>335</td>
</tr>
<tr>
<td>CCPP</td>
<td>Caprine</td>
<td>6,645</td>
<td>3,522</td>
<td>2,187</td>
</tr>
<tr>
<td>Helminthias</td>
<td>Bovine / Caprine</td>
<td>780</td>
<td>8,233</td>
<td>973</td>
</tr>
<tr>
<td></td>
<td>/ Ovine</td>
<td></td>
<td>6,469</td>
<td>6,764</td>
</tr>
<tr>
<td>Ticks/mange/lice</td>
<td>Bovine / Caprine</td>
<td>2,653</td>
<td>130</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>/ Ovine / Camellida</td>
<td>3,726</td>
<td>102</td>
<td>53</td>
</tr>
<tr>
<td>Trypanosomiasis</td>
<td>Bovine / Caprine</td>
<td>2,989</td>
<td>1,191</td>
<td>652</td>
</tr>
<tr>
<td></td>
<td>/ Ovine / Camellida</td>
<td>1,096</td>
<td>944</td>
<td>272</td>
</tr>
<tr>
<td>Eye wound infect</td>
<td>Bovine / Caprine</td>
<td>63</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>/ Ovine / Camellida</td>
<td>92</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>148</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Wounds</td>
<td>Caprine / Ovine</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blackquater</td>
<td>Caprine / Ovine</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blackquarter</td>
<td>Caprine / Ovine</td>
<td>18</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>NSD</td>
<td>Caprine / Ovine</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaplasmosis</td>
<td>Bovine</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>Donkey</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Caprine / Bovine</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>28,949</td>
<td>13,970</td>
<td>12,494</td>
</tr>
</tbody>
</table>

The above diseases treated totaling to 55,413 were treated in the period of Jan to March. In the period of November, to Dec 2,000 a total of 18,558 animals were treated. The GOK treated as below see table

### DISEASE SURVEILLANCE SUMMARY (GOK Lokitaung / Kalokol)

<table>
<thead>
<tr>
<th>DISEASE</th>
<th>SPECIES</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBPP</td>
<td>Bovine</td>
<td>NIL</td>
</tr>
<tr>
<td>CCPP</td>
<td>Caprine</td>
<td>825</td>
</tr>
<tr>
<td>Helminthias</td>
<td>Caprine/Ovine</td>
<td>12,606</td>
</tr>
<tr>
<td>Ticks/mange/lice</td>
<td>Caprine / Ovine / camels</td>
<td>30,506</td>
</tr>
<tr>
<td>Trypanosomiasis</td>
<td>Bovine / Camellida</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>110</td>
</tr>
<tr>
<td>Eye wound infect</td>
<td>Caprine / Ovine / camels</td>
<td>444</td>
</tr>
<tr>
<td>Goat pox</td>
<td>Caprine / Ovine</td>
<td>1720</td>
</tr>
</tbody>
</table>
### Table:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Species</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>BQ</td>
<td>Bovine</td>
<td>5</td>
</tr>
<tr>
<td>H/ Septicaemia</td>
<td>Bovine</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>46,371</strong></td>
</tr>
</tbody>
</table>

Therefore total number of animals treated in the period is 120,342.

As can be seen from the above tables above, the species most treated again are the caprine and ovine (sheep & goats) these are followed by the bovine (cattle) and lastly the camels.

It can be seen from the table that most animals treated were adults with medium age following and the small last. Diseases/infestations that seem to be prevalent are CCPP, Helminthiasis, and Trypanosomiasis.

For the period of Nov to Dec 2000 and May 2001 the treatments were not categorized into Large, medium and small.

#### Constraints in project implementation

The constraints experienced during implementation were as follows.

- Time was short and a lot had to be done the exercise was underestimated.
- Logistics of drug and equipment procurement difficult due to the CDTF rules.
- The poor supply of CCPP vaccine.
- Lack of good vehicles for hire since there were other relief interventions going on.
- The non-project areas were not incorporated initially while the whole district was affected by drought. This necessitated the need for GOK intervention.
- Approval procedures took long.

#### 4. Conclusion

The subsidized animal health delivery service went on well in all the project areas and those intervened by the GOK. The stockowners were happy of the intervention as it helped save their sick stock at a time when needed. The CAHWs too were happy as those who utilized their drugs well made some good income.

Most disappointing to the stockowners as well as the CAHWs was the announcing of the termination of the drug subsidy in early March. The six months seemed such a short time to them, many were requesting for extension of the exercise.

The situation of insecurity along the common border of the Turkana and Pokot as well as the international boundaries of Uganda and Sudan caused more tension and hopelessness to the Turkana pastoralists causing fear and tension.

All in all the exercise was a worthy cause in a time when needed most by the community. VSF-B and SNV strived to their best to ensure that the implementation was smooth. This did not go without its problems, but at least most of what was intended was achieved.
### Hel Disease Monitoring Format

**KEY**
- **-** Treated
- **+** Repeat Rx
- **O** Dead
- **X** Not Rx
- **□** Total Rx
- **□** Total Death

<table>
<thead>
<tr>
<th>NAME OF CAHW</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OUT</td>
<td>DATE IN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF SUPERVISOR</th>
<th>SIGN</th>
</tr>
</thead>
</table>

### Ccpp Disease Monitoring Format

**KEY**
- **-** Treated
- **+** Repeat Rx
- **O** Dead
- **X** Not Rx
- **□** Total Rx
- **□** Total Death

<table>
<thead>
<tr>
<th>NAME OF CAHW</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OUT</td>
<td>DATE IN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF SUPERVISOR</th>
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NAME OF CAHW: ____________________  LOCATION: ____________________

DATE OUT: __________  DATE IN: __________  TOTAL DAYS: __________

NAME OF SUPERVISOR: ____________________  SIGN: ____________________

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