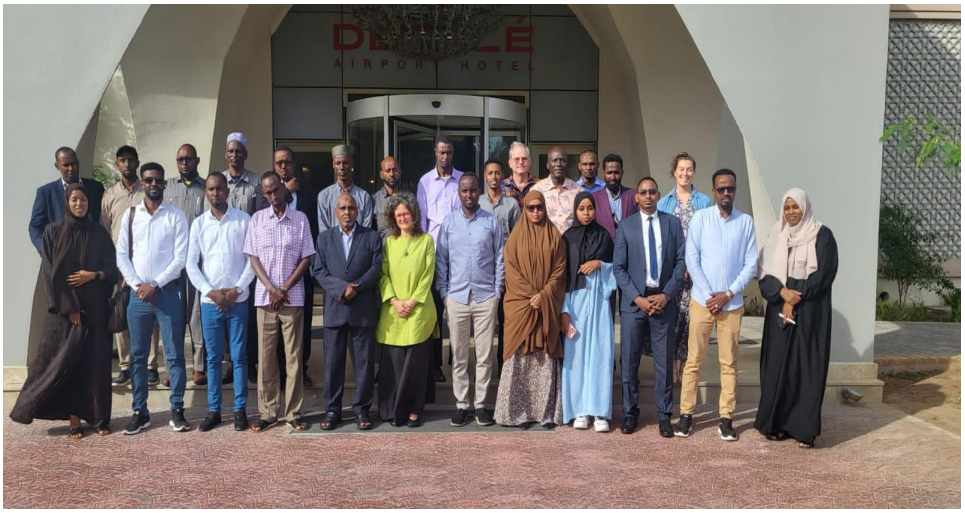
# Opportunities for One Health Integration of Community Animal and Community Health Workers

## Somalia Community One Health Workshop Report

April 26-28, 2023



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# Table of Contents

# Acknowledgement

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Which can be downloaded from https://www.penaph.net/resources/

# Workshop Objectives

One Health (OH) is an active area of discussion and innovation at the international and national level and most strategic planning on the adoption of One Health has focused at these higher levels of government. At the same time, changes at the community level are taking place through local interventions and the involvement of the non-governmental actors. The objective of this workshop was to discuss the current national situation in the One Health Sectors (Health, Animal Health and the Environment) in Somalia at all levels, acknowledge challenges and changes, and develop a consensus road map on the way forward to the implementation of One Health that includes the community level. The goal was to maximize benefits for both normal and emergency contexts through the selection of strategies that are appropriate across the spectrum of development and emergency needs. Flexible models that could quickly be adapted to respond to a humanitarian crisis while reinforcing resilience and enhancing coping mechanisms over the longer term are needed.

The purpose of the scenario workshop included developing lessons learned on service delivery and One Health at the community level and discussion of the way forward to strengthen access to and integration of human health, animal health and environmental services. Selected representatives and stakeholders from different sectors (e.g., health, agriculture and livestock, environment) and with different roles (e.g., Community Animal Health Workers (CAHWs), Community Health Workers (CHWs), local implementing partners, District/Regional/State and Federal Governmental Officials, technical advisors) were invited. The intent was to keep the meeting small but have representatives of the full range of stakeholders. It is hoped that this will encourage open communication across sectors and levels.

The environment continues to play an increasing role as a driver of emergencies and health impacts. The role of environmental interventions in mitigation of emergencies is also evolving. Participants were interested to fully include the environmental dimension in the workshop discussions, including impacts on communities in the area as well as suggested steps forward.

Somalia is exposed to a chronic emergency situation in which the delivery of humanitarian interventions often overlaps with the provision of longer-term development assistance. Participants were asked to work through different response options considering this scenario and were facilitated to explore the impact of different policy options as well as various outcomes based on their suggested actions. The scenario workshops generated new insights among the participants including the study team and led to alignment by stakeholders on a set of action points outlining the way toward a strengthened One Health approach to community-level health interventions. Lessons and insights were captured as products for inclusion in the project's deliverables with the intent of broadening the impact of the workshop beyond the host location.

# Workshop Results

## Participant Workshop Goals

Participants were asked on the first day to describe the outputs they would like to see from this workshop. Participants noted the chronic nature of drought and insecurity in Somalia as the context for their discussion. Goals ranged in scope from a basic assessment of what One Health systems currently operate in Somalia and where those applications are lacking throughout the country, to the creation of a national platform for One Health situated within the Prime Minister's office.

Participants hoped to answer questions like, "What is the status of our One Health structure? How do these ministries work together? What is their channel of communication? All the way from the top ministries to the grassroots community level. What OH approaches have been tried in the context of Somalia?"

Largely, participants hoped to gain a better understanding of the meaning of One Health, the current level of adoption of One Health strategies within Somalia health systems, the appropriateness of OH in emergencies, and how One Health could more intentionally be integrated into the country's health and environment structures.

## Setting the Scene: Highlights from the Project Presentation

The Project presentation described the objectives, activities and outputs of the *Opportunities for One Health Integration of Community Animal and Community Health Workers* study. The opportunity was taken to interactively define One Health with the participants and achieve a common understanding of the nature of One Health approaches. The current issues and status of the adoption of One Health in countries in the region was described. Thereafter, the presentation highlighted key aspects of the context of service delivery in Somalia noting how events over the past several decades had shaped delivery of One Health services and the depth of need. The long standing political economic conditions, persistent drought and climate change challenges were noted. Aspects such as levels of dependency, needs and expectations as well as people's ingenuity and business acuity in the face of adversity were discussed.

## Participant's Overview of Current One Health Institutions in Somalia

One Health is a new concept in Somalia and national institutions have begun to consider adoption of OH approaches. A National One Health Technical Working Group (TWG) has recently been created as a collaboration between Ministries and staff have been delegated from the OH sectors. The National OH TWG is chaired from the Federal Ministry of Health and has not yet held its first meeting. A precursor One Health Technical Working Group has considered zoonotic disease and developed contingency plans. To date, One Health strategic planning and institutionalization has not been extended to States and local levels.

Descriptions of local service institutions reflect important areas of local variation. In the health sector, Community Health Workers (CHWs) are linked to the Primary Health Unit (PHU) at the village level. CHWs provide health education and vaccination and have the capacity to treat common diseases like malaria and cholera; they also refer patients to higher level facilities. The level of education of CHW is not standardized across the country, with some individuals trained to treat common diseases and others able only to provide education. Despite PHU are reportedly widely distributed in Somalia, they often provide minimal services and lack readiness. CHWs are location based and do not follow pastoral migrations. They are staff assigned to a specific location and are usually not able to move with people. In the grazing areas, the communities may be served by another PHU, but often they are in areas that are not serviced by any PHU and as a result do not have access to health services. CHW workers are treated more as members of staff or community employees recruited from the community and do not follow a community-based model.

In the livestock sector, Community Animal Health Workers (CAHWS) play a critical role and are often called to treat the sick animals. CAHWs tend to be livestock owners and, when pastoral groups move, they frequently move with them. Community animal health workers tend to earn their own incentives through their activities. They usually receive a first supply from the government or the organization involved in their training, and then gain their income by providing services and selling the drugs to the local pastoralist. Among CAHWs, entrepreneurial approaches are encouraged.

The participants clearly indicated there are gaps in human and, to a lesser extent, animal health due to conflict and difficulties of movements and access to health facilities. In grazing areas, local communities rarely have access to health services. The nature of production systems is changing. Agropastoralism is increasing and pastoralism is adopting motorized transport. Traditional pastoralism tended to involve mainly young men moving on foot. Nowadays, it is common to see whole families moving with livestock over longer distances searching for pasture using trucks. Thus, health and animal health issues and needs are evolving.

# Options and Opportunities for One Health Innovation

## Traditional Institutions

The participants explained the community institutions that make decisions at the community level. Importantly, there is a council of elders that has the role of deciding issues related to emergency services, development activities, and support conflict resolution in case of need. Somali social structure is largely clan based. In locations where more than one clan is present shared decision-making platforms are present. The ***guddigga tuulada*** is a traditional committee that handles both relief and development issues. Communities have groups with representation from all the clans present for youth, women, religious leaders and elders. The participation of the *guddigga tuulada* is essential for successful health, animal health and environmental interventions. These structures do not depend on external support but have an important role in decision-making and equitable participation of the community in development and relief actions.

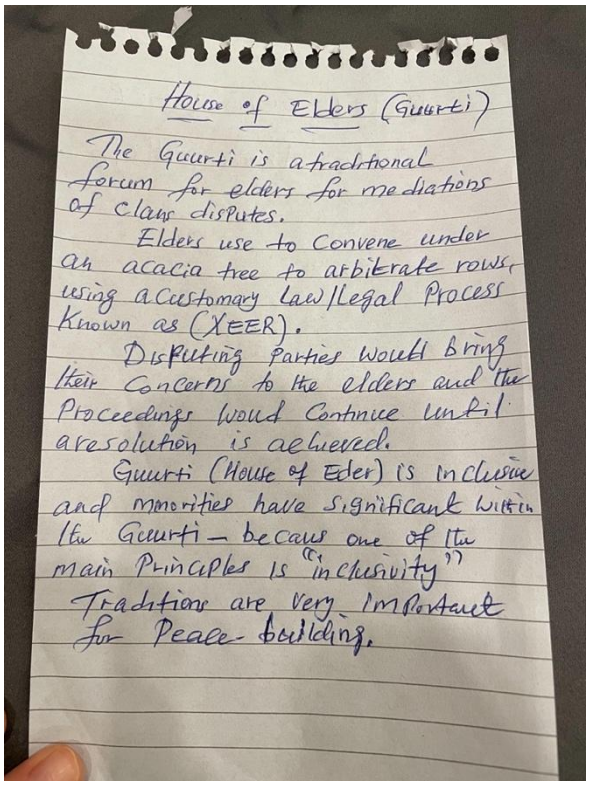

Figure 1: The House of Elders

The ***guurti*** is a council of elders for resolving disputes at the village level with representation from all clans. The note at left was a summary provided by the Director of the Environmental Management Department of the Federal Ministry for the Environment and Climate Change on the discussions in his group regarding community institutions. His input reflects recognition at the highest levels of government of the important role of traditional institutions in service delivery.

## Incentives

The participants felt that even in emergency contexts action should be taken to put service delivery on a more sustainable basis. The limited capacity of communities to pay for services in such situations was generally agreed. However, the participants shared the view that humanitarian One Health services could adopt more sustainable models that were compatible with development needs. There was consensus that incentives for community workers should be generated from their activities rather than as stipends. The trend was away from models of purely free delivery to approaches that facilitated communities purchasing power to cover the cost of incentives for service suppliers. Suggested mechanisms for generating activity-based incentives included donor or community paid options.

Ways identified were:

- Cost-sharing - community contributions
- User fees to cover service cost (cost of drugs and vaccine covered by public sector)
- Unconditional and conditional cash transfer (from donors)
- Kick start investments or kits
- Public-private partnerships
- Livestock associations (working with a health center, association, etc.)
- Private pharmacies. veterinary or human health clinics and services providers
    - Public sector supplies medicines and vaccines
    - Provision of services through pharmacies, veterinary or human health clinics and service providers based on vouchers
    - Vaccinators participating in a ministry program should receive reimbursement and payment per person or animal vaccinated
- Income generating activities linked to health service provision

One idea brought forward was including or ear-marking funds from unconditional cash transfers for OH services. Provision of vouchers and use of private suppliers was also advocated for to enhance service availability, both as mechanism for providing relief and for purchase of services.

## Approaches to Integration

In working groups, the meeting discussed the different options to OH integration at the community level. For the most part, groups preferred to keep both CHWs and CAHWs, but to see them integrated in a One Health network. They wished that their roles remained distinct and specialized to their species of interest. At the same time, most participants advocated for cross-training or joint training. Cross-training implied training both types of workers on each other responsibilities so that they could better support each other. Joint training referred to training the two types of workers together on how to address shared problems like control of zoonosis where each type of worker has his own role, but they work coordinated in the implementation of the human and animal interventions.

The concept of Community Environmental Workers was introduced and widely supported. This is a new category of community worker not yet available in Somalia. Participants felt the need to create such a new cadre to ensure the three key pillars of the One Health could be rightly addressed at the community level as well. The Community Environmental Worker will focus on environmental and agricultural activities and services.

# Recommendations on the Way Forward

## One Health Integration of Community Services in Somalia

### Objective:

Effective, sustainable, community owned OH integration of services accessible to all stakeholders to support development and emergency relief

### Integrated Community Service Team:

The consultation reached a consensus that community level services should be integrated in a common network with three different types of workers:

- Community Health Workers (CHW) (including all CHWs, providing general and maternal health services)
- Community Animal Health Workers (CAHWs)
- Community Environment Workers (CEWs)

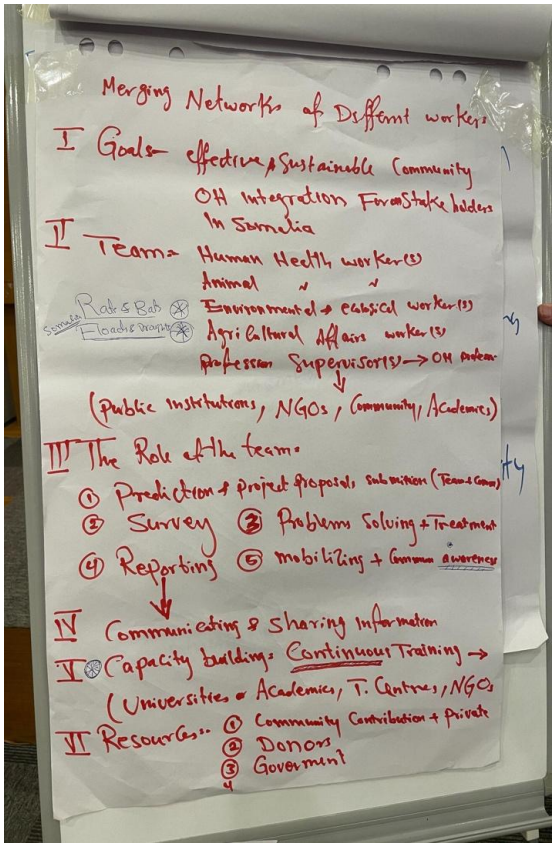

Figure 2: Group report: Merging Networks

The workers should participate in joint trainings and coordination meetings, but each category of worker will be the leader in their respective fields. Workers should collaborate and support each other across fields to deliver services.

A Community One Health Supervisor operating from a Primary One Health Unit will be technically responsible for all community workers in a common network. Traditional community institutions (*guddiga tuulada*) will select candidate workers and contribute to supervising workers in relation to the operational and social components of their work (e.g., level of activity, providing equal access, appropriate behavior, etc.).

The One Health Team will be integrated in the already existing system to ensure communication, information sharing (e.g., routine data reporting and disease surveillance) and referral with line ministries and respective departments is maintained.

## Roles:

- **CHW** (*daryelaha caafimadka dadka*) **and CAHW** (*daryelaha caafimadka xoolaha*) will provide basic services including curative treatment, information dissemination and mobilization, referral and support interventions such as vaccination programs. The roles of OH workers will be clearly defined in Terms of Reference.
- **CEW** (*daryelaha caafimadka deezanka*) will conduct information dissemination, monitoring and reporting on programs to protect natural resources and mitigate untoward effects of agricultural activities. They will promote good practice in agriculture and natural resource use and mobilize efforts to implement environmental protection activities. They will promote good practices in rangeland management including tree planting to reverse desertification. They will promote social change behavior among the community. The roles of OH workers will be clearly defined in Terms of Reference.
- **The Community** will contribute to support the community workers and benefit from their services. The community (elders and *guddigga tuulada*) will have a role in the management and oversight of community services and community workers. Although inputs delivered through community services may be subsidized as appropriate to conditions, the community will contribute the community workers incentives through appropriate public-private-community partnership strategies.
- **The Public sector** will coordinate policy, legislation and advocacy for integrated One Health service, will participate in the design process and contribute to the financial support of community services. The Public sector will support the mobilization of investment to establish programs, mobilize emergency funding to mitigate the impact of disasters and save lives and livelihoods when appropriate to conditions.
- **The NGOs** will be partners in implementation and provide technical assistance, capacity building and contribute the mobilization of investment to build resilience and establish emergency and development programs that compliment each other. They will support mobilization of emergency funding to mitigate the impact of disasters and save lives and livelihoods when appropriate to condition.

Figure 3: Community elder from Gedo region discussing the way forward

- **Donors** will be a key source of investment and provide guidance. Key resources are expected for both emergency/humanitarian and development aid designed to meet both short term and long term goals.

- **Knowledge institutions** (e.g., National Public Health institutes, Universities and Research institutions) will plan and carry out research to ensure the generation of evidence and inform policy and the design of actions.

## Resources:

The goal is to build a sustainable system for both development and emergency relief contexts. Three types of needs have been identified:

- Investment, to design and implement the system
- Operating costs, to run the system over time
- Emergency relief, to adapt the system in case of sudden humanitarian crisis

Recognizing recurrent security and climatic crises in the region, the consultation would like to create conditions that maximize participation and that will facilitate transitions between emergency and development contexts. To this end, the meeting felt that public, private and community partnerships with innovative models of financing need to be incorporated in all plans.

The public sector, donors and NGO community is viewed as the primary source of investment and emergency relief. Opportunities for private investment should also be investigated and developed.

To an extent appropriate to conditions, recurrent costs should be jointly covered with the beneficiary community. The OH sector should move away from purely free services and seek methods that build sustainable, market-based service infrastructure. Models that include the involvement of private practitioners and private supply networks and approaches such as provision of vouchers to obtain services and inputs should be explored. *Given the intensity of need, it is often not possible that the service user is the ultimate source of payment. However, the sector needs to move away from a charity-based model to market systems that are adapted to recurrent humanitarian crises.*

## One Health Coordination:

Adoption of OH policies, structures and methods should continue at all levels. Initiatives from both the national and grass roots levels are appropriate to enhance implementation in a timely manner.

- OH National Technical Working Group will provide the political framework for integration
- State, Regional and District OH Platforms will guide implementation of integrated models
- Primary OH Units will support and oversee community OH services

State, Regional and District OH Platforms have not been established yet. A process for stakeholders' consultation will be necessary to ensure the institutionalization of One Health at all levels of intervention. This will help the definition of goals and vision and the development of action plans of the multisectoral collaboration platforms.

## Capacity Building:

The implementation of the One Health Integrated Community Service will require an intense capacity building program for different cadres, including community workers, supervisors and institutional partners at all levels.

- Defined curriculum for each category of community OH workers
- Defined curriculum for capacity building on integration of OH workers, Primary OH Units and Community One Health Supervisors
- Joint Training and Cross Training leading to mutual understanding of roles and support for implementation of activities
- Capacity building and mentoring for supervisory staff to establish and maintain Primary OH Units
- Capacity building to develop community management and cost sharing mechanisms for OH services
- Follow-up mentoring and assessment of capacity building program effectiveness

## Next Steps:

The consultation identified the following steps to initiate the creation of the One Health Integrated Community Service in Somalia.

- Engage the OH National TWG and present them the plan proposed by stakeholders for the One Health Integrated Community Service. Since the TWG has just been established, it could be possible to influence their agenda and include the proposed integration of community services in national One Health plans
- Engage Federal, State, and District Ministries and departments and present them the plan for the One Health Integrated Community Service, advocating for its actualization at the community level
- Characterize the problem and collect data to inform the design of the program at the community level and develop a detailed action plan for its implementation
- Develop a model of the community level One Health Team and pilot it in local actions to generate evidence and support the development of national policies
- Mobilize resources to test the model in pilot actions
- Create a follow-up group to continue the exchange on the One Health Integrated Community Service and pursue how actions are developing and evolving at the community level
- Support a continuous learning process, integrating in the proposed plan for One Health Integrated Community Services the lessons learnt from partners (e.g., VSF-Suisse and the HEAL project

# Annexes

## Annex 1: Workshop Approach

The scenario workshop brought together representative professional and community OH stakeholders from the national, state and local levels. The Health, Animal Health and Environmental sectors were included. The workshop was participatory in nature and utilized largely on facilitated group discussions and brainstorming sessions to map the way forward. The bulk of the workshop involved participants dividing into breakout groups to decide as a team how to respond to One Health scenarios in both normal and emergency contexts.

The Scenario Workshop Implementation Guide was provided to participants either before or at the start of the workshop to help orient expectations and the discussion.

### Opening Plenary

Each Scenario workshop was opened by Ministry Officials and the local non-governmental agency host. Thereafter, the participants introduced themselves and a discussion of the participants expectations for the meeting was held. This led to a joint statement of the workshop objectives defined by the organizers and participants.

The project team gave one interactive presentation at the workshop's opening to introduce the project, the nature of One Health and the status of One Health globally, and to set the scene for discussions.

The presentation explored the difference between the concepts of community interventions and community-based interventions in interactive discussion and suggested that both approaches can be appropriate depending on the context. A program that recruits community members as employees, pays salaries and defines tasks is an example of a community activity. To be community-based the program would need to empower the community as a partner in the design, management, and support of the program. Most interventions combine aspects of the two approaches and fall somewhere on a spectrum of options.

The distinctions between collaboration and integration and collaboration approaches to One Health was discussed. It was noted that most OH programs were initiated as collaborations where representatives of separate Ministries came together on a part time basis in OH platforms to discuss joint programs. The platforms were not empowered to make decisions or given their own budget. Increasingly, countries are moving beyond this model to create OH platforms with dedicated staff, decision-making roles, and budget allocations.
Many participants were previously familiar with One Health as a concept, though this was the first exposure for others.

## Plenary and Group Discussions

Thereafter, the participants described and analyzed the existing human, animal and environmental systems and services present in the country both in normal times and in an emergency context. This included the types, selection, training, roles, supervision and incentive systems of community workers in both normal and emergency contexts.

Thematic discussions were conducted on a range of topics relevant to the sustainability accessibility and integration of services under the OH umbrella. These topics included:

- Collaboration between One Health stakeholders vs. integration of One Health services
- Approaches to integration of community services with the following examples given:
    - Networking existing workers in a shared system
    - Cross-training existing workers to provide support/provide services across specializations
    - Moving to OH workers with integrated roles.
- The role and range of services offered by community workers
- Examples of public-private-community partnerships and future trends
- Incentives for workers ranging from stipends, retention of partial payments for services to voucher systems
- Transhumant communities and access to services

The plenary developed an overview of public-private community partnerships and their application to community health model. Importantly, a distinction was drawn between the question of who pays for services and the mechanisms established for delivery of services. Examples were discussed were private service providers participated in the management of vaccination or the logistics of pharmaceutical supplies, but the public sector supported all costs.

Sessions examined approaches to integration and whether a shared network, shared responsibilities or cross-trained staff makes would lead to a wider One Health impact in Somalia.

Once the thematic discussions were completed, the meeting shifted to the scenario sessions where the considerations raised in the thematic discussions were synthesized into an overview of the way forward for OH services at the community level. Because of the long standing political economic situation in Somalia, the group mainly focused on a scenario of chronic emergency where and looked at how the OH system could be mobilized to address humanitarian emergencies, while promoting long term achievements.

The approach was taken that development to emergency settings were a continuum which required flexible systems that needed to be capable of adapting to immediate conditions while supporting long term development. In all countries where the scenarios workshops were held, emergencies related to climate, security and economic conditions were a significant, if not the

predominant, reality. All workshops stressed the importance of moving forward with development while meeting emergency needs.

Closing remarks were offered by representatives of the various ministries, NGOs and communities, as well as by workshop organizers.

The detailed agenda is included in Annex 2.

# Annex 2: Detailed Agenda

<table>
<tr><th></th><th>April 26</th><th>April 27</th><th>April 28</th></tr>
<tr><td>8:30 AM</td><td>Formal Opening</td><td rowspan="2">Discussion of Approaches to Integration</td><td rowspan="6">Discussion of the synthesis on the way forward and action points<br>Followed by closing</td></tr>
<tr><td>9:30 AM</td><td>Introductions</td></tr>
<tr><td>10:00 AM</td><td>Workshop Objectives</td><td rowspan="4">Traditional social institutions<br><br>Appropriate activities for integration of Community Health and Community Animal Health Workers<br><br>The impact of incentive systems on service availability and implementation</td></tr>
<tr><td>10:30 AM</td><td>Community One Health Integration Presentation</td></tr>
<tr><td>11:00 AM</td><td>Stakeholder Objectives</td></tr>
<tr><td>11:30 AM</td><td>Community Workers vs Community-based Workers</td></tr>
<tr><td>12:00 PM</td><td rowspan="2">Lunch</td><td rowspan="2">Lunch</td><td rowspan="2">Closing prior to Friday Prayers and Lunch</td></tr>
<tr><td>12:30 PM</td></tr>
<tr><td>1:00 PM</td><td rowspan="4">Overview of Current National Community-level Health Systems</td><td rowspan="4">Working groups Scenario under emergency conditions</td><td rowspan="6"></td></tr>
<tr><td>1:30 PM</td></tr>
<tr><td>2:00 PM</td></tr>
<tr><td>2:30 PM</td></tr>
<tr><td>3:00 PM</td><td rowspan="3">Strengths and challenges of current community human, animal health programs and environmental interventions</td><td rowspan="3">Synthesis discussion of Scenario</td></tr>
<tr><td>3:30 PM</td></tr>
<tr><td>4:00 PM</td></tr>
<tr><td>4:30 PM</td><td>Closing</td><td>Closing</td></tr>
</table>

# Annex 3: Participants

## Overview of Participants

A wide range of stakeholders were represented in the workshop. These include the following. The detailed list of participants, with designation and institution, is reported in the table below:

- Community leaders/elders
- Community Animal Health Workers
- Community Health Workers
- Community Multisectoral Stakeholders Committees
- National Ministry of Health representatives
- State Ministry of Public Health representatives
- National Ministry of Livestock representatives Regional Ministry of Livestock representatives
- Representatives of the National OH Technical Working Group
- Ministry of Environment and Climate Change representative
- Veterinarians
- District Health and Animal Health representatives
- FAO Somalia
- CEDA – National Organization working with VSF (Health Project Coord)
- Representatives of Agricultural Universities
- VSF Suisse

| S/N | Name | Gender | Designation | Institution | Email |
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