REPUBLIC OF KENYA

MINISTRY OF HEALTH

Transforming Health Systems for Universal Care Project

Vulnerable and Marginalized Groups Planning Framework (VMGPF)

March, 2016

Prepared by Ministry of Health[1] with Technical assistance from

Julius Muchemi
Safeguards and Social Development
ERMIS Africa
Tel: +254 720 703606
Email: julius@ermisafrica.org

This VMGPF for the project has been prepared based on the OP 4.10 of the World Bank and the applicable laws and regulations of the Government of Kenya. The OP 4.10 is triggered when it is likely that groups that meet criteria of OP 4.10 "are present in, or have collective attachment to, the project area". It is to guide the preparation of subprojects that may affect Vulnerable and Marginalised Groups (VMGs) in the proposed project areas.

OP 4.10 'contributes to the Bank's mission of poverty reduction and sustainable development by ensuring that the development process fully respects the dignity, human rights, economies, and cultures of Indigenous Peoples. For all projects that are proposed for Bank financing and affect Vulnerable and Marginalised Groups (VMGs), the Bank requires the borrower to engage in a process of free, prior, and informed consultation leading to broad community support. The Bank provides project financing only where free, prior, and informed consultation results in broad community support to the project by the affected vulnerable and marginalised groups'. Such Bank-financed projects include measures to;

1. Avoid potentially adverse effects on the Indigenous Peoples' communities; or
2. When avoidance is not feasible, minimize, mitigate, or compensate for such effects;
3. Ensure that the vulnerable and marginalised people receive social and economic benefits that are culturally appropriate and gender as well as inter-generationally inclusive; and that the VMGF is based on free, prior and informed consultations with indigenous peoples leading to broad community support.

The objectives of the policy are to avoid adverse impacts on vulnerable and marginalised groups, secure broad community support for the project and to provide Vulnerable and Marginalized Groups (VMGs) with culturally appropriate benefits.

The Ministry wishes to thank the many health actors from the National, County Governments, VMGs, IPOs and NGOs who participated in the consultations and disclosure workshops.

[1] Mr Joachim Mwanza, Dr Omar O.A,, Dr. Valeria Makory, Ms Catherine Ndiso

LIST OF ABBREVIATIONS

ANC	Antenatal Care
AWPs	Annual Work Plans
BP	Bank Policy
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CoK	Constitution of Kenya
CPS	Country Partnership Strategy
CSO	Civil society organizations
CRA	Commission on Revenue Allocation
CRD	Civil Registration Department
CRVS	Civil Registration and Vital Statistics
DoHCF	Division of Health Care Financing
DPs	Development Partners
EAs	Environmental Assessments
EIA	Environmental Impact Assessment
EMP	Environmental Management Plan
ESIA	Environmental and Social Impact Assessment
ESMP	Environmental and Social Management Plan
FPICon	Free, Prior and Informed Consultation
FS	Feasibility Study
GDP	Gross Domestic Product
GOK	Government of Kenya
GRM	Grievance Redress Mechanism
HCWMP	Health Care Waste Management Plan
HIS	Health Information System
HFS	Health Financing System
IDA	International Development Association
IP	Indigenous Peoples
IPOs	Indigenous Peoples Organizations
KMTC	Kenya Medical Training College
KNCHR	Kenya National Commission on Human Rights
KQMH	Kenya Quality Model for Health
Kshs.	Kenyan Shilling
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MEWNR	Ministry of Environment, Water and Natural Resources
MSME	Micro, Small and Medium-scale Enterprises
MoA	Ministry of Agriculture
MoDP	Ministry of Devolution and Planning
MoEST	Ministry of Education, Science and Technology
MoPHS	Ministry of Public Health and Sanitation
MoU	Memorandum of Understanding
NCBF	National Capacity Building Framework
NEMA	National Environment Management Authority
NGO	Non-Governmental Organisation
OP	Operational Policy
PAD	Project Appraisal Document

PAP	Project Affected Persons
PHC	Public Health Care
PIU	Project Implementation Unit
PDO	Project Development Objective
PIC	Public Information Center
PICD	Participatory Integrated Community Development
PIM	Participatory Impact Monitoring
PIM	Project Implementation Manual
PMU	Project Management Unit
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
RMNCAH	Reproductive, Maternal,,Newborn, Child, Adolescent Health
SA	Social Assessment
SIA	Social Impact Assessment
SLM	Sustainable Land Management
Sub TWG	Sub Technical Working Group
TA	Technical Assistant
THS-UC	Transforming Health Systems for Universal Care
UHC	Universal Health Care
UN	United Nations
UNDRP	Declaration on the Rights of Indigenous Peoples
US$	United States Dollars
VMG	Vulnerable and Marginalized Groups
VMGF	Vulnerable and Marginalized Groups Framework
VMGP	Vulnerable and Marginalized Groups Plan
WB	World Bank

Table of Contents

EXECUTIVE SUMMARY

Project Development Objective

1. The Government of Kenya has requested the World Bank to help fund the Transforming Health Systems for Universal Care (THS_UC) project. The project development objective (PDO) is "*to improve utilization and quality of primary health care (PHC) services with a focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services."* The Project will achieve this objective by: (i) improving access to and demand for quality PHC services; and (ii) strengthening institutional capacity in selected key areas to accelerate progress towards universal health care (UHC) in the recently devolved Kenya health system.

Project Beneficiaries

2. While the Project is expected to benefit the whole population, its key beneficiaries are women of reproductive age including adolescents and children under five who utilize PHC services most. As development partners (DPs) are already providing different support especially to the underserved counties, the Project will provide flexible funding to all 47 counties to address critical gaps in improving utilization of quality PHC services. The Project enhances focus on results by allocating resources to each county based on the improved coverage of essential services that are directly linked to health, population, and development outcomes (see selected indicators below).The special attention will be paid to the underserved in each county.

PDO Level Results Indicators

3. The key result (outcome) indicators are:

(a) Children younger than one year who were fully immunized (percentage)
(b) Pregnant women attending at least four antenatal care (ANC) visits (percentage)
(c) Births attended by skilled health personnel (percentage)
(d) Women aged 15-49 years currently using a modern family planning method (percentage)
(e) Inspected facilities meeting safety standards[2] (percentage)

Project Components

4. The pathway to improve utilization of quality PHC services. Expected outcomes, which will be measured by the indicators above, include improved access to and quality of PHC services among the underserved and improved health seeking behaviors, eventually leading to improved utilization of quality PHC services. Implementing a set of evidence-based - high impact, cost effective – interventions is expected to contribute to UHC with improved equity and enhanced efficiency.

Component 1: Improving PHC Results

5. **Component 1 aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH**. It will support counties to scale up evidence-based, county appropriate supply- and demand- side key priority interventions along the continuum of care. This component will focus on: (i) making existing facilities functional

[2] At least 61% or above

to deliver quality essential PHC services; and (ii) enhancing demand generation at the community and facility levels. The former includes expanding the availability of quality basic emergency obstetric and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care (CEmONC), and ensuring an effective referral system. The latter includes strengthening community units to (i) deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition as well as (ii) engage beneficiaries in delivery of PHC services.

Component 2: Strengthening Institutional Capacity

6. **Component 2 aims to strengthen institutional capacity to better deliver quality PHC services under Component 1.** This component will focus on three key areas:

2.1. Improving Quality of Care: The Project will support (i) the Department of Health Standards, Quality Assurance and Regulations as well as the health regulatory boards to: (a) strengthen inspection for licensure of private health facilities and gazettement for public health facilities; and (b) institutionalize quality assurance towards certification; (ii) the Division of Family Health to (a) develop and/or disseminate RMNCAH related strategies and guidelines including adolescent sexual and reproductive health and nutrition, and (b) conduct operations research; and (ii) the Kenya Medical Training College (KMTC) to strengthen midwifery training

2.2. Strengthening Monitoring and Evaluation (M&E) and Civil Registration and Vital Statistics (CRVS): The Project will support the Division of Health Information, Monitoring & Evaluation and Research to: (i) operationalize the M&E framework; (ii) strengthen the health information system (HIS) and medical records management; and (iii) working closely with Civil Registration Department (CRD), pilot innovative approaches to improving coverage of vital events registration within the health sector (e.g., pay for registration, mobile CRVS office, birth registration with immunization, etc.)

2.3. Supporting Health Financing Reforms towards UHC: The Project will support the Division of Health Care Financing (DoHCF) to: (i) disseminate the HFS to get buy-in drawing from the recently completed stakeholder analysis; (ii) conduct analytical work to inform the implementation of health system financing (HSF) and health-financing reforms towards UHC; and (iii) build capacity for UHC leadership at the national and county level.

Component 3: Project Management

7. **Component 3 aims to facilitate and coordinate project implementation and enhance cross-county and intergovernmental collaboration.** This will include two areas:

3.1. Project Management (including M&E and fiduciary activities): The Project will finance project management staff at national and county levels of government, office equipment, operating costs, and logistical services for day-to-day project management. This also includes: (i) M&E activities such as annual cross-county verification through peer reviews, periodic surveys and process evaluation to monitor implementation progress and address any implementation challenges; (ii) fiduciary activities such as independent integrated fiduciary review agent; (iii) safeguards activities such as social assessment and preparation or revision of safeguards-related plans; and (iv) TA and

capacity building activities to support the Project sub-technical working group (TWG) under the Intergovernmental Forum for Health in carrying out their responsibilities, inter alia, reviewing county performance, and the quality of annual work plans (AWPs), and selecting proposals to promote cross-county and inter-governmental collaboration.

3.2. Cross-county and Inter-governmental Collaboration: The Project will finance activities that promote cross-county initiatives and inter-governmental collaboration to address common demand and supply-side barriers. Examples include cross-county study tours to share knowledge, capacity building in areas that affect several counties such as drafting county health bills, and improving supply chain management of strategic commodities. A call-for-proposal approach will be used. Every year, the PMT will issue a call for proposals in collaboration with the national and county governments and facilitate TA for proposal reviews. The Project sub-TWG will approve proposals, which will be concurred by the Bank. The winner(s) will be required to implement the proposals and report the findings and lessons learned through the Inter-governmental Forum for Health.

Vulnerable and Marginalized Groups Framework

8. The World Bank policy OP. 4.10 [3]is being triggered for THS-UC project for the 47 counties within the country. Some of the counties, such as Trans-nzoia, Bungoma, Keiyo-Marakwet, Uasin Gishu, West Pokot, Turkana, Baringo, Nakuru, Narok, Laikipia, Samburu, Marsabit, Wajir, Garissa, Tana river, Lamu, Kilifi and Kwale, among others have known populations of groups that have meet the criteria of OP 4. 10. Since the location of the micro-projects is as yet unknown, a Vulnerable and Marginalized Framework (VMGF) is being prepared to guide the preparation of plans to mitigate any negative effects and to enhance benefits of the THS-UC micro-projects. The VMGF, which will be disclosed before project appraisal outlines the processes and principles of: (a) screening to determine if a proposed sub-project investment will be undertaken in the vicinity of vulnerable and marginalized communities; and (b) the preparation of a vulnerable and marginalized groups plan (VMGP), including the social assessment process, consultation and stakeholder engagement, disclosure procedures, communication and grievances redress mechanism. A detailed VMGP will be prepared for each micro-project once the location is identified and screening conducted has determined that VMGs are present in the area.

9. This Vulnerable and Marginalized Groups Framework (VMGF) sets out:

- *The types of sub-projects likely to be proposed for financing under the project.*
- *The potential positive and adverse effects of such sub-projects investments on VMGs.*
- *A plan for carrying out the social assessment for such sub-projects.*
- *A framework for ensuring free, prior, and informed consultation with the affected VMGs at each stage of project preparation and implementation.*

[3] World Bank, Operational Policy (OP) 4.10 Indigenous Peoples, July 2005. The OP 4.10 contemplates that different terminologies may be applied in different countries without affecting the application or substance of the policy. It states: "*Indigenous Peoples* may be referred to in different countries by such terms such as *indigenous ethnic minorities*; *aboriginals*, *hill tribes*, *minority nationalities*, *scheduled tribes*, or *tribal groups*. The use of such terminologies in no way dilutes the requirements for application of the policy. The 2010 Constitution of Kenya (COK) uses the term "vulnerable groups" and "marginalized communities." The term safeguards instruments "VMGF" and "VMGP" are in substance and process equivalent to IPPS and IPPFs and in line with the constitutionally-sanctioned terminology in the COK 2010.

- *Institutional arrangements (including capacity building where necessary) for screening project-supported activities, evaluating their effects on VMGs, preparing VMGPs, and addressing any grievances.*
- *Monitoring and reporting arrangements, including mechanisms and benchmarks appropriate to the project.*
- *Disclosure arrangements for VMGPs to be prepared under the VMGF.*

10. This VMGF establishes an appropriate gender and inter-generationally inclusive framework that provides opportunities for consultation at each stage of project preparation and implementation and other local civil society organizations (CSOs) identified by the affected Vulnerable and Marginalized Groups. **Free and prior informed consultation of the vulnerable and marginalized communities leading to broad community support will be conducted at each stage of the project, and particularly during project preparation, to fully document their views and ascertain broad community support for the project.**

Table 1: VMGs Present in THS-UC Project Operational Area that could meet the criteria of OP 4.10.

Name	Other Names (derogatory)	Estimated Population[4]	Livelihood[5]	Counties[6]
1. **Dorobo**	Dorobo	10,000	HG /Farmers	Kiambu (Lari – Kambaa area) Wamba
2. **Sengwer**	Charangany	50,000	HG/Farmers	Trans-Nzoia;
3. **Ogiek**	Dorobo	40,000	HG/Farmers	Nakuru, Baringo, Narok, Koibatek, Nandi, Naivasha, Bungoma
4. **Waatha**	Wasanye	13,000	HG/Farmers	Kwale; Kilifi
5. **Wasanye**	Sanye		Farmers/Fishing	Kwale; Kilifi
6. **Wakifundi**	Washuyu	3,500	Fishing, Mangrove traders	Kwale
7. **Watswaka**			Fishing, Mangrove traders	Kwale
8. **El Molo**		2,900	Fishing	Samburu
9. **Ilchamus**		33,000	Fishing/Farmers/ Livestock Keeper	Baringo
10. **Endorois**	Dorobo	60,000	Fishing/Farmers/ Livestock Keeper	Baringo
11. **Rendille**		62,000	Pastoralists	Marsabit
12. **Gabra**			Pastoralists	Marsabit
13. **Samburu**			Pastoralists	Samburu
14. **Ilkonono**			Blacksmith	Samburu
15. **Maasai**		666,000	Pastoralists	Narok (wmbaa)
16. **Aweer**	Boni		Hunter-gatherers /fishing	Lamu
17. **Dassanach**	Shangila		Pastoralist	Marsabit

[4] Internet based – several sites
[5] Source: ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012
[6] Ibid.

18. **Emolo**			Fishing and peasant pastoralist	Marsabit
19. **Borana**				
20. **Turkana**				
21. **Somalia**				

Source: ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012

Table 2: Other potential groups that the project should validate their characteristics include

Potential VMGs	Locality to conduct the screening
1. Malakote /	Mombasa
2. Munyoyae /	Mombasa
3. Wanyasa / Malawi	Mombasa
4. Makonde	Mombasa
5. Wafrere – people from frere town in Mombasa	Mombasa
6. Nubian	all counties
7. Riba (people eating dead camel)	Mandera
8. Rirbahar (people of the ocean)	Mombasa
9. Corner tribe	Mandera
10. Deis	Marsabit (shores of lake Turkana in Ilelet)
11. Orma	Tana river
12. Pokomo	Tana river
13. Werdei (Tana river)	Tana river
14. Gal jiil (Gar – foreigner/pagan/camel, Jiil –love) isolated village	Mandera, Wajir, Garissa,

Source: MoH consultations and ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012

Vulnerable & Marginalized Groups Requirements

11. The World Bank's Operational and Procedural Policies, specifically OP 4.10 apply to the project. To comply with OP 4.10 the Government of Kenya has prepared this VMGF which establishes a mechanism to determine and assess future potential social impacts of THS-UC planned sub-projects on vulnerable and marginalized groups, and to ensure that these groups will benefit from the project in a culturally appropriate manner. Other requirements of the policy are:

12. **Free and Prior Informed Consultation.** Projects affecting the vulnerable and marginalized groups, whether adversely or positively, therefore, need to be prepared with care and with the participation of targeted communities. The requirements include social analysis to improve the understanding of the local context and affected communities; a process of free, prior, and informed consultation with the affected vulnerable and marginalized communities to expressed their views on preferred project design considerations that would lead to broad community support to the project; and development of project-specific measures to avoid adverse impacts and enhance culturally appropriate benefits.

Consultation and Stakeholder Engagement

13. This framework seeks to ensure that VMGs are informed of the impacts, consulted, and mobilized to participate in the relevant subprojects. The MOH PMU to be established by MOH for the oversight and implementation of the project will engage in a wide array of stakeholders

at community and county levels, including Non-Governmental Organizations (NGOs) and Cultural Institutions active in the project area to undertake consultations from the very beginning and will continue till end of the project. The project team will undertake prior consultations with any likely impacted VMGs and those who work with and/or are knowledgeable in VMGs development issues and concerns. To facilitate effective participation, the VMGF will: (a) follow a timetable to consult VMGs at different stages of the project program cycle, especially during preparation of any civil works program;(b) also, the MOH PMU will undertake a social impact analysis (SIA) to gather relevant information on (i) demographic data; (ii) social, cultural and economic situation; and (iii) social, cultural and health impacts, both positive and negative, on the vulnerable and marginalized groups in the relevant project area; and

14. A grievance redress mechanism will be developed for addressing the grievances from the affected VMGs related to subproject implementation. The procedure for grievance redress will be incorporated in the project information pamphlet to be distributed prior to implementation. Participatory consultation with affected households will be undertaken during project planning and implementation stages.

15. The MOH will establish a mechanism to receive and facilitate resolution of affected VMGs concerns, complaints, and grievances about the project's safeguards performance at each subproject having VMGs impacts, with assistance from Non-Governmental Organisations (NGO). Under the Grievance Redress Mechanism (GRM), a Grievance Redress Committee (GRC) will be formed for each project with involvement of VMGs representative & local stakeholders. The GRCs are to be formed and activated during the VMGPs implementation process. Assistance to VMGs will be given to deposit, document and record the complaints in an appropriate language and fora. The grievance redress mechanism is designed with the objective of solving disputes at the earliest possible time and at the lowest levels where the VMGs reside for quick resolution.

16. The traditional dispute resolution structures existing for each of the VMGs will be used as the first step in resolving grievances. The GRM may draw on and be part of that proposed VMGF for the THS-UC project. The grievance mechanisms will include: (a) County Grievance Redress Committees (CGRC), including representatives from the MOH; county administration representative, sub-country leadership, and two VMGF VMGs; and (b) sub-county Grievance Redress Committees (SCGRC) based in each administrative location where projects are located and shall be the voice of the VMGs to include administration, CHC including men, women, and youth. The participation of local leaders and VMGs in disseminating information and resolving disputes will be important once VMGP implementation starts. VMG representatives will participate in the project workshops at mid-term and at the end of VMGP implementation. To the extent possible, the VMGP should include social accountability tools to assess the quality of VMGP implementation, and in some cases, assist the VMGP team in tracking expenditures.

17. All the grievances will be channeled to the existing structures of the project and then to those at a national level, with last recourse being the Kenyan Courts of Law.The VMGF will make the public aware of the GRM through public awareness campaigns.

18. Marginalized and minority communities will be provided with a variety of options for communicating issues and concerns, including in writing, orally, by telephone, over the internet or through more informal methods as part of the grievance redress mechanism. In the case of marginalized groups (such as women and youth), a more proactive approach may be needed to

ensure that their concerns have been identified and articulated. This will be done, for example, by providing for an independent person to meet periodically with such groups and to act as an intermediary. Where a third party mechanism is part of the procedural approach to handling complaints, one option will be to include women or youth as representatives on the body that deals with grievances. It should be made clear that access to the mechanism is without prejudice to the complainant's right to legal recourse. Prior to the approval of individual VMGPs, the affected VMGs will have been informed of the process for expressing dissatisfaction and seeking redress. The grievance procedure will be simple and administered as far as possible at the local levels to facilitate access, flexibility and ensure transparency.

Disclosure

19. This VMGF and project VMGPs will be made available to the affected VMGs in an appropriate form, manner, and language. The World Bank will make them available to the public in accordance with World Bank Policy on Disclosure of Information, and the GOK will also make the documents available to the affected communities in the same manner as the earlier draft documents.

20. Each subproject VMGP will be disclosed to the affected VMGs with detailed information of the subproject. This will be done through public consultation and made available as brochures, leaflets, or booklets, using local languages. Summary of the VMGP will be made available in hard copies and in relevant languages as appropriate at: (i) Offices of the MOH; (ii) Sub County or County Office; and (iv) any other local level public offices. Electronic versions of the framework as well as the VMGPs will be placed on the official website of MOH and the official website of the World Bank after approval and endorsement of the VMGF and each VMGP by the World Bank.

21. The disclosure of this Vulnerable and Marginalized Framework (VMGF) and health care waste management plan was held at the (Nairobi, at Silver Springs Hotel) on March 21st, 2016. It was attended by about 60 participants from 9 counties (Baringo, Kwale, Bungoma, Narok, Nakuru, Kiambu, Samburu, Nairobi, and Kilifi). These included representatives from National Government (20), County Government Reps; several project implementing agencies (MOH, KMTC); Representatives of VMGs/IPOs (Ogiek, Dorobo, Ilchamus, Endorois, Maasai, Samburu, Turkana, Ilkonono, Waatha, Wakifundi and Watswaka) and NGOs (ERMIS Africa) (Annex 12)

22. Through the national Public Consultative workshop, the VMG provided an overall support for the project with highlights on areas of enhancement of the framework and project. The initial field consultations were applauded as well as the efforts done in holding a national disclosure workshop. The VMGs requested for the following adjustments: (i) Consideration of traditional knowledge through training of traditional birth attendants; (ii) increased and official assurance on the safety of vaccines; (iii) adequate staffing of health facilities in the VMG areas; (iv) provision of health services in areas faced with inter-community conflicts; (vii) access of services to pastoralist even as they migrate from place to places; (viii) continued and structured provision of scholarship opportunities to VMGS in medical colleges; (ix) representation of VMGs in health in local and county health governance structure; (x) sharing of final VMGF with VMGs through appropriate forum; (xi) consideration for new health infrastructures in VMGs localities currently with no infrastructure; (xii) safeguard the project from political capture; and (xiii) referral of need for communication infrastructure development to other relevant ministries (Annex 11). The framework will be disclosed on the MoH Website and a summary will also be put in at least two leading Newspapers. Finally, the Framework will be uploaded in the World Bank Infoshop.

1.0 BACKGROUND

Project Development Objective

1. The project development objective (PDO) is "*to improve utilization and quality of primary health care (PHC) services with a focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH) services."* The Project will achieve this objective by: (i) improving access to and demand for quality PHC services; and (ii) strengthening institutional capacity in selected key areas to accelerate progress towards UHC in the recently devolved Kenya health system.

Project Beneficiaries

2. While the Project is expected to benefit the whole population, its **key beneficiaries are women of reproductive age including adolescents and children under five who utilize PHC services most**. As DPs are already providing different support especially to the underserved counties, the Project will provide flexible funding to all 47 counties to address critical gaps in improving utilization of quality PHC services. The Project enhances focus on results by allocating resources to each county based on the improved coverage of essential services that are directly linked to health, population, and development outcomes (see selected indicators below).The special attention will be paid to the underserved in each county.

PDO Level Results Indicators

3. The key result (outcome) indicators are:
   (a) Children younger than one year who were fully immunized (percentage)
   (b) Pregnant women attending at least four antenatal care (ANC)visits (percentage)
   (c) Births attended by skilled health personnel (percentage)
   (d) Women aged 15-49 years currently using a modern family planning method (percentage)
   (e) Inspected facilities meeting safety standards[7] (percentage)

Project Components

4. Expected outcomes, which will be measured by the indicators above, include improved access to and quality of PHC services among the underserved and improved health seeking behaviors, eventually leading to improved utilization of quality PHC services. Implementing a set of evidence-based - high impact, cost effective – interventions is expected to contribute to UHC with improved equity and enhanced efficiency.

Component 1: Improving PHC Results

5. **Component 1 aims to improve the delivery, utilization, and quality of PHC services at the county level with a focus on RMNCAH**. It will support counties to scale up evidence-based, county appropriate supply- and demand- side key priority interventions along the continuum of care. This component will focus on: (i) making existing facilities functional to deliver quality essential PHC services; and (ii) enhancing demand generation at the community and facility levels. The former includes expanding the availability of quality basic emergency

[7] At least 61% or above

obstetric and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care (CEmONC), and ensuring an effective referral system. The latter includes strengthening community units[8] to (i) deliver preventive and promotive health care including access to safe water and sanitation, improved hygiene practices and nutrition as well as (ii) engage beneficiaries in delivery of PHC services.

Component 2: Strengthening Institutional Capacity

6. **Component 2aims to strengthen institutional capacity[9] to better deliver quality PHC services under Component 1.** This component will focus on four key areas:

2.1. Improving Quality of Care: The Project will support (i) the Directorate of Health Standards, Quality Assurance and Regulation as well as the health regulatory boards to: (a) strengthen inspection for licensure of private health facilities and gazettement for public health facilities; and (b) institutionalize quality assurance towards certification;[10,11] (ii) the Division of Family Health to (a) develop and/or disseminate RMNCAH related strategies and guidelines including adolescent sexual and reproductive health and nutrition, and (b) conduct operations research; and (ii) the Kenya Medical Training College (KMTC) to strengthen midwifery training

2.2.Strengthening Monitoring and Evaluation (M&E) and CRVS: The Project will support the Division of Health Information, Monitoring & Evaluation and Research to: (i) operationalize the M&E framework; (ii) strengthen the HIS and medical records management; and (iii) working closely with Civil Registration Department (CRD), pilot innovative approaches to improving coverage of vital events registration within the health sector (e.g., pay for registration, mobile CRVS office, birth registration with immunization, etc)

2.3. Supporting Health Financing Reforms towards UHC: The Project will support the Division of Health Care Financing (DoHCF) to: (i) disseminate the HFS to get buy-in drawing from the recently completed stakeholder analysis; (ii) conduct analytical work[12] to inform the implementation of HSF and health-financing reforms towards UHC; and (iii) build capacity for UHC leadership at the national and county level.

Component 3: Project Management

[8] Community unit represents the lowest administrative level of the health system. Each community unit comprises about 5,000 people and is supposed to be served by a network of community health workers (CHWs) under the supervision of community health extension workers (CHEWs) linked to the peripheral health facility. CHWs deliver primary care services to households focusing on preventive and promotive heath (e.g., addressing environmental or socioeconomic risk factors) and refer clients to the peripheral health facility for advanced care.

[9] As per the 2010 Constitution, the National Government will focus on formulation of policy, strategy and guidelines as well as provision of TA to the county level only under Component 2 (e.g., updating DHIS2 manual and training of trainers at the national and county level) and the Counties will be responsible for the activities within the Counties (e.g., training health workers and compiling data per the new guidelines) under Component 1.

[10] Kenya Health Quality Improvement Policy 2015 – 2030, *Draft*

[11] Implementation Guidelines for the Kenya Quality Model for Health (2011)

[12] Potential areas of analytical work include: developing appropriate provider payment mechanisms and client-oriented primary care networks; designing and costing the essential package for health (EPH) and developing a framework for updating it periodically; jointly with social protection secretariat, develop a framework for identifying the poor for the purposes of health insurance subsidies and piloting it in selected counties; and developing appropriate structures for pooling and purchasing arrangements.

7. **Component 3 aims to facilitate and coordinate project implementation and enhance cross-county and intergovernmental collaboration.** This will include two areas:

3.1. Project Management (including M&E and fiduciary activities): The Project will finance project management staff at national and county levels of government, office equipment, operating costs, and logistical services for day-to-day project management. This also includes: (i) M&E activities such as annual cross-county verification through peer reviews, periodic surveys and process evaluation to monitor implementation progress and address any implementation challenges; (ii) fiduciary activities such as independent integrated fiduciary review agent; (iii) safeguards activities such as social assessment and preparation or revision of safeguards-related plans; and (iv) TA and capacity building activities to support the Project sub-technical working group (TWG) under the Intergovernmental Forum for Health in carrying out their responsibilities, inter alia, reviewing county performance, and the quality of annual work plans (AWPs), and selecting proposals to promote cross-county and inter-governmental collaboration.

3.2. Cross-county and Inter-governmental Collaboration: The Project will finance activities that promote cross-county initiatives and inter-governmental collaboration to address common demand and supply-side barriers. Examples include cross-county study tours to share knowledge, capacity building in areas that affect several counties such as drafting county health bills, and improving supply chain management of strategic commodities. A call-for-proposal approach will be used. Every year, the PMT will issue a call for proposals in collaboration with the national and county governments and facilitate TA for proposal reviews. The Project sub-TWG will approve proposals, which will be concurred by the Bank. The winner(s) will be required to implement the proposals and report the findings and lessons learned through the Inter-governmental Forum for Health.

Vulnerable and Marginalized Groups Framework

8. The World Bank policy OP. 4.10 is being triggered for THS-UC project for the 47 counties within the country. Some of the counties, such as Trans-nzoia, Bungoma, Keiyo-Marakwet, Uasin Gishu, West Pokot, Turkana, Baringo, Nakuru, Narok, Laikipia, Samburu, Marsabit, Wajir, Garissa, Tana river, Lamu, Kilifi and Kwale, among others have known populations of groups that meet the criteria of OP 4. 10. Since the location of the micro-projects is as yet unknown, a Vulnerable and Marginalized Framework (VMGF) is being prepared to guide the preparation of plans to mitigate any negative effects and to enhance benefits of the THS-UC micro-projects. This VMGF outlines the processes and principles for: (a) screening to determine if a proposed sub-project investment will be undertaken in the vicinity of vulnerable and marginalized communities; and (b) the preparation of a VMGP, including the social assessment process, consultation and stakeholder engagement, disclosure procedures, communication and grievances redress mechanism. A detailed VMGP will be prepared for each micro-project once the location is identified and screening conducted has determined that VMGs are present in the area.

9. This Vulnerable and Marginalized Groups Framework (VMGF) sets out:

- *The types of sub-projects likely to be proposed for financing under the project.*
- *The potential positive and adverse effects of such sub-projects investments on VMGs.*
- *A plan for carrying out the social assessment for such sub-projects.*
- *A framework for ensuring free, prior, and informed consultation with the affected VMGs at each stage of project preparation and implementation.*

- *Institutional arrangements (including capacity building where necessary) for screening project-supported activities, evaluating their effects on VMGs, preparing VMGPs, and addressing any grievances.*
- *Monitoring and reporting arrangements, including mechanisms and benchmarks appropriate to the project.*
- *Disclosure arrangements for VMGPs to be prepared under the VMGF.*

10. This VMGF establishes an appropriate gender and inter-generationally inclusive framework that provides opportunities for consultation at each stage of project preparation and implementation and other local civil society organizations (CSOs) identified by the affected Vulnerable and Marginalized Groups. **Free and prior informed consultation of the vulnerable and marginalized communities leading to broad community support will be conducted at each stage of the project, and particularly during project preparation, to fully document their views and ascertain broad community support for the project.**

International, Regional and Country Policy and Legal Frameworks on Vulnerable and Marginalized Groups and Communities

11. **Definition and Treatment by the African Commission on Human and Peoples Rights (ACHPR)**

- *The Africa region has also taken important steps to recognize and apply the concept of Indigenous Peoples*: The ACHPR, a sub-body of the African Union, adopted in 2005 the "Report of the African Commission's Working Group of Experts on Indigenous Populations/Communities[13]." The report recognizes the existence of populations who self-define as Indigenous Peoples, who are distinctly different from other groups within a state, have a special attachment to and use of their traditional land, and who experience subjugation, marginalization, dispossession, exclusion or discrimination because of their cultures, ways of life or modes of production different from those of the dominant society. The ACHPR report concludes that these types of discrimination and marginalization threaten the continuation of Indigenous Peoples' cultures and ways of life and prevents them from being able to genuinely participate in decisions regarding their own future and forms of development. The report is the ACHPR's official conceptualization of, and framework for, addressing issues pertaining to VMGs, and as such it is an important instrument for recognizing Indigenous Peoples in Africa, improving their social, cultural, economic and political situation, and for protecting their human rights. The report outlines the following key characteristics, which identify certain social groups as VMGs/IPOs in Africa:
- *Their cultures and ways of life differ considerably from the dominant society*
- *Their cultures are under threat, in some cases to the point of extinction*
- *The survival of their particular way of life depends on access and rights to their lands and the natural resources thereon*
- *They suffer from discrimination as they are regarded as less developed and less advanced than other more dominant sectors of society*
- *They often live in inaccessible regions, often geographically isolated*
- *They suffer from various forms of marginalization, both politically and socially.*

[13]See ACHPR, *Report of the African Commission's Working Group of Experts on Indigenous Populations*

12. *The ACHPR report concludes that these types of discrimination and marginalization threaten the continuation of Indigenous Peoples' cultures and ways of life and prevents them from being able to genuinely participate in decisions regarding their own future and forms of development.* The report is the ACHPR's official conceptualization of, and framework for, addressing issues pertaining to Indigenous Peoples, and as such it is an important instrument for recognizing Indigenous Peoples in Africa, improving their social, cultural, economic and political situation, and for protecting their human rights. In line with the approach of the United Nations[14], the ACHPR emphasizes the principle of self-identification, and stresses that the criteria for identifying Indigenous Peoples in Africa is not mainly a question of aboriginality but of the above factors of structural discrimination and marginalization. The concept should be understood as an avenue for the most marginalized to advocate their cause and not as an attempt to deny any African his/her rights to their African identity.15 The report emphasizes that the African peoples who are applying the concept include mainly hunter-gatherers and pastoralists.

Definition and Treatment by the World Bank's Policy

13. *The World has a set of "Do No Harm" safeguard policies that are meant to protect project affected persons (PAPs) from impacts and actions of Bank financed projects:* Some of the World Bank's development activities have significant impacts on the rights and livelihoods of VMGs including groups that meet the criteria of OP 4.10 Indigenous Peoples – groups that meet the World Bank OP 4.10 criteria for indigenous peoples typically may constitute the "poorest of the poor and who continue to suffer from higher rates of poverty, lower levels of education and a greater incidence of disease and discrimination than other groups" (World Bank 2010). Since the early 1980s the World Bank Group (WBG) has adopted a number of policies, designed to mitigate harm to such groups of indigenous peoples in WBG-financed projects (Mackay, 2005).

14. *The World Bank Operational Policy/Bank Procedures Indigenous Peoples (OP/BP 4.10) seeks to ensure that* Bank-financed projects are designed not only to avoid adverse impacts but also so that VMGs can receive project benefits in a culturally appropriate manner. The policy provides processing requirements for projects that may affect VMGs that include: (i) screening, (ii) social assessment, in consultations with communities involved, (iii) preparation of VMG Plan (VMGP) or Vulnerable and Marginalized Groups Framework (VMGF) and, (iv) disclosure. It also requires the borrower to seek broad community support of VMGs through a process of free, prior and informed consultation before deciding to develop any project that targets or affects VMGs.

15. *The World Bank, like the UN, has no definition of IP: because of the varied and changing contexts, in* which VMGs live, and because there is no universally accepted definition of IP (paragraph 3), **OP 4.10 presents a set of characteristics for identifying VMGs**. For purposes of this policy, the term" Indigenous Peoples" is used in a generic sense to refer to a distinct, vulnerable, social and cultural group[i] possessing the following characteristics in varying degrees:

[14]E.g. the ILO Convention 169 and the UN Declaration on the Rights of Indigenous Peoples

[15]See ACHPR, Report of the African Commission's Working Group of Experts on Indigenous Populations/Communities, Banjul & Copenhagen: ACHPR & IWGIA, 2005; and ACHPR, Indigenous Peoples in Africa: the Forgotten Peoples? The African Commission's work on Indigenous Peoples in Africa, Banju l & Copenhagen: ACHPR & IWGIA, 2006.

- *self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;*
- *collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territoriesii*
- *customary, cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and*
- *an indigenous language, often different from the official language of the country or region.*

Treatment of VMGs and 2010 Constitution of Kenya Framework

16. The African Commission's Working Group of Experts on Indigenous Populations and Communities affirms "almost all African states host a rich variety of different ethnic groups. All these groups are indigenous to Africa. However, some are in astructural subordinate position to the dominating groups and the state, leading to marginalization and discrimination. It is this situation that the indigenous concept, in its modern analytical form, and the international legal framework attached to it, addresses" The CoK, 2010, does not specifically use the term indigenous peoples (IPs), it is nevertheless robust in articles that define vulnerability and marginalization, including issues that IPs cite as the reasons for their self-identification. It also addresses social exclusion in general. *Article 260 of the Constitution defines a "marginalized community" as:*

(a) a community that, because of its relatively small population or for any other reason, has been unable to fully participate in the integrated social and economic life of Kenya as a whole;
(b) a traditional community that, out of a need or desire to preserve its unique culture and identity from assimilation, has remained outside the integrated social and economic life of Kenya as a whole;
(c) an indigenous community that has retained and maintained a traditional lifestyle and livelihood based on a hunter or gatherer economy; or
(d) pastoral persons and communities, whether they are (i) nomadic; or (ii) a settled community that, because of its relative geographic isolation, has experienced only marginal participation in the integrated social and economic life of Kenya as a whole[16].

17. *Similarly, the CoK, 2010, defines 'marginalized group' as*: a group of people who, because of laws or practices, on, or after the effective date, were or are disadvantaged by discrimination on one or more of the grounds in Article 27 (4) which prohibits discrimination on the basis of ethnic or social origin, religion, conscience, belief, culture, dress or language. In addition, article 27(6) calls on the state to undertake, 'legislative and other measures, including affirmative action programmes and policies designed to redress any disadvantage suffered by individuals or groups because of past discrimination'. This article prohibits both direct and indirect discrimination.

18. *Articles 56 and 260 of the Constitution are a clear demonstration of the intentions of the country to deal with the concerns of minority and marginalized groups:* The definition of marginalized communities and groups by the COK, 2010, and the provisions for affirmative action programmes for minority and marginalized groups are efforts to provide a legal

[16]Ditto

framework for the inclusion of minority and marginalized groups into mainstream development of the country. These articles present the minority and marginalized groups including groups that fit the OP 4.10 criteria as a unique category of certain segments of the Kenyan population that deserve special attention in order to bring them to par with the rest of the country.

19. *The Constitution of Kenya requires the State to address the needs of vulnerable groups, including "minority or marginalized[17]" and "particular ethnic, religious or cultural communities" (Article 21.3):* The Specific provisions of the Constitution include: affirmative action programs and policies for minorities and marginalized groups (Articles 27.6 and 56); rights of "cultural or linguistic" communities to maintain their culture and language (Articles 7, 44.2 and 56); protection of community land, including land that is "lawfully held, managed or used by specific communities as community forests, grazing areas or shrines," and "ancestral lands and lands traditionally occupied by hunter-gatherer communities" (Article 63); promotion of representation in Parliament for "…(d) ethnic and other minorities; and (e) marginalized communities" (Article 100); and an equalization fund to provide basic services to marginalized areas (Article 204). In implementing Article 59 of the Constitution, the government has created a) the Human Rights Commission b) the Commission on Administrative Justice and c) the Gender Commission.

20. The Revenue Allocation Commission, mandated by Article 204 of the Constitution to earmark 0.5% of annual state revenue to the development of marginalized areas, in addition to 15% of national revenue for direct transfer to county governments.

Health Provisions in Kenya's policy and legislative Framework

21. Other Legal and policy provisions that facilitate the operationalization of OP 4.10 within Kenya's policy and legislative framework and that are relevant to THS-UC project (Table 3).

Table 1: Health provisions under the Kenya policy and legislative framework

	Policy and Legal Instrument	**Relevant Provision**
	Constitution of Kenya, 2010	
	Governance Level	
	i. National Government	FOURTH SCHEDULE Part 1—National Government 23. National referral health facilities. 28. Health policy.
	ii. County Government	Part 2—County Governments 2 County health services, including, in particular— (a) county health facilities and pharmacies; (b) ambulance services; (c) promotion of primary health care;
	Health Facilities and Services	

[17] World Bank, Operational Policy (OP) 4.10 Indigenous Peoples, July 2005. The OP 4.10 contemplates that different terminologies may be applied in different countries without affecting the application or substance of the policy. It states: "*Indigenous Peoples* may be referred to in different countries by such terms such as *indigenous ethnic minorities*; *aboriginals*, *hill tribes*, *minority nationalities*, *scheduled tribes*, or *tribal groups*. The 2010 Constitution of Kenya uses the term "vulnerable groups" and "marginalized communities". The use of such terminologies in no way dilutes the requirements for application of the policy as explained in footnote 4.

	i. Standard for health ii. Healthcare services iii. Reproductive healthcare	(Article 43) Every person has the right; (1) (a) To the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare;
	iv. Sanitation	CoK 2010. Part 2. Article 2. (b) to accessible and adequate housing, and to reasonable standards of sanitation;); (d) To clean and safe water in adequate quantities. (2) A person shall not be denied emergency medical treatment.
	v. Food	(c) To be free from hunger and have adequate food of acceptable quality; (d) To clean and safe water in adequate quantities.
	vi. Emergency medical treatment	(2) A person shall not be denied emergency medical treatment.
	vii. Pregnancy viii. Health status	Article 27,4) The state shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, color, age, disability, religion, conscience, belief, culture, dress, language or birth
	ix. Redress mechanism	70. (1) If a person alleges that a right to a clean and healthy environment recognized and protected under Article 42 has been, is being or is likely to be, denied, violated, infringed or threatened, the person may apply to a court for redress in addition to any other legal remedies that are available in respect to the same matter.
	Health Facilities	(2) The national government shall use the Equalisation Fund only to provide basic services including water, roads, health facilities and electricity to marginalised areas to the extent necessary to bring the quality of those services in those areas to the level generally enjoyed by the rest of the nation, so far as possible.
	Health services	56. The State shall put in place affirmative action programmes designed to ensure that minorities and marginalized groups— (e) have reasonable access to water, health services and infrastructure.
Maternal		Mother and child health is well captured under reproductive health care. The constitution under Article 43(a) says that every person has a right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; Article 26(1) every person has the right to life;
Child		Article 43 (2) The life of a person begins at conception. Every measure should therefore be taken to avoid mother and child mortality. CoK, 2010: Article 53. (1) Every child has the right— (c) to basic nutrition, shelter and health care;
The Kenya National Youth Charter 2013 **The National Reproductive Health Policy, 2008**		

Youth		**The Kenya National Youth Charter 2013** article 10; The youth of Kenya have a right to safety, reproductive and health care. **The National Reproductive Health Policy, 2008** Has identified the need to improve the sexual and reproductive health of youth with disabilities.
The National Reproductive Health Policy, 2008 **The Rights of Persons with Disability Bill (RPD) 2014** **Persons with Disabilities Act (No. 14 of 2003)** **he Kenya National Youth Charter 2013**		
Person with disabilities		**The National Reproductive Health Policy, 2008** recognizes that women with disabilities are also entitled to access reproductive health services. It has identified the need to improve the sexual and reproductive health of youth with disabilities. **The Rights of Persons with Disability Bill (RPD) 2014** (article 9)(1) The appropriate government shall ensure that persons with disabilities have access to appropriate information regarding reproductive and family planning;(2)No person with disability shall be subjected to any medical procedure which leads to infertility without his or her free informed consent. **Persons with Disabilities Act (No. 14 of 2003)**. Section 20 of the mandates the National Council for Persons with Disabilities to monitor the provision of health care to persons with disabilities so as to ensure that the services are devoid of any form of discrimination **The Rights of Persons with Disability Bill (RPD) 2014** (article 9)(1) The appropriate government shall ensure that persons with disabilities have access to appropriate information regarding reproductive and family planning;(2)No person with disability shall be subjected to any medical procedure which leads to infertility without his or her free informed consent. **The Kenya National Youth Charter 2013** (article 11); outlines Social protection for young persons with disabilities and in disadvantaged and marginalized communities.
Person with HIV/AIDS		**Kenya HIV/AIDS Prevention And Control Act 2006** (Article 36); Discrimination in health institutions no person shall be denied access to health care services in any health institution, or be charged a higher fee for any such services, on the grounds only of the person's actual, perceived or suspected HIV status.
Health Bill **Operational research** **Presidential directive**		

RMNCA issues	Health Bill – at 3rd reading in parliament	RMNCA issues
	Operational research	WHO Good Clinical Practice Institutional Review Board
	Presidential directive	preferential rights for medical coverage – medical bill

22. Vulnerable populations mostly include women, children, the aged, displaced people, ethnic minorities and people living with disabilities. Health inequalities experienced by such populations are rooted in lack of political, social and economic power. Failure by the state to identify health needs of a vulnerable group results in breach of the non-discrimination tenet and consequently in lack of essential service delivery.

Vulnerable and Marginalized Groups (VMGs) in the Project Area

23. The THS-UC plan to improve the delivery and use for quality primary health services with a focus on Reproductive, Maternal, Neonatal, Child, and Adolescent (RMNCA) in all the 47 counties in Kenya. During project appraisal, it became apparent that minority, vulnerable and marginalized groups might be found in the project area thus triggering OP 4.10 and so, necessitating interpretation of Article 260 of the CoK, 2010 in addition to the application of OP 4.10. For this reason, the project utilized a Vulnerable and Marginalized Groups Screening Form (Template 6) that was applied across the proposed project operational area. The screening relied on existing documentation review –including VMGF/P, field reports, publications), and key informant interviews. A list of those profiled as marginalized groups/communities are as indicated in Annex 5.

24. Some of the key factors that continue to affect and maintain the marginalization of VMGs communities in Kenya include:

- *Dispossession of ancestral lands including lack of access and/or no control or legal recognition of such land and other natural resources.*
- *A focus on modern agriculture versus preservation of livelihoods of hunter and gatherers and pastoralist groups.*
- *Limited access to education, resulting in inability to compete for employment opportunities.*
- *Unequal development of health care and other social infrastructure* and;
- *Limited access to justice and increased conflict and a deteriorating security situation and recurrent inter-ethnic conflicts.*

25. *The preliminary screening has identified several 12 marginalized communities[18] whom are present in 8 of the targeted 21 counties who could possibly meet criteria for OP 4.10.* Their livelihoods cover forest adjacent communities/hunter gatherers currently transitioning to agro-pastoralims, Fishing/Farming communities, pastoralists, and artisanal blacksmith. These include: Sengwer (Trans-Nzoia); Ogiek of Mt Elgon (Bungoma and Trans-nzoia Counties) and Mau Forest Complex (Nakuru, Narok, and Nandi Counties); Endorois (Baringo County); Dorobo of Kinale Forest (Kiambu County) and of Mathew ranges (Samburu County); and

[18] Most of the communities are likely to meet the characteristics described under OP 4.10.

Watha around Arabuko forest (Kilifi County) (Figure 1) (ERMIS Africa, 2015). These groups, their livelihoods and locations are presented in the Annex 5 and their locations are illustrated also Map Figure 1 below.

26. Kenya is home to a number of groups who self-identify as Indigenous Peoples (see figure 1 for an illustration of how they are spread across the Kenya). Some of communities within the ***Ogiek, Sengwer, Ilchamus, Boni/Aweer and Waatha, and some specific pastoral communities of the Maasai, Turkana and Samburu*** have met the criteria set out in World Bank OP 4.10. However, the policy is not triggered by name but by meeting criteria in the policy and thus, field verification is required to characterise the groups and determine whether they meet the criteria.

27. In addition to OP 4.10, screening and profiling of marginalized communities and marginal groups will be done in line with the interpretation of Constitution of Kenya, 2010, article 260, which provides criteria that can be used as a basis for profiling of communities and groups that could possibly be identified as "Marginalized Communities" and "Marginalized Groups".[19] ***See annex 2***) for a profile of indicative groups that could meet the criteria based on the criteria derived from CoK, 2010 section 260 ***(see annex 3)***. The VMGF presents the World Bank's OP 4.10 policy criteria for determining if the identified groups based on an initial screening meet the characteristics of Indigenous Peoples as per OP 4.10. Site specific verification is required given the fast pace of urbanization and social economic change in Kenya. Hence for that reason, the list provided here is indicative. A two-step -process will be applied including (a) screening and (b) field verification. Where the MoH confirms the existence of VMG within sub-project operational area, MoH will carry out a social analysis and the process of free, prior and informed consultations, for purpose of ascertaining whether the respective VMG broadly support the project; where such broad VMG support for the project exist, as confirmed by the World Bank, MoH will proceed to prepare VMG for each sub-project site.

28. *Indigenous Peoples (OP 4.10) will be triggered*[20] *by proposed component 1 to be implemented under the MoH.* Since THS-UC is countrywide in nature an initial screening indicates the presence of groups that meet the World Bank criteria for indigenous peoples who are likely to be present in, or have collective attachment to the sub-project areas where component 1 might be implemented. While the exact sites of the sub-projects remain unknown at this point, a preliminary assessment indicates that the project is likely to be implemented in areas where the following VMGs are present (Figure 1).

[19] The Constitution states that a marginalized community/groups is one that meet the following criteria: (a) **A community** that are unable to participate in the integrated social economic life of Kenya as a whole due to (i) relatively small population or (ii) any other reasons; (b) **Traditional Community** that has remained outside the integrated social and economic life of Kenya as a whole; (c) **Indigenous community** that has retained a traditional lifestyle and livelihood based on a hunter-gatherer economy; and (d) **Pastoral persons or communities**, whether: (i) **nomadic or (ii) a settled community** that, because of its relative geographic isolation, has experienced only marginal participation in the integrated social and economic life of Kenya .

[20] The Constitution Article 260 states that a marginalized community/groups is one that meet the following criteria: (a) **A community** that are unable to participate in the integrated social economic life of Kenya as a whole due to (i) relatively small population or (ii) any other reasons; (b) **Traditional Community** that has remained outside the integrated social and economic life of Kenya as a whole; (c) **Indigenous community** that has retained a traditional lifestyle and livelihood based on a hunter-gatherer economy; and (d) **Pastoral persons or communities**, whether: (i) **nomadic or (ii) a settled community** that, because of its relative geographic isolation, has experienced only marginal participation in the integrated social and economic life of Kenya .

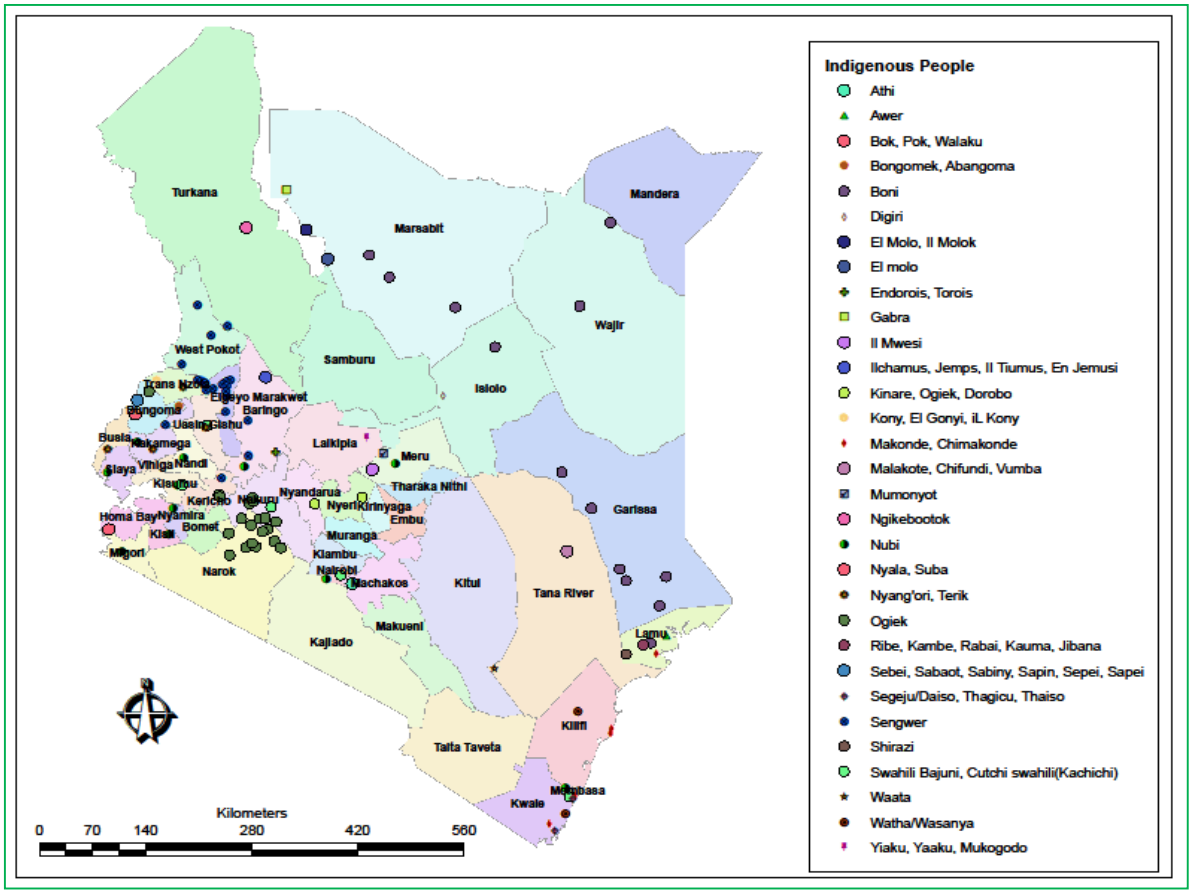


Figure 1: Map showing locations of and Marginalized Groups /IPs in Kenya (ERMIS Africa, 2012)

29. Some of these are hunter-gatherers with some transitioning to agro-pastoralism, others nomadic or semi-nomadic pastoralists and other artisanal blacksmiths and fishing communities[21,22]In the absence of updated and reliable statistics, it is difficult to give precise demographic data of the various groups. Estimations vary greatly and depend variable personal or institutional judgments of which group is considered as Indigenous Peoples in Kenya. Some experts have put the total population of groups that self-identify as Indigenous Peoples at around 1.5 million.[23]

30. **VMGPs whose livelihoods are linked to Forest/Natural Resources/Forest Adjacent Communities – Hunter gatherers:** The hunter-gatherer groups are generally found in the forested areas of the central Rift Valley province, in the western part of the country: Moving from south to north, these groups include: the Ogiek (approx. 20,000), who live in the Mau Forests; the Sengwer (30,000) of the Cherangany Hills and Kapolet Forest in Trans Nzoia, Marakwet and West Pokot Districts[24] and the Yaaku (less than 1,000) who live in the Mukogodo forest -west of Mount Kenya, in the Laikipia District. Two more groups are the Watta (a few thousands) who live dispersed in the southern coastal areas of the Coast region,

[21]See the Report of the UN Special Rapporteur on Indigenous Peoples in Kenya, UN Doc. A/HRC/4/32/Add.3, 26 February 2007; the Report of the African Commission's Working Group of Experts on Indigenous Populations/Communities; Banjul & Copenhagen: ACHPR & IWGIA, 2005; and the website of the International Working Group on Indigenous Affairs (IWGIA) at http://www.iwgia.org/regions/africa/kenya.

[22] Source: ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012

[23]Kipuri, Naomi. "Kenya and its Indigenous Peoples" (unpublished paper). This number does not include all pastoral groups in Kenya; all pastoral groups make up about 25% of the Kenyan population.

[24] Rodolfo Stavenhagen, 2006, Mission to Kenya UN Doc. A/HRC/4/32/Add.3, 26 February 2007, para. 39

and the Elmolo (a few hundreds) who are a small fishing community living on the shores of the Lake Turkana.

31. These hunter-gatherers are often derogatorily addressed as Torobbo, Dorobo, Ndorobo, or Wandorobo, which are all Swahili terms deriving from "Il Torobbo," the Maa-term for people without cattle, i.e., in the Maasai understanding "poor people:" In the coastal areas, hunter-gatherers are mostly addressed by the Somali term "Boni", which refers to someone without any permanent residence, and/or "Sanye", which means in Somali "to gather together to use for a general purpose". The people themselves, however, usually refer to themselves by their own names.

32. Hunter gatherers include the Dorobos, Sengwer, Ogiek, Waatha, WaSasnye, and El Molo.

33. **Agro pastoralists communities** include the Wasanye, Il and Chamus Endorois community living adjacent to Lake Baringo and near Lake Baringo, the El Molo.

34. **Pastoralists.** Most of Kenya's pastoralists live in the arid Northern Kenya: They include, moving from east to west, the Somali (500,000) along the border to Somalia; the Borana (150,000) the Rendile (20,000), the Gabra (20,000) and the Turkana (250,000 – 350,000). The Samburu (100,000) live in the southern part of Northern Kenya. Other pastoralists are found in the southern part of the country, along the Rift Valley: the Maasai (155,000), in the southern part in the Narok and Kajiado districts bordering with Tanzania; the Endorois (60,000), near Lake Bogoria; and the Pokot (100,000) in West Pokot district in the central-western part of the country. A small group of Maasai live in Laikipia, in the center of the county, near Dol Dol.

A Two Step Process.

Step 1: Primary Screening --
35. The steps to be undertaken for the preparation of a VMGP for each sub-project investment will include a screening process, to determine whether VMGs are present in, or have collective attachment to, the sub-project area (using the proposed tool in annex 2). This screening will be conducted by the environmental and social specialists within the Project Coordination Unit. Ideally the screening for VMGs should consider the GOK's framework for identification of Vulnerable and Marginalized Groups (VMGs) according to the Constitution of Kenya (CoK) 2010 however, the Bank criteria for identification of VMGs as per OP. 4.10 will be used to make a final determination.

Step 2: Secondary Screening: Social Assessment:
36. If, based on the screening, it is concluded that VMGs are present in, or have collective attachment to, the sub-project area, a social assessment/analysis will be undertaken by MoH under the THS-UC project, with direct support of the safeguard officer in the MOH PMU to evaluate: the scale appropriate for primary health interventions, gathering of baseline information on demographic, social, cultural and political characteristics of affected VMGs, the land and territories that the traditionally owned or customarily used or occupied, and naturally resources they depend on; identification of key project stakeholders and elaboration of a culturally appropriate process for consulting with the VMG at each stage of the sub-project preparation and implementation; assessment of FPI-Consultation with VMG of potential adverse impacts and risks as well as lack of access to opportunities relative to other social groups; and measure to address the adverse impacts and ensure the VMG receive culturally appropriate benefits under the THS-UC sub-project. The breadth, depth, and type of analysis

in the social assessment/analysis will be proportional to the nature and scale of the proposed activity under the THS-UC project component 1.

37. The various tasks for generating data and information for developing the VMGF will be conducted using several methodological approaches (see Table 4) including: interview with key informants, focused groups discussions with both men and women disaggregated in terms of ages, marital status, and other categories as will be determined through consultation with ministry of health and VMG leaders.

Table 4: Approach to social assessment /analysis for the THC-UC project

Tasks	Data and Information	Methodology
1.1 Define requirements of consultation with VMG 1.2 Identify what processes are needed to conduct a free prior and informed consultations with affected groups	• VMG governance and leadership structures • VMG decision making process • Local consultation process and protocol • Communication channels /spaces • Language • Gaps analysis	• **Documentation review** KHSP and HISP • **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)* • **Focused Groups Discussions** *(Identified communities and specifics groups)*

1.3 Provide mechanisms that the project need to adopt to ensure that the VMG participate and benefits from the project as required by the WB OP 4.10	• VMG participation spaces
	• VMG perceptions on primary health care services
	  • Family planning
	  • Antenatal care
	  • Child delivery
	  • Post-natal care
	  • Adolescent reproductive health services
	  • Quality of health care (access to information, access to health personnel, their safety (physical, sexual etc), equipment, commodities, water, effectiveness of care services
		• **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*
		• **Focused Groups Discussions** *(with women of different age structures)*

1.4 Summarize the concerns and comments of the consulted VMG 1.5 Indicate how this need to be taken into account in the project design	• Participants concerns • Participants comments • Analysis and recommendations	• **Focused Groups Discussions** ***(****Identified communities and specifics groups)* • **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*
1.6 Describe the procedure for Framework for Free, Prior, Informed consultations	• Communication structures • Communication channels	• **Focused Groups Discussions** ***(****Identified communities and specifics groups)*
1.7 Identify institutions (formal and informal)	• VMG social, economic and cultural, and political institutional structures	• **Focused Groups Discussions** ***(****Identified communities and specifics groups)*

1.8 Recommendation on how their capacity can be enhanced	• Democratic processes elections and voting out leaders • Decision making processes • Capacity gaps in terms of (leadership, democratic processes, administrative, management, technical – primary health care) • Capacity development process (availability of women, youth, literacy, opportunities, forums, processes)	• **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*
1.9 Grievance Redress Mechanism & Complain Handling Process	• VMG Governance process and structures • Local grievance redress mechanism • Communication channels /spaces • Complaints uptake • Complaints sorting • Complaints handling organs • Feedback mechanism • Redress process for grievances including	• **Focused Groups Discussions (***Identified communities and specifics groups)* • **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*
1.10 Describe the mechanism and benchmarks appropriate to the project monitoring and evaluating the implementation of the VMGP 1.11 Specify the arrangement for the participation of affected VMGs in the validation of monitoring and evaluation of reports	• Participatory Impact monitoring process • Definition of impact boundaries • Definition of types of impacts • Identification of impacts indicators • Composition of PIM Teams • Data collection and analysis • Triangulating results • Feedbacks mechanism to project beneficiaries • Utilization of PIM results	• **Focused Groups Discussions (***Identified communities and specifics groups)* • **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*
1.12 Document appropriate disclosure arrangements for the VMG plans to be prepared under the VMGF	• VMG governance and leadership structures • VMG decision making process • Local consultation process and protocol • Communication channels /spaces • Language • Gaps analysis	• **Focused Groups Discussions (***Identified communities and specifics groups)* • **Consultations** *(key informants at the Ministry and County Government, Local opinion leaders)*

38. Preparation of a specific sub-project VMGPs will be done in accordance with the requirements of OP 4. 10: utilizing (i) summary information from the social assessment; (ii) results of FPI-Consultation; including (iii) FPI-Consultation framework to be used, (iv) action plan of measures to ensure VMG receive social and economic benefit (health services, equipment and facilities as appropriate) that are culturally appropriate and measures for enhancing the capacity of MoH, (v) action plan to address adverse impacts, (vi) a grievance redress mechanism; and (vii) monitoring and evaluation and reporting mechanisms and benchmark. The VMGP preparation process will be guided by appropriate participatory approach for purposes of ensuring free prior and informed consultation. Each VMGP will be

submitted to the Bank for review before the respective investment is considered eligible for Bank financing under the broader project framework.

39. The need for VMGPs will depend on (a) the presence of VMGsthat meet the OP 4.10 criteria. The VMGPs will capture the nature and scale of the project impact and vulnerability of VMGs, including (i) adverse impacts on customary rights of use and access to land and natural resources; (ii) negative effects on the socioeconomic and cultural integrity; (iii) effects on health, education, livelihood, access to the project benefits, and social security status; and (iv) other impacts that may alter or undermine traditional knowledge and customary institutions. It will also identify ways in which to bring the benefits from the project to VMG communities are technically feasible. The social assessment will identify requirements for preparing a VMGP.

40. The VMGPs will set out the measures whereby the PIU will consult with VMGs and ensure that (i) affected VMGs receives culturally appropriate social and economic benefits; and (ii) when potential adverse impacts on VMGs are identified, these will be avoided to the maximum extent possible. Where this avoidance is proven to be impossible, VMGP will outline measures to minimize, mitigate, and compensate for the adverse impacts.

41. The level of detail and comprehensiveness of VMGP will vary depending on the specific project and the nature of impacts to be addressed. If VMGs are the sole or overwhelming majority of the project beneficiaries, the elements of the VMGP could be integrated into the project design or documents to ensure that all VMGs participate in and receive culturally appropriate benefits from the project.

2.0 POTENTIAL POSITIVE AND NEGATIVE IMPACTS ON VMG

42. The THS-UC project will be an integrated multi-year RMNCAH Investment Framework to address persistently high maternal, neonatal and child morbidity and mortality. The RMNCAH Investment Framework specially aims to: (i) increase demand for and utilization of RMNCAH services by improving knowledge, attitudes, and behaviors of communities towards the continuum of essential care services such as family planning, ANC, skilled delivery, PNC, and adolescent reproductive health services; (ii) increase access to RMNCAH services by strengthening county's capacity (e.g., financing, workforce, products, information and governance) to deliver effective and efficient integrated interventions at the communities and facilities; and (iii) improving quality of RMNCAH services by ensuring constant availability of essential inputs (e.g., human resources, equipment, commodities, water, etc.) and enforcing quality of care standards for improved client experience, patient safety and effectiveness of care. Each county will prepare their annual work plan to address persistently high maternal, neonatal and child morbidity and mortality taking county context into account.

43. *Thus, it should be noted that minimal, if any, negative impacts are anticipated as a result of the THC-UHC project.* Most of the impacts anticipated will be positive for all communities, including for VMGs. As a result, a key focus of the VMGF and the VMGPs will be to propose pro-active steps for such groups to benefit from the project. It is generally envisaged that the Vulnerable and Marginalized Populations do not have access to primary health services in a similar way to other ethnic communities in Kenya.

44. The THC-UHC project and sub-project has a likelihood of precipitating a range of political and governance, institutional, environmental, social, economic, technological, technical skills, fiduciary related positive and negative impacts. The THC-UHC project is assigned EA category B, based on the screening during project preparation. There are no significant and/or irreversible adverse environmental and social issues anticipated from the investments to be financed under the Project. Disposal of medical waste may lead to relatively minor environmental pollution during provision of primary care services.

45. **Social Risks.** The main social risk is that of exclusion of the VMGS. Social risks envisioned in the implementation process include: (i) possibility of elite capture at the community and county levels thus excluding target groups; (ii) political capture as the project is being launched in the lead up to the national elections in 2017; (iii) leakages of inputs and resources as funds and facilities are to be channeled to county health facilities. These risks will be mitigated through the following: (a) capacity development of key MoH and other health service organizations participating in the project implementation; (b) awareness creation and building capacity VMG's community health structure (community health volunteers/workers) primary health care community levels, lobbying and advocacy skills to understand and influence the primary health care services, use appropriate participatory approaches for improving health services uptake, application of social accountability tools at community and county health services levels for transparency.

46. A key principle of the project is inclusion and therefore the VMGF will focus on how to ensure that VMG are aware of the project and can participate. The project is therefore triggering the OP 4.10 Indigenous Peoples which has led to the preparation of this Vulnerable and Marginalized Group Framework (VMGF). This VMGF covers: (i) screening to determine presence of Vulnerable and Marginalized Groups (Indigenous Peoples per OP 4.10 criteria) in

the project areas and, if present, (ii) measures to ensure they benefit from the project activities through the preparation of a Vulnerable and Marginalized Group Plan (VMGP).

47. **Environmental Risks.** The envisaged environmental risks at project implementation include biomedical waste which may be solid or liquid. (a) Infectious waste include discarded blood, sharps, unwanted microbiological cultures and stocks, identifiable body parts, other human or animal tissue, used bandages and dressings, discarded gloves, other medical supplies that may have been in contact with blood and body fluids, (b) and laboratory waste that exhibits the characteristics described above. include: compliant collection, treatment and disposal of biohazards, such as biomedical waste, sharps, pathological and chemotherapy waste across; and (c) waste sharps include potentially contaminated used (and unused discarded) needles, scalpels, lancets and other devices capable of penetrating skin. The MoH will develop an HCWMP and relevant manual for addressing such biomedical waste

48. **Other risks at the county level include weak capacity to implement and monitor safeguards at the county level as this is a recently devolved function.** A training component is included into the project design targeting counties to address this as well training for communities and provision of the HCWMP and VMGF to guide development of plans and legal requirements for VMG including mother /women, neonate, child and adolescent policy.

49. Socio-cultural issues in some target communities may hinder health service uptake. Several cultural barriers were identified during the consultation session with the VMG's. e.g circumcision of women at delivery time, failure to breastfeed neonate until naming is done which could take a week, gender-based cultural prejudice that hinder males to be injected by female medical staff on body parts regarded as private, preference for women to deliver at home where local health facilities are run by male midwifery, fear to use family planning methods that have generally been associated with interference of female libido among others (*see Table 5 and Annexes 6- 9 for VMGs consultative meetings held in Kiambu, Baringo, Samburu and Kwale*).

Proposed Mitigation Measures

50. To avoid or minimize adverse impacts and, at the same time, ensure enhancement of benefits and full participation of the vulnerable groups, measures shall include:

Disclosure Mechanism

51. THS-UC project will ensure that all project design frameworks and consecutive processes and activities are disclosed in culturally appropriate and accessible manner using FPI-Consultation guidelines stipulated in this document.

Capacity Development of VMG and Stakeholders

52. THS-UC project and/or ongoing KHSSP will finance and support the development of and training on standardized training modules on the following subjects in a culturally appropriate manner:

(a) Module 1: Background on Health Services Delivery
(b) Module 2: Leadership, Management And Governance
(c) Module 3: Planning Within a Health Facility
(d) Module 4: Financial Management In A Health Facility
(e) Module 5: Supply Chain Management
(f) Module 6: Supporting Health Facility Workforce
(g) Module 7: Health Facility Management Information System

(h) Module 8: Resource Mobilization & Management
(f) Module 9: Results Based Financing (RBF)
(g) Module 10: Environmental and social safeguards

Table 5: Summary of Strength, Opportunities, Risks and threats (SORT) analysis

Cohorts	**Positive Impacts (Strengths & Opportunities)**	**Negative Impacts** *Exclusion due to:*
VMG's in general (all (cohorts)	• Improved maternal, neonatal and child survival • Improved community wellbeing	i. Cultural mismatch between the health staff approach and the VMGs ii. Geographic isolation (remote localities with medical facilities) iii. Nomadic, pastoralism, fishing schedule (move the from medical facilities, does not allow them to access vaccination campaigns) iv. Misappropriation of drugs and medical equipment by medical staff and charging private in government medical facilities and services v. Lack of capacity to meaningfully participate in local health governance structure vi. Traditional settlement of rape cases
Reproductive health	• Improve sexual health • Improved family welfare	vii. Lack adequate knowledge on contraceptives viii. Cultural values that hinder men from being treated by female medicate staff
Maternal	• Improved maternal health • Improved neonate survival and child health	ix. Psycho-social misconceptions hindering women from deriving under the assistance of male midwifery
Neonate	• Increased neonate survival • Increased child registration and consequent inclusion in planning	x. Retrogressive culture such as delayed breastfeeding due to child naming protocols
Child	• Reduced mortality • Improved child protection	
Adolescent	• Reduced unwanted pregnancy • Continuity with education mostly where girls drop out of school after pregnancy • Improved health due to reduced bad practical such as FMG • Improved youth friendly services	xi. Lack of youth friendly health services xii. Retrogressive culture such as: FGM

Table 6: Potential negative challenges and mitigation measures for THS-UC

Component 1	**Negative Impacts**	**Possible Actions**	**Responsibilities and Issues**
VMG's in general (all (cohorts)	Exclusion due to: • Cultural mismatch between the health staff approach and the VMGS • Geographic isolation (remote localities) • Nomadic, pastoralism, fishing schedule • Misappropriation of drugs and medical equipment by medical staff • Lack of capacity to meaningfully participate in local health governance structure	• Community wide awareness creation • Capacity development • Provision of medical training opportunities to VMG's • Establish health facility where there are lacking – where VMG coverage is low • Training VMG in advocacy, leadership and governance to meaningfully participation in local health governance structure and processes (health facility and services operational decisions)	MoH CHU County Government FBO Private sector
Reproductive health	• Inadequate knowledge on contraceptives • Cultural values that hinder men from being treated by female medicate staff	• Appropriate awareness creation • Capacity development	MoH CHU County Government FBO Private sector
Maternal	• Psycho-social misconceptions hindering women from delivery under the assistance of male midwifery	• Appropriate awareness creation • Capacity development	MoH CHU County Government FBO Private sector
Neonatal	• Retrogressive culture such as delayed breastfeeding due to child naming protocols	• Awareness creation	
Child	• Child labor		MoH CHW County Government
Adolescent	• Lack of youth friendly health services • Retrogressive culture such as: FGM	• Design of youth friendly services	MoH CHUW County Government FBO Private sector

3.0 PLANS FOR CARRYING OUT SOCIAL ASSESEMENT

53. The social assessment will be conducted after the national and county launching of the THS-UC project and disclosure at VMG sites based on primary screening. The social assessment will utilize PICD process and tools for project initiation and community entry which entail consultations with VMG elders and other opinion leaders and VMGO.

Social Assessment Process

54. **Analysis:** If, based on the screening, the MOH PMU concludes that VMGs are present in, or have collective attachment to, the project area; the MoH will undertake a social assessment to evaluate the project's potential positive and adverse effects on the VMGs, and to examine project alternatives where adverse effects may be significant. The breadth, depth, and type of analysis required for the social assessment will be proportional to the nature and scale of the proposed sub project's potential and effects on the Vulnerable and Marginalized Groups present, whether such effects are positively adverse (see Annex 3for details). The MOH PMU will prepare detailed Terms of Reference (ToR) for the social assessment study once it is determined that VMGs are present in the project area. *Annex 8 contains draft sample ToRs for the development of a VMGPs.*

55. **Consultation and participation:** Where the project affects VMG's, the MOH PMU will engage in free, prior, and informed consultation with them. To ensure such consultation, the MOH PMU:

(a) establishes an appropriate gender and intergenerationally inclusive framework that provides opportunities for consultation at each stage of project preparation and implementation among the implementing structures, the VMG's, the VMG Organizations (VMGOs) if any, and other local civil society organizations (CSOs) identified by the affected VMG's;
(b) uses consultation methods25 appropriate to the social and cultural values of the affected VMG's and their local conditions and, in designing these methods, gives special attention to the concerns of VMG's women, youth, and children and their access to primary health care services; and
(c) Provides the affected VMG's with all relevant information about the project (including an assessment of potential adverse effects of the project on the affected VMG's communities) in a culturally appropriate manner at each stage of project preparation and implementation.

56. In deciding whether to proceed with respective sub-project, initially under component 1, MOH PMU will ascertain, on the basis of social analysis, FPI-Consultation, whether the affected VMG communities provide their broad support to the project. Where such support will be provided, the MOH PMU will prepare a detailed report that will document:

(a) the findings of the social assessment;
(b) the process of free, prior, and informed consultation with the affected VMG communities;

[25] Such consultation methods (including using indigenous languages, allowing time for consensus building, and selecting appropriate venues) facilitate the articulation by VMG of their views and preferences.

(c) additional measures, including project design modification, that may be required to address adverse effects on the VMG and to provide them with culturally appropriate project benefits;
(d) recommendations for free, prior, and informed consultation with and participation by VMG during project implementation, monitoring, and evaluation; and
(e) any formal agreements reached with VMG and/or the VMGOs.

57. The MOH PMU will then submit the social assessment report for inspection by the World Bank and advice based on the outcome of the Free Prior and Informed Consultation with the VMG as a basis for determining whether there is such report.

58. The social assessment will be conducted using documentation review, interviews with key informants and focused group discussion with the VMG's, the VMG Organizations (VMGOs) if any, and other local civil society organizations (CSOs) identified by the affected VMG's. The process will utilize PICD tools and will generated the data and information based on the indicators summarized in Table 9.

4.0 FRAMEWORK FOR FREE, PRIOR, INFORMED CONSULTATION

Overview of application of FPI-Consultation

59. The World Bank's policy OP 4.10 requires that a process of free, prior, informed and accessible consultation leading to broad community support, with the affected vulnerable and marginalized communities throughout the THS-UC project design and implementation process. The framework will be utilize appropriate participatory approaches to achieve high level consultation for every stage of project design, implementation and monitoring and evaluation. The (FPI-Consultation) will used in conjunction with the HCWMP/P to ensure that any potential negative impacts are avoided, minimized and/compensated, and further that they share benefits accruing from THS-UC project.

60. Free, prior, informed and accessible consultation (FPI-Consultation), refers to a process whereby affected vulnerable and marginalized communities, freely have the choice, based on sufficient information concerning the benefits and disadvantages of the project and how these activities occur.

61. The participatory approach will ensure that gender, youth, persons with disabilities in the respective VMG area targeted, any negative impact is addressed and the as well share benefits accruing from the THS-UC project and its sub-projects. Free and prior informed consultation of the vulnerable and marginalized communities will be conducted at each stage of the project, and particularly during project preparation, to fully identify their views and ascertain their broad community support for the project.

Box 1. The Elements of Free, Prior and Informed Consultation

- Free – people are able to freely make decisions without coercion, intimidation or manipulation
- Prior – sufficient time is allocated for people to be involved in the decision-making process before key project decisions are made and impacts occur
- Informed – people are fully informed about the project and its potential impacts and benefits, and the various perspectives regarding the project (both positive and negative)
- Consultation – there are effective uses of consultation methods appropriate to the social and cultural values of the affected Indigenous Peoples' communities and their local conditions and, in designing these methods, gives special attention to the concerns of Indigenous women, youth, and children and their access to development opportunities and benefits.

Adapted from UN Permanent Forum on Indigenous Interests (UNPFII), the Tebtebba Foundation, the International Indian Treaty Council and others.

FPI-Consultation Tools

62. THS-UC project will utilize an evidenced approach and tools to ensure FPI-Consultation is observed throughout the life of project. The proposed FPI-Consultation tools will include stakeholder's attendance list using Template 1 and VMG members list using Template 2 (both attached in Appendix I), photographic evidences and minutes and/or back-to-office report.

5.0 INSTITUTIONAL FRAMEWORK

Institutional arrangement

63. **The Intergovernmental Forum for Health will oversee the achievement of the Project objective.** With devolution, the Inter-governmental Forum for Health was set up to bring together health sector senior managers from National and County Governments and key stakeholders to: (i) share experiences in managing devolved health services; (ii) deliberate over issues affecting health service delivery under devolution; and (iii) forge relationships between the two levels of government. Co-chaired by the Cabinet Secretary (CS), MOH and Chair of the County Executive (CE) Forum for Health, the Intergovernmental Forum will be tasked to provide the overall strategic direction and make key decisions with respect to implementation of the Project. A Project sub-TWG will be set up under the Intergovernmental Forum.

64. As the proposed Project will be implemented by the multiple implementing entities, a coordination team will be designated at the county and national level respectively to mitigate risks. County Governments will be responsible for the implementation of Component 1, while the MOH, KMTC, and CRD will be co-responsible for the implementation of Component 2. Project implementation will be mainstreamed into the AWP of all implementing entities. Project Management, under Component 3, will be the responsibility of the MOH PMT. To facilitate key decisions that affect the project implementation at both levels of government and coordination among various implementing entities, the Project sub- TWG will be created under the Intergovernmental Forum for Health.

65. **VMG's Level (Community level).** The Community Health Committee (CHC) and Community Health Volunteers (CHV) will form the VMG's health governance structure at the community level. The CH consisting of chair from the V developing primary health care work plans to be implemented by the community health volunteers. The CHC will consist of a mix of VMGs representatives, MHO in charge of the health facility and others like public health officer etc. The CHV are VMGs selected from the various villages to support in health concerns, community mobilization, and responses.

Community Strategy

66. The community health strategy (CHS) was initiated in 2006 to fast track the establishment of Community Units so as to bring service to the community, by empowering communities with health information and essential services. The CHS is designed against the background precepts of Constitution of Kenya, 2010 *"of health care"* for all and Vision 2030 aim of *"providing quality health care system"* and utilizing department of public health Key Essential Package for Health (KEPH) approach which recognizes the community as critical level of health service delivery.

67. KEPH is designed as an integrated collection of cost-effective interventions that addresses common diseases, injuries and risk factors, including diagnostic and health services, to satisfy the demand for prevention and treatment of these conditions (Ministry of Health, 2006) (see Table 7)

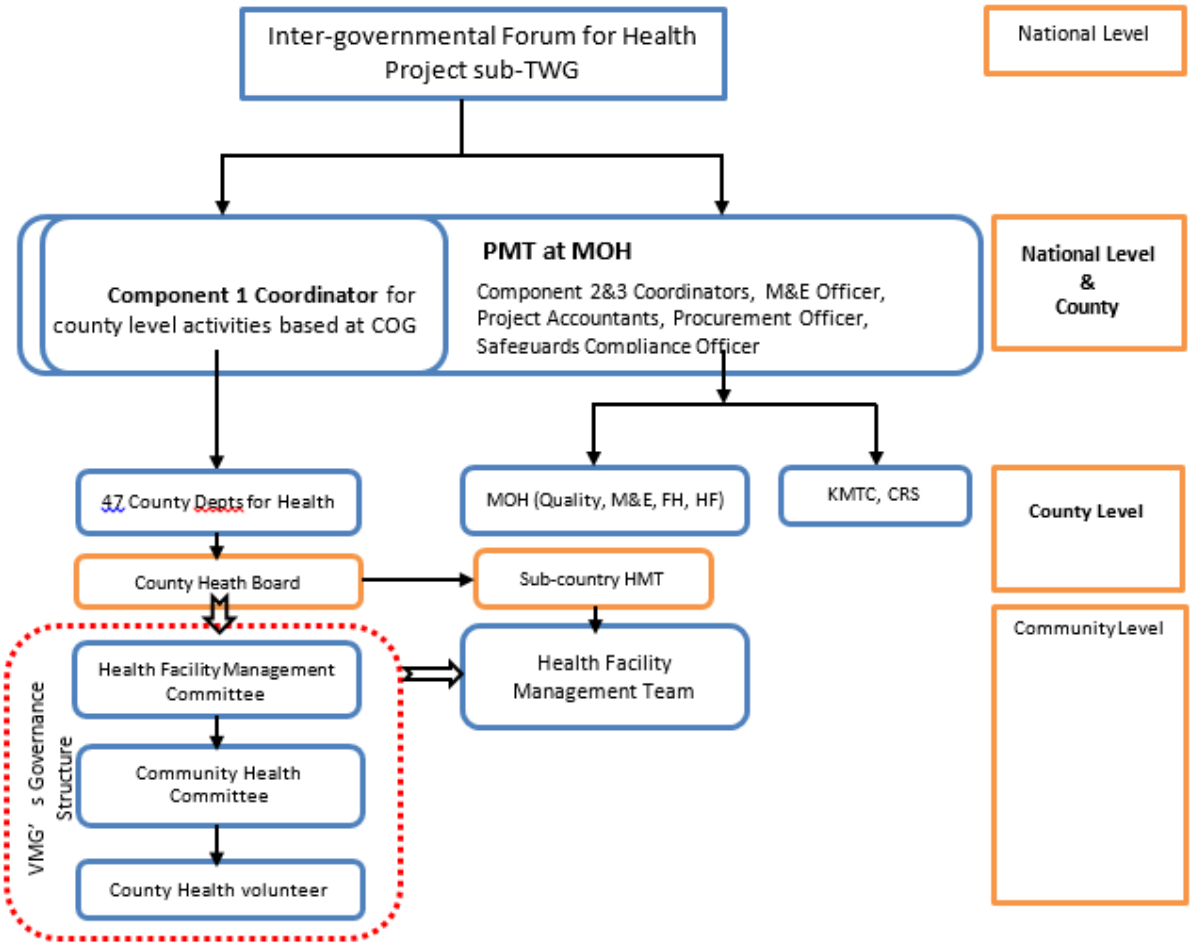


Figure 2: THS-UC Institutional Framework

Table 7: KEPH Cohorts adopted by Ministry Health, 2016

Cohorts	Description
• Pregnancy and the newborn (up to 28 days):	The health services specific to their is age-cohort across all the policy objectives
• Childhood (29 days – 59 months);	The health services specific to the early childhood period
• Children and youth (5 – 19 years)	The time of life between childhood and maturity
• Adulthood (20 -59 years)	The economically productive period of life
• Elderly (60 years – above)	The post-economically productive period of life

68. The CHS actualizes the KEPH, with an overall goal of enhancing community access to health care in order to improved productivity and thus reduce poverty, hunger, child and maternal deaths, as well as improved education performance across all the development goals set out under the Vision 2030. The goal of CHS approach is to improve the health status of Kenyan community through the initiation and implementation of life-cycle focused health actions at level one. This is achieved through:

(a) Providing level one services for all cohorts and socio-economic groups including the differently-abled", taking their needs and priorities
(b) Building the capacity of community health extension workers (CHEWs) and community owned resources persons (CORPs) to provide services at level one

(c) Strengthening health facility-community linkage through effective decentralization and partnership for the implementation of level one services
(d) Strengthening the community in progress realize their rights to accessible and quality care and to seek accountability from facility-based health services

69. Community level activities focus on effective communication strategy will contribute towards the achievement of the health sectors goals and the Kenya's Vision 2030, while also fulfilling the government's responsibility to her citizens as spelt out in the constitution.

70. The CHS strategy's objectives is to enhance community access to health care by:

(a) Providing a clear and informed road maps for communication planning, implementation and monitoring of coherent and coordinated programming
(b) Providing a framework for coordination of communication interventions for CHS
(c) Increasing awareness about the CHS at all levels
(d) Building commitment from the government and partners to provide resources for CHS
(e) Providing capacity strengthening for CHS communication implementers at all levels to manage the ACSM program though affective planning, implementation, monitoring and evaluation
(f) Increase uptake of health services by all cohorts facilitated by transfer of knowledge and skills at household and community level

71. The CHS achieve this through five broad strategies (see Table 8).

Table 8: CHS strategy by Ministry Health, 2016

CHS Strategy	**Description**
Strategy One	Advocacy to policy makers, program planners and media
Strategy Two	Capacity strengthening in management for health communication
Strategy Three	Behavioral change communication
Strategy Four	Mobilization and coordination of communication partners and stakeholders
Strategy Five	CHS knowledge Management and Documentation

72. The CHS is implemented through a five step approach (see Table 9)

Table 2: CHS steps (Ministry Health, 2016)

CHS Steps	Details	Information
1. Understanding the CHS situation	The process entails interviews with community members, health care provided and community implementers (CHEWs, CHCs, CHWs, Community leaders, and local CBO and NGO implementers)	• Understanding of CHS across all stakeholders • Identified information needs • Key audience • Problems and challenges • Existing opportunities • Threats • Resources
2. Focusing and designing the CHS communication	Step uses Social-ecological model to show how an individual (self) is directly influence by the family, peers and community which in turn operate in complex environments	Advocates that people need • Information that is: o timely, o accessible o relevant

	of indirect influencers such as policy makers and decision makers	• Motivation and ability to act
3. Creating of messages and materials for CHS approach	The process entails communication strategy for policy makers, programme planners, media	• Advocacy • Social mobilization • Behavioral change communication • Mobilization and communication partners and stakeholders • Knowledge management and documentation
4. Implementing and monitoring the CHS communication strategy	Development to plans	Implements and monitors activities
5. Evaluating and re-planning of CHS communication intervention	Evaluation impacts and allows steering of the plans	Continuous assessment Mid –term assessment

Capacity Building

73. As the target groups become clearer and awareness of the social and economic inclusion principle of the project is widely shared, the VMG's members will be invited to participate in training and capacity building sessions. The VMG's may have specific capacity building needs, and dedicated skills training funded through potentially dedicated funding. Youth from the VMG's like in other communities, may need separate training programs, tailored to their needs and lifestyle.

74. ***Social inclusion***: The stakeholder will be trained on strategies for enhancing social inclusion such as: (i) good communication, (ii) social awareness actions, (ii) creation and utilization of databases on vulnerable communities and groups such as: marginalized communities, women, youth, person with disabilities, aged members of the community. The skills gained will be used to mobilize and create awareness among the VMGs, develop Community Development Plans, build capacity on VMG and support the VMG to implement, monitor and evaluate their action plans

75. ***Community Health Strategy Module:*** The national and county government, health services providers and VMG's will be capacity build on the CHS process and VMGF principles and elements (Table 10)

Table 3: Capacity building at national, county and community level for THS-UC

Level	Key target groups	Type of Training
National level	• MoH PMU	• Sensitization on the THS-UC project design and delivery details • CHS process
County level	• County Health Departments • Country Health Boards • MoH • Sub-county Health Management Team	Community Health Strategy • Social safeguard framework • Application of the screening tools (checklists)Conflict Resolution and the grievance mechanism

Community level	• Health Facility Management Team • Health Facility Management Committee • Community Health Units (CHCs, CHVs)	Community Health Strategy • Social safeguard framework • Application of the screening tools (checklists) • Conflict Resolution and the grievance mechanism • Social Audits • Report Writing • Citizen and Stakeholder Engagement

Citizen Engagement

76. The CE will contribute to achievement of the PDO through (i) improved demand for health services as a result of enhanced community participation in decision making and management processes (ii) improved governance as a result of strengthened health facility governance structures, (ii) empowered communities as a result of functional Community Units (CU) and increased community participation in health service delivery and (iv) improved quality of health services as a result of feedback systems and grievance redress mechanisms (Annex 14).

77. The practical CE activities will be undertaken at both county and health facility levels based on the Ministry of Health's Implementers' Manual for Social Accountability in the Health Sector: for County Health Managers and Other Health Stakeholders, published in 2014. This coupled with the Community Strategy, are, ideally, the blueprint for CE activities in the health sector. For the county level, the county governments and County Health Management Teams (CHMTs) are critical in leading the process.

78. Activities and corresponding results indicators will be centred on the three components of CE,

(a) **Information Sharing:** To what extent is health and operational information made publicly and interactively available,
(b) **Community Participation:** This is primarily hedged on the Community Strategy, and specifically Community Units being made more functional as well as Community Based Monitoring (CBM) mechanisms being established while also strengthening existing mechanisms such as having community representatives in the boards and management committees of health facilities and
(c) **Grievance Redress Mechanisms (GRM):** To what extent are feedback and grievance redress mechanisms available at the community level.

Vulnerable and Marginalized Groups Plans

79. This Vulnerable and Marginalized Groups Framework contains specific measures to ensure that the VMGs receive social and economic benefits that are culturally appropriate, including measures to enhance the capacity of the project implementing agencies and other stakeholders. This VMGF calls for the preparation of a VMGP for each sub projects screened and found to be implemented in areas where VMGs are present or have a collective attachment. The Vulnerable and Marginalized Groups Plan will be prepared through an appropriate participatory approach that are highly participatory, flexible and pragmatic manner, and its step-wise details will be detailed in a Project Implementation Manual..

Elements of a Vulnerable and Marginalized Groups Plan

80. All the VMGPs will be prepared by MoH, as per the budgets (see Table 11), with the plans bearing the following elements, as needed:

(a) A summary of a scale appropriate to the project, of the legal and institutional framework applicable to VMG's. Relevant baseline information on the demographic, social, cultural characteristics of the affected Indigenous Peoples' communities, and the natural resources on which they depend within project affected area.
(b) A summary of the social analysis/assessment findings
(c) A summary of the framework and results of the free, prior, and informed consultation with the affected VMGs that was carried out during project preparation and that led to broad community support for the project.
(d) An action plan of measures to ensure that the VMGs receive social and economic benefits that are culturally appropriate, including, if necessary, measures to enhance the capacity of the project implementing agencies.
(e) When potential adverse effects on VMGs are identified, appropriate action plans of measures to avoid, minimize, mitigate, or compensate for these adverse effects.
(f) The cost estimates and financing plan for the VMGP. Accessible procedures appropriate to the project to address grievances by the affected VMGs arising from project implementation. When designing the grievance procedures, the borrower takes into account resolution of grievances at lowest levels possible; the availability of judicial recourse and customary dispute settlement mechanisms among the VMGs'.
(g) Mechanisms and benchmarks appropriate to the project for monitoring, evaluating, and reporting on the implementation of the VMGP. The monitoring and evaluation mechanisms should include arrangements for the free, prior, and informed consultation with the affected VMGs'.

Grievance Redress Mechanisms

81. A grievance redress mechanism will be developed for addressing the grievances from the affected VMGs related to component 1. The procedure of grievance redress will be incorporated in the project information pamphlet to be distributed prior to implementation. Participatory consultation with VMGs will be undertaken during project planning and implementation stages.

82. THS-UC project will establish a mechanism to receive and facilitate resolution of affected VMGs concerns, complaints, and grievances about the project's safeguards performance with assistance of their VMG organization and other non-state primary health care actors. Under the Grievance Redress Mechanism (GRM), a Grievance Redress Committee (GRC) will be formed VMG locality with relevant representatives & other relevant local stakeholders. The GRCs are to be formed and activated during the VMGPs implementation process. Assistance to VMGs will be provided by the THC-UHC project to document and record the complaints. The grievance redress mechanisms is designed with the objective of solving disputes at the earliest possible time and at the lowest levels where the project affected persons reside for quick resolution. The traditional dispute resolution structures existing for each of the VMGs will be used as the first step in resolving grievances.

83. The VMG's will be provided with a variety of options for communicating issues and concerns, including in writing, orally, by telephone, over the internet or through more informal methods as part of the grievance redress mechanism. In the case of marginalized groups (such as women and young people), a more proactive approach may be needed to ensure that their concerns have been identified and articulated. This will be done, for example, by providing for an independent person to meet periodically with such groups and to act as an intermediary. Where a third party mechanism is part of the procedural approach to handling complaints, one option will be to include women or youth as representatives on the body that deals with grievances. It should be made clear that access to the mechanism is without prejudice to the complainant's right to legal recourse. Prior to the approval of individual VMGPs, the affected VMGs will have been informed of the process for expressing dissatisfaction and seeking redress. The grievance procedure will be simple and administered as far as possible at the local levels to facilitate access, flexibility and ensure transparency.

6.0 MONITORING AND EVALUATION

84. All project results indicators will be disaggregated by cohort (men, women, mother, neonates, child and adolescent). The project will also enhance inclusion of vulnerable hard-to-serve female headed households, child-headed households those living in the targeted counties or those from marginalized communities of Kenya.

85. The Kenya demographic and health survey of 2015 will be used as the baseline for the project. The key finding are as follows (see annex 13):

- Women have an average of 3.9 children.
- The contraceptive prevalence rate of any contraceptive method among married women is 58%.
- Infant mortality rate is 39 deaths per 1,000 live births and under-five mortality rate is 52 deaths per 1,000 live births.
- 61% of births were delivered in a health facility.
- 68% of children received are fully vaccinated.
- 26% of children under 5 are stunted (too short for age).
- 48% of Kenyan household population has access to an ITN.
- 53% of women and 46% of men were tested for HIV in past 12 months and received the results of the test.
- 21% of women in Kenya are circumcised.

86. The implementation of VMGPs will be monitored (see Table 11). The PMU at the MOH will establish a monitoring system involving the MOH staff at national and county level, as well as community groups of VMGs to ensure effective implementation of VMGP. A set of monitoring indicators will be determined during VMGP implementation and will be guided by the indicators contained in the VMGF document**.** The PIU support consultants will carry out monitoring as will the World Bank social staff. Appropriate monitoring formats will be prepared for monitoring and reporting requirements.

87. For any micro-project found to have significant adverse impacts on VMGPs, external experts or NGOs will be engaged by the MOH PMU to verify monitoring information of the VMGP for those micro-projects. The MOH PMU and NGOs will collect baseline data including qualitative information and analyze the same to assess the impacts of the project on groups that meet the OP 4.10. The experts will advise on compliance issues and if any significant issues are found, the PIU will prepare a corrective action plan or an update to the approved VMGP. The MOH PMU will follow up on implementing the corrective actions to ensure their effectiveness.

88. **Monitoring Indicators: s**everal key indicators and topics for monitoring and evaluation of VMGP are (i) process of consultation activities; (ii) inclusion of community health governance structures and processes; (iii) primary health status of VMGPs in comparison with pre project condition (iv) VMGs wellbeing status of as identified in the SA; (v) any disadvantaged conditions to VMGs that was not anticipated during the preparation of VMGPs, that required corrective actions; and (vi) grievance redress issues. The VMGP will collect required data/information and regularly analyze project outputs and impacts considering impact on VMGs, and semi-annually report the results to the Bank.

89. ***Annual Reporting and Performance Review Requirements***. Annual progress reports will be prepared by the PIU and the preparation of the progress reports will be supported by the environmental and social safeguards specialists in the project at the county and community levels. These reports will be submitted to the Bank.

90. ***Budget.*** All costs for implementation of the safeguards instruments (VMGF and HCWMP) will be financed by THS-UC. The costs of the VMGF and EMSF will be estimated during appraisal based on interviews with community members, relevant national and county government officials. This will be updated after the detailed survey and investigation as well as further consultations with VMGs.

91. ***Assessment of capacity and preparedness for appraisal***. MoH will need to build the capacity to apply, implement and monitor the safeguards instruments. The county staff and all other relevant stakeholder will be trained on the required polices and use of the social and environmental screening tools.

92. All the VMGPs will include a consultation and stakeholder engagement strategy to ensure that PAPS are informed, consulted, and mobilized to participate in the relevant projects, a **Grievance Redress Mechanisms** related to project implementation; and a process for Bank and Government **Disclosure** to the public in accordance with Bank Policy on Disclosure of Information. Consultations with local stakeholders (e.g. from the relevant national and County line Ministries and representatives of VMGs will be undertaken during the preparation of the social and environmental documents.

Table 4: Monitoring and Evaluation Indicators for THS-UC VMGF

Component	Basis for	VMGF & KDHS Indicators	Responsibility	Data Sources
	Governance			
VMGF	• Process of consultation activities; • Inclusion of community health governance structures and processes; • Primary health status of VMGs in comparison with pre-project condition • VMGs wellbeing status of as identified in the SA; • Any disadvantaged conditions to VMGs that was not anticipated during the preparation of	• No of consultative activities (awareness, capacity building, etc for the VMG's • VMGF Governance structure established • RMNCA project activities carried out • No of VMGs reached per cohort per service • Complaints uptake and responses • Grievances redressed	MoH County Government VMG's CHC/V Stakeholders MoPSYG	KDHS THS-UC Community health unit reporting tool

	VMGPs, that required corrective actions; and • Grievance redress issues.			
Component 1	**MDG Outcome**			
VMG's in general (all (cohorts)	SD-Goal 1: Eradicate extreme poverty and hunger	• Prevalence of underweight children under 5 years of age	MoH MoA CHC/V	KDHS THS-UC
	Goal 2: Achieve universal primary education	• Net attendance ratio in primary education • Literacy rate of 15-24 year olds	MoH MoEduc Partners CHC/V Stakeholders	KDHS THS-UC
	SD-Goal 3: Promote gender equality and women's empowerment	• Ratio of girls to boys in primary, secondary, and tertiary education	MoH MoEduc Partners CHC/V Stakeholders	KDHS THS-UC
	SMD-Goal 6: Combat HIV/AIDS, malaria, and other diseases	• Condom use at last high-risk sex (MSM, WSW, Anal sex) • Population age 15-24 with comprehensive knowledge of HIV • Ratio of school attendance of orphans to school attendance of non-orphans age 10-14	MoH MoEduc Stakeholders CHC/V	KDHS THS-UC
	SD-Goal 7: Ensure environmental sustainability	• Population using an improved water source • Population using an improved sanitation facility	MoH MoEduc MoEWNR CHC/V Stakeholders	KDHS THS-UC
Reproductive health	• Improved child spacing (better child survival) • Improved maternal health	• use of modern contraceptive methods (mCPR)	MoH Stakeholders	KDHS THS-UC
Maternal	MD-Goal 5: Improve maternal health	• Adolescent birth rate • Contraceptive prevalence rate (mCPR) • Antenatal care coverage (ANC_4)	MoH Partners CHC/V Stakeholders	KDHS THS-UC

		• Births attended by skilled health professional (SBA)		
Neonatal	• Increased neonate survival • Increased child registration and consequent inclusion in planning	• Neonatal mortality rate (within 28 days) • Fresh Still Birth (FSB)	MoH Stakeholders/partners CHC/V	KDHS THS-UC
Child	• Reduced mortality • Improved child protection	• Under-five mortality rate • Infant (upto 1 year) mortality rate • Proportion of 1 year-old children immunized against measles (9 month and 18 months)	MoH MoEduc Partners CHC/V	KDHS THS-UC
Adolescent	•	• Reduced unwanted pregnancy • Continuity with education mostly where girls drop out of school after pregnancy • Improved health due to reduced bad practices such as FMG • Access to sexual and reproductive health services	MoH MoPSYG Partners CHC/V	KDHS THS-UC

7.0 DISCLOSURE

93. This VMGF and sub project VMGPs will be made available to the affected VMGs in an appropriate form, manner, and language. Various project design, launching, implementation, monitoring and evaluation, and implementation completion sessions will be disclosed and/or communicated throughout the project phase. Once the Bank accepts the documents as providing an adequate basis for project appraisal, the Bank will make them available to the public in accordance with Bank Policy on Disclosure of Information, and the GOK will also make the documents available to the affected communities in the same manner as the earlier draft documents.

94. Each project VMGP will be disclosed to the affected VMGs with detailed information of the project. This will be done through public consultation and made available as brochures, leaflets, or booklets, using local languages. Summary of the VMGP will be made available in hard copies and in language at: Offices of the MoH; Sub County or County Office; and any other local level public offices.

95. Electronic versions of the framework as well as the VMGPs will be placed on the official website of MoH and the official website of Bank after approval and endorsement of the VMGF and each VMGP by the Bank.

96. The National Public consultation of the Vulnerable and Marginalized Framework, (VMGF) and health care waste management plan was held at the (Nairobi, at Silver Springs Hotel) on March 21st, 2016. It was attended by about 60 participants from 9 counties (Baringo, Kwale, Bungoma, Narok, Nakuru, Kiambu, Nairobi, Samburu, and Kilifi). These included representatives from National Government (20), several project implementing agencies (MOH, KMTC); Representatives of VMGs/IPOs (Ogiek, Dorobo, Ilchamus, Endorois, Maasai, Samburu, Turkana, Ilkonono, Waatha, Wakifundi and Watswaka) and NGOs (ERMIS Africa) (Annex 12)

97. Through the national disclosure workshop, the VMGs provided overall support for the project with highlights on areas of enhancement of the framework and project. The initial field consultations were applauded as well as the efforts done in holding a national disclosure workshop. The VMGs requested for the following adjustments: (i) Consideration of traditional knowledge through training of traditional birth attendants; (ii) increased and official assurance on the safety of vaccines; (iii) adequate staffing of health facilities in the VMG areas; (iv) provision of health services in areas faced with inter-community conflicts; (vii) access of services to pastoralist even as they migrate from place to place; (viii) continued and structured provision of scholarship opportunities to VMGS in medical colleges; (ix) representation of VMGs in health in local and county health governance structure; (x) sharing of final VMGF with VMGs through appropriate forum; (xi) consideration for new health infrastructures in VMGs localities currently with no infrastructure; (xii) safeguard the project from political capture; and (xiii) referral of need for communication infrastructure development to other relevant ministries (Annex 11). The framework will be disclosed on the MoH Website. Finally, the Framework will be uploaded in the World Bank Infoshop. Response for details on issues raised and responses by MoH (see Annex 11).

8.0 INDICATIVE BUDGETS FOR IMPLEMENTING THE VMGF

98. The budgets for implementing the VMGF will be as presented in Table 12.

Table 5: Monitoring and Evaluation Indicators for THS-UC VMGF

Level	Type of Training	Budgets [KES]
National level	• Sensitization on the THS-UC project design and delivery details • CHS process	*1 Training Sessions* Hiring of venue – KES 2,000,000 Training Materials = KES 700,000 Transport = KES 500,000 Technical Assistance = KES 3,000,000
County level (47)	Community Health Strategy • Social safeguard framework • Application of the screening tools (checklists) • Conflict Resolution and the grievance mechanism • Social Audits • Report Writing • Citizen and Stakeholder Engagement	*5 Training Sessions (County)* Hiring of venue – KES 12,000,000 Training Materials = KES 4,200,000 Transport = KES 3,000,000Technical Assistance = KES 22,500,000
Project implementing Staff	Community Health Strategy • Social safeguard framework • Application of the screening tools (checklists) • Conflict Resolution and the grievance mechanism • Social Audits • Report Writing • Citizen and Stakeholder Engagement	*5 Training Sessions (County)* Hiring of venue – KES 12,000,000 Training Materials = KES 6,000,000 Transport = KES 3,000,000 Technical Assistance = KES 22,500,000
Community level	Community Health Strategy • Social safeguard framework • Application of the screening tools (checklists) • Conflict Resolution and the grievance mechanism • Social Audits • Report Writing • Citizen and Stakeholder Engagement	*5 Training Sessions Community level)* Training Materials = KES 10,000,000 Transport = KES 6,000,000
Total		***107,000,000***

REFERENCES

ALRMP, 2004. Final Report of the Social Analysis Study. Study and report by Tacitus Ltd: The participatory Development Consultants.

GoK, 2009. Indigenous Peoples Planning Framework for the Kenya Adaptation to Climate change in Arid and Semi-Arid Lands (KACCAL) project. Financed by GoK and World Bank

Julius Muchemi and Albrecht Ehrensperger (2010). Ogiek People Ancestral Territories Atlas: Safeguarding territories, Cultures and Natural Resources of Ogiek Indigenous People in the Eastern Mau Forest, Kenya; Published by ERMIS Africa and CDE, 2009: ISBN 978-9966-7321-0-1

Julius Muchemi, David Kiptum, Onesmus Murkomen and Solomon Cherongos (2010). Mapping Sengwer (Cherangany) Ancestral entitlements in Cherangany Hills. The Past, Present and Future of Sengwer (Cherangany) Indigenous People.

Ministry of Health, 2012. Community health strategy for community health services. http://www.slideshare.net/chskenya/chs-kenya-national-communicationstrategyforcommunityhealthservices20122017

Ministry of Lands. 2007. *Land Policy*, May 2007. Nairobi: Ministry of Lands, Republic of Kenya.

Muchemi J., Crawhall N., Pedone G. Koinante J. Kiptum Y. Kuria K. 2009. Kenya case study: Participatory 3-Dimensional Modelling; published in African Indigenous Peoples' Workshop on effective use of Information Communication Technology (ICTs) in environmental advocacy, IPACC/CTA, Cape Town, South Africa.

PLA 54: 2006. Participatory Learning and Action: Mapping for Change: practice, technology and communication: CTA, IIED: Editors Jon Corbett, Giacomo Rambaldi, Peter Kyem, Dan Weiner, Rachel Olson, Julius Muchemi, Mike McCall and Robert Chambers. http://www.iapad.org/review_pla54.htm, for multilingual CD http://pgis2005.cta.int/pla_cd.html: ISSN: 1357-938X and ISBN: 1 84369 605 3

Republic of Kenya 2012. The County Governments Act, 2012. Edited by Republic of Kenya. Nairobi: National Council for Law Reporting.

Republic of Kenya, 2003. Persons with Disabilities Act (No. 14 of 2003)

Republic of Kenya, 2008. The National Reproductive Health Policy, 2008

Republic of Kenya, 2012. Constitution of Kenya, 2010

Republic of Kenya, 2013. The Kenya National Youth Charter 2013

Republic of Kenya, 2013. The Kenya National Youth Charter 2013

Republic of Kenya, 2014.The Rights of Persons with Disability Bill (RPD) 2014

Through the Eyes of Hunter-Gatherers: participatory 3D modelling among Ogiek indigenous peoples in Kenya: Editors Giacomo Rambaldi, Julius Muchemi, Nigel Crawhall, Laura

Monaci: http://idv.sagepub.com/cgi/content/abstract/23/2-3/113: Information Development, Vol. 23, No. 2-3, 113-128 (2007) DOI: 10.1177/0266666907078592

Uquillas, Jorge. 2009. Kenya NRM Project and Western Kenya CDD and Flood Mitigation Project: Report on the Measures to Improve Implementation of the World Bank Operational Policy on Indigenous Peoples. World Bank.

World Bank. 2010. Draft Screening of Vulnerable Indigenous Peoples in Kenya. Draft report prepared by Julius Muchemi (consultant) for the proposed Kenya Electricity Expansion Project.

ANNEXES

Annex 1: Contents of Vulnerable and Marginalized Groups Planning Framework (VMGPF)

OP 4.10, Indigenous Peoples Planning Framework also referred to Vulnerable and Marginalized Groups Planning Frame work (VMGPF)	**These policies were prepared for use by World Bank staff and are not necessarily a complete treatment of the subject.**
1. The Indigenous Peoples Planning Framework (IPPF) or Vulnerable and Marginalized Groups Planning Framework sets out: (a) The types of programs and projects likely to be proposed for financing under the project. (b) The potential positive and adverse effects of such programs or projects on Indigenous Peoples. (c) A plan for carrying out the social assessment for such programs or projects. (d) A framework for ensuring free, prior, and informed consultation with the affected Indigenous Peoples‘ communities at each stage of project preparation and implementation . (e) Institutional arrangements (including capacity building where necessary) for screening project-supported activities, evaluating their effects on Indigenous Peoples, preparing IPPs, and addressing any grievances. (f) Monitoring and reporting arrangements, including mechanisms and benchmarks appropriate to the project. (g) Disclosure arrangements for Vulnerable and Marginalized Groups Plans to be prepared under the VMGPF (h) Indicative budget for the implementation of the VMGPF	

Annex 2: Criteria for screening VMGs using World Bank OP 4.10 and Constitution of Kenya, 2010

	Criteria
World Bank OP 4.10	1.0 Identity
	Self-identification
	Recognition of this identity by others
	2.0 Collective attachments
	Distinct habitats
	Ancestral territories
	Natural resources
	3.0 Distinct Customary institutions
	Cultural Institutions
	Economic Institutions
	Social Institutions
	Political Institutions
	4.0 Indigenous Language (provide example)
	Indigenous language
	Neighboring languages
	National Language
Constitution of Kenya, 2010	5.0 Social assessment
	Population (small)
	Unique culture
	Traditional lifestyle
	Traditional Livelihood
	Geographic location
	Distinct Language

Annex 3: Checklist for Tracking VMGP Implementation

To be filled by THS-UC MOH PMU at community and county level projects and World Bank as part of review and monitoring

Criterion		Y/N	Explanation
Screening			
1. Have all VMGs in project area been identified (is screening adequate)?			Not stated
			The names of some groups have been mentioned; baseline survey has been proposed; Aggregates all groups together
			Detailed description of all indigenous groups is given
Social Assessment			
2. Has a social assessment been done (Is baseline data given)?			Not stated. Follow up and verify. Must be commensurate to impacts.
			Proposed to collect all relevant data - no specifics; data briefly stated; or not updated, data not disaggregated
			Disaggregated population data of IP; relevant socio-economic indicators have been stated; data that needs to be collected are listed;
3. Has legal framework been described?			Not stated. Verify and include.
			Brief mention of framework given. Expand on relevant sections.
			Constitutional provisions, legal statutes and government programs in relevant sectors related to indigenous peoples stated
4. Have benefits/ adverse impacts to VMGs groups been identified?			Not Discussed
			Potential impacts have been briefly discussed
			Potential positive and negative impacts identified and discussed
Consultation, Participation, Community Support			
5. Have VMGs been involved in free, prior and informed consultation at the project implementation stage? Are there any records of consultation?			Not determinable. Follow up.
			Brief mention that consultations have taken place; no details provided. Verify and secure documentation and follow up.
			Detailed description of process given; appropriate methods used, interlocutors are representative
6. Does project have verifiable broad community support (and how has it dealt with the issue of community representation)?			Not stated
			States that IP groups will be involved in preparing village/community action plans; participation process briefly discussed
			Detailed description of participation strategy and action steps given
7. Is there a framework for consultation with VMG during the project implementation?			No
			Passing mention
			Detailed arrangements
Indigenous People Plan			
8. Is there a specific plan (implementation schedule)?			Not stated. Develop one.
			Flexible time frame (activities need to be proposed); given activity wise; year-wise distribution; mentioned but integrated into another project document (RAP, etc.); no separate treatment; combined with RAP;
			Detailed description given

9. Does the VMGP include activities that benefit VMGs?			Not stated
			Activities stated but not detailed
			Activities clearly specify
10. Are activities culturally appropriate?			Not stated
			Cultural concerns noted but not explicit
			Activities support cultural norms
11. Have institutional arrangements for the VMGP been described?			Not stated
			Mentioned but integrated into another project document RAP, etc.); no separate treatment
			Detailed description of agencies involved in implementation of plan, including applicable IPO's or tribal organizations.
12. Is a separate budget earmarked for the VMGP?			Not stated. Develop one
			Mentioned but integrated into another project document (RAP, etc.); not broken down activity-wise
			Detailed description given
13. Are there specific monitoring indicators?			Not mentioned
			Proposed that monitoring indicators shall be designed later; Project outcomes that need to be monitored are stated
			Monitoring indicators disaggregated by ethnicity
14. Has a complaint/conflict resolution mechanism been outlined?			Not mentioned. Needs to be effected.
			Passing mention of mechanism in document
			Detailed description and few concrete steps of mechanism given
15. Were the VMP/VMGF disclosed in Infoshop and in Country in an appropriate language?			No, then need to consult and disclose.
			Disclosed in Infoshop make it available at county and community level
			Detailed Summary in appropriate form, manner and language
Special Considerations			
17. What other consideration can be taken to be pro-active to assure that VMGs are aware of the project, participate and benefit from of benefits in the commercial development of natural and cultural resources?			None
			Passing mention
			Detailed considerations
18. Does the sub-project require the physical relocation of IPs?.		N	The project will NOT physically relocate families and/or individuals under the CDD component. Should a proposed sub-project require physical relocation other options should be considered as there will be no relocation undertaken for the CDD projects at community level.

Annex 4: Profile of some VMGs in Kenya

Agro Pastoralists/Fishing

Wasanye

1. Originally, Mpeketoni and its surroundings were inhabited by Swahilis called Wabajuni and a small hunting and gathering tribe by the name of Wasanye or the Sanye who are almost extinct. In the early 1970s Mpeketoni was transformed into a settlement area for landless Kenyans. Most of those who settled there were Kenyans from up country who had been living in Tanzania but decided to return home due to changing political climate. It emerged during these consultative meetings that the Saanye currently occupy the areas of Mapenya, Mkunumbi, Ndambwe, Witu and Kipini in Mpeketoni.

2. They are currently doing subsistence farming, fishing at Kizuke beach as well as harvesting honey in the forest in the Witu forest. There has been a debate on whether the Sanye are part of the Watha community that occupies parts of Kwale, Kilifi, Tana River and Taita Taveta within the Kenyan coast. Currently, the community has three young men who have completed form four and a young girl who is now in form two. This community claims to have been dominated by the neighbouring Bajuni and the landless settlers from up country who settled in Mpeketoni area in the 1970s.

El molo

3. The **El Molo**, also known as **Elmolo**, **Dehes**, **Fura-Pawa** and **Ldes**, are an ethnic group mainly inhabiting the northern Eastern Province of Kenya. They historically spoke the El Molo language as a mother tongue, an Afro-Asiatic language of the Cushitic branch. The El Molo today primarily inhabit the northern Eastern Province of Kenya. They are concentrated in Marsabit District on the southeast shore of Lake Turkana, between El Molobay and Mount Kulal. In the past, they also dwelled in parts of the Northern Frontier District.

4. El molo is a community or a tribe that lives along the shores of Lake Turkana on the southeastern side of the lake. They are the smallest community in Kenya because they have a population of about 300 people. The name of this tribe (El molo) originated from a phrase of Maasai community meaning "those who make a living from other sources other than cattle". The original homeland of El molo is not known because some people are saying that they came from Somalia while others are saying that they came from Ethiopia. With increase in the intermarriages between the El molo and Samburu and Turkana people, there is increase chance of extinction of the El molo community. In fact there are few people from El molo community who speak the language purely. The language is only spoken well by the elders.

5. The life of the El Molo is generally based on fishing, using spears or harpoons, fishing rods (made from the roots of an acacia with doumpalm fiber and a forged iron point or hook) and nets(made from doumpalm fiber).

6. Currently the El Molo are affected by increased pollution of the Lake, lack of sanitary facilities and lack of access to fresh drinking water.

IL-chamus of Baringo

7. Il Chamus are ma-speaking plain Nilotes closely related to the Samburu. Originally, the community practiced pastoralism but due to cattle rustling by the Pokot community, they have started farming through irrigation with water drawn from Lake Baringo and fishing within the same lake. They are originally a pastoralist people who used to live on the mainland but due to clashes they have been forced to migrate to an island in Lake Baringo. It is a very traditional and culturally bound society, hierarchical and male-dominated. They live from fishing in small boats made of balsam tree that dates back maybe a thousand years. They also make some souvenirs and have some livestock. Many are uneducated and with little or no formal education. They communicate mainly in their local language. Their population is estimated at 34,000. They are located in the Country: Southeast and south shore of Lake Baringo, and southwest shore as far north as Kampi ya Samaki.

8. Livelihood: The majority of the Ilchamus practice both livestock rearing and agriculture, but on the islands in Lake Baringo there are about 800 Ilchamus who live nearly entirely from fishing. The mainland Ilchamus are semi-pastoralists with a long history of small scale agriculture. The main types of livestock owned by the Ilchamus are cattle (zebus), sheep (red maasai and dopper cross) and goats (small east African), but their herds are significantly smaller than those of their neighbours. The key problems here are the insufficient security against aggressions from their neighbours, access to water and pressure of other people on their land due to the non-existence of land titles. The nearest markets are at Marigat and Kiserian.

9. The Ilchamus fishing communities, on four of the seven islands of Lake Baringo, has a total population of around 800 people. Due to the absence of significant rains and irrigation systems, they don't cultivate anything and the grazing areas on the island sustain only very limited numbers of livestock. The only source of income is fishing (Ol Kokwai), jobs in the Baringo island camp. Income from fishing (Tilapia, Catfish and Mudfish) has reduced significantly over the last years as industrial fishing carried out in 70s and 80s from the mainland and by migrants from other areas have significantly reduced the stocks. As they are unable to stop fishing to allow the stock to recover, even their very limited fishing reduces the stocks further. The ever reducing stocks are associated by the villagers to environmental degrading (sedimentation from erosion along the contributors) and overexploitation in the 70s and early 80s, and on the other hand to the increasing population of crocodiles, which are totally protected and are said to affect not only the fish stocks, but also cause significant losses of livestock and even human lives.

10. Agriculture is carried out at very small scale and nearly entirely for subsistence due to limited rainfalls in the area and due to the fact that the Ilchamus have been displaced from their former land in which they had established small scale irrigation schemes. Two modern irrigation schemes (with small dams) at the Perkerra and Molo Rivers have enhanced the situation and enable the families involved to produce enough to even commerce parts of it. The main products cultivated are maize, beans and millet.

11. Cultural Profile: Traditionally the Ilchamus don't seem to have any central authority, but are ruled by the elders of the patrilineages. The Ilchamus claim that structures above the level of the clan were first introduced in the 60s in preparation of independence. The first sub-chief was elected around 1970. Presently, Ilchamus chiefs and councillors have been elected in all six locations where they constitute the majority, but in none where they are in

the minority. Because of their being considered as a Maasai subgroup and due to that as nomadic herders, their relation to and dependence on land for their small scale agriculture have not been considered when "developing" the area. The Ilchamus have been moved around by all kinds of people and for all kinds of activities and interests. The last major displacement took place in the 40s and 50s, when significant Ilchamus populations were moved away for the Perkerra Irrigation scheme near Marigat.

Endorois

12. Endorois community is a minority community that was living adjacent to Lake Baringo. However, the Government of Kenya forcibly removed the Endorois from their ancestral lands around the Lake Bogoria area of the Baringo and Koibatek Administrative Districts, as well as in the Nakuru and Laikipia Administrative Districts within the Rift Valley Province in Kenya, without proper prior consultations, adequate and effective compensation. Endorois are a community of approximately 20,000 people who, for centuries, have lived in the Lake Bogoria area. They claim that prior to the dispossession of Endorois land through the creation of the Lake Hannington Game Reserve in 1973, and a subsequent re-gazetting of the Lake Bogoria Game Reserve in 1978 by the Government of Kenya, the Endorois had established, and, for centuries, practiced a sustainable way of life which was inextricably linked to their ancestral land.

13. At independence in 1963, the British Crown's claim to Endorois land was passed on to the respective County Councils. However, under Section 115 of the Kenyan Constitution, the Country Councils held this land in trust, on behalf of the Endorois community, who remained on the land and continued to hold, use and enjoy it. The Endorois' customary rights over the Lake Bogoria region were not challenged until the 1973 gazetting of the land by the Government of Kenya.

14. The area surrounding Lake Bogoria is fertile land, providing green pasture and medicinal salt licks, which help raise healthy cattle. Lake Bogoria is central to the Endorois religious and traditional practices. The community's historical prayer sites, places for circumcision rituals, and other cultural ceremonies are around Lake Bogoria. . Although the High Court recognized that Lake Bogoria had been Trust Land for the Endorois, it stated that the Endorois had effectively lost any legal claim as a result of the designation of the land as a Game Reserve in 1973 and in 1974. It concluded that the money given in 1986 to 170 families for the cost of relocating represented the fulfillment of any duty owed by the authorities towards the Endorois for the loss of their ancestral land. To date, however, the Endorois community are yet to receive compensation for this eviction.

15. Livelihood: Dependent on land and fishing from Lake Bogoria. Critically, land for the Endorois is held in very high esteem, since tribal land, in addition to securing subsistence and livelihood, is seen as sacred, being inextricably linked to the cultural integrity of the community and its traditional way of life. Land, they claim, belongs to the community and not the individual and is essential to the preservation and survival as a traditional people. Endorois health, livelihood, religion and culture are all intimately connected with their traditional land, as grazing lands, sacred religious sites and plants used for traditional medicine are all situated around the shores of Lake Bogoria. At present the Endorois live in a number of locations on the periphery of the Reserve.

Pastoralists

16. Most of Kenya's pastoralists live in the arid Northern Kenya: They include, moving from east to west, the Somali (500,000) along the border to Somalia; the Borana (150,000) the Rendile (20,000), the Gabra (20,000) and the Turkana (250,000 – 350,000). The Samburu (100,000) live in the southern part of Northern Kenya. Other pastoralists are found in the southern part of the country, along the Rift Valley: the Maasai (155,000), in the southern part in the Narok and Kajiado districts bordering with Tanzania; the Endorois (60,000), near Lake Bogoria; and the Pokot (100,000) in West Pokot district in the central-western part of the country. A small group of Maasai live in Laikipia, in the center of the county, near Dol Dol. In the counties selected for the THS-UC the following pastoralist groups could meet the Op 4.10 criteria: (Rendile, Samburu, Inkumono and Maasai.

Rendille

17. The Rendille are a Cushitic tribe that inhabits the climatically harsh region between Marsabit hills and Lake Turkana in Northern Kenya where they neighbor the Borana, Gabbra, Samburu and Turkana tribes. They (Rendile) consist of nine clans and seven sub clans. They are culturally similar to the Gabbra, having adopted some Borana customs and being related to the Somali people to the east. Rendille are semi-nomadic pastoralists whose most important animal is the camel. The original home of the Rendille people was in Ethiopia. They were forced to migrate southwards into Kenya due to frequent conflicts with the Oromo tribe over pasture and water for their animals. Being pastoralists, the lifestyle of the Rendille revolves around their livestock. In the northerly areas, camels are their main source of livelihood. This is because camels are best adapted to the desert conditions that prevail in the northern Kenya. The camels are an important source of milk and meat for the Rendille people. When migrating to new pastures, the camels are also used to carry all the family possessions in a specially designed saddle. The Rendille people living in the southern and less dry part of their region have had a good relationship with their Samburu neighbors where intermarriage with the Samburu has led to the emergence of a hybrid culture. Their ceremonies are similar to the Old Testament Jewish traditions, providing a basis for discussion of Christ's sacrifice and an opportune introduction to personal salvation.

18. Traditionally the Rendille are a very religious people, believing in one God, an omnipresent creator and provider who answers prayer and cares for the poor. They practice many magical rituals, involving their camels or sheep. For example, the way a certain bull camel approaches a proposed new settlement area is taken as a good or bad omen. A propitious camel may be placed outside the camp facing the direction of an expected enemy attack in order to prevent the attack. Age-sets are the main component of Rendille society.

19. The oral history of this Cushitic tribe indicates they are of Jewish descent. They traveled through the Suez Canal through Ethiopia to their present homeland. They descended through the Cushitic family lines with the Somali people. When the Somali people were traveling from the Suez Canal through Ethiopia the Somali people chose to go toward Somalia for good pastures. The Rendille people refused to go with them and separated to their present homeland around Marsabit.

20. They had rejected the land of the Somali's and were thereafter called Rertit. The Somalis consider them rejected people. Their name "Rendille" is a colonial misinterpretation of the

word "rertit", which means separated, refused or rejected in the Somali and Rendille languages. The Rendille occupy an area in Northeastern Province of Kenya from the Merille River and Serolivi in the South to Loyangalani in the North from Marsabit and Merti in the East to Lontolio in the West. The climate of their homeland is semi arid. The Rendille people speak Rendille, which is very close to Somali but is spoken more slowly. Many Rendille also speak Samburu (the tribe neighboring them to the South). Those of the Rendille language are called Rendille and those who speak Samburu are called Arielle Rendille.

21. There are about eight or nine sub clans including the Urowen, Dispahai, Rongumo, Lukumai (Nahgan), Tupsha, Garteilan, Matarbah, Otola, and Saale with an estimated population of 63,000. They are located in the country in: Eastern Province, Marsabit District, between Lake Turkana and Marsabit Mt. The primary towns include Marsabet, Laisamis, Merille, Logologo, Loyangalani, Korr, Kamboi, Ngurunit, and Kargi.

22. **Livelihood:** The Rendille people are traditionally pastoralists keeping goats, sheep, cattle, donkeys, and camels. Their nomadic lifestyle is become more prominent in the areas exposed to little urbanization and modernization. In the recent past though, their livelihood has experienced constant competing interests from the Samburus and Gabras leading them to constant conflict over land and water resources particularly at the borderline of the boundary districts. In the most cases, the raids and conflicts have had the objective to replenish their herds depleted by severe droughts, diseases, raiding or other calamities. Elders often sanction the raids blessing raiders before they set off. During draught some take little lambs to the raga or laga (dry river bed) and sacrifice them to god asking for rain. Others go to Mount Moile where the women sing and pour milk and men offer sacrifices of goats to the gods and ask for rain

23. **Cultural Profile:** In terms of creed, many Rendille practice a traditional religion centered on the worship of Waaq/Wakh. In the related Oromo culture, Waaq denotes the single god of the early pre-Abrahamic, montheistic faith believed to have been adhered to by Cushitic groups.Some Rendille have also adopted Islam or Christianity. Initiation rituals take place precisely every seven or fourteen years, creating a series of generational age-sets, each with its own role in society. In the common Kenyan practice, the first initiation is circumcision. Men have many stages of warrior-hood, but women are simply married or unmarried.

24. Traditional dress includes beautiful beads worn by the women around the neck, wrists, and **ankles**. Children can often be seen without clothing. The moran wears colorful shukas (clothe wrapped around their bodies) and colors their hair with a mud/mineral mixture. Men often wear a wrapped cloth rather than trousers. Western clothing is becoming more popular, but more among the men than the women.

25. Ancestral spirits of deceased men must be appeased. Among some of the Rendille, after a man dies, the manyatta will be burned, a sheep slaughtered, and the family must move to another place. Rites of passage include the young men (moran) living in the bush, learning traditional skills, and undergoing traditional circumcision. Men marry after circumcision and the time of becoming a moran is as young as about eighteen to twenty years.

26. The Rendille are organized into an age grade system of patrilineal lineage groups (keiya), which are subsumed under fifteen clans (goup). Of those, only nine are considered authentic Rendille. These Northern Rendille or Rendille proper are consequently the only ones that

are included in the traditional Rendille moiety (belesi). The remaining six clans that are excluded from the moiety consist of mixed individuals. Five of those clans are of Rendille (Cushitic) and Samburu (Nilotic) descent. Collectively, the latter hybrid groups are referred to as the Ariaal or Southern Rendille.

Samburu

27. The Samburu people live in northern Kenya, where the foothills of Mount Kenya merge into the northern desert. As cattle-herding Nilotes, they reached Kenya some five hundred years ago, moving southwards along the plains of the Rift Valley in a rapid, all-conquering advance. The Samburu are related to the Masai although they live just above the equator where the foothills of Mount Kenya merge into the northern desert and slightly south of Lake Turkana in the Rift Valley Province of Kenya. They are semi-nomadic pastoralists whose lives revolve around their cows, sheep, goats, and camels. Milk is their main stay; sometimes it is mixed with blood. Meat is only eaten on special occasions. Generally they make soups from roots and barks and eat vegetables if living in an area where they can be grown. Most dress in very traditional clothing of bright red material used like a skirt and multi-beaded necklaces, bracelets and earrings, especially when living away from the big cities.

28. The Samburu developed from one of the later Nilotic migrations from the Sudan, as part of the Plains Nilotic movement. The broader grouping of the Maa-speaking people continued moving south, possibly under the pressure of the Borana expansion into their plains. Maa-speaking peoples have lived and fought from Mt. Elgon to Malindi and down the Rift Valley into Tanzania. The Samburu are in an early settlement area of the Maa group. Those who moved on south, however (called Maasai), have retained a more purely nomadic lifestyle until recently when they have also begun farming. The expanding Turkana ran into the Samburu around 1700 when they began expanding north and east.

29. The language of the Samburu people is also called Samburu. It is a Maa language very close to the Maasai dialects. Linguists have debated the distinction between the Samburu and Maasai languages for decades. Generally between five and ten families set up encampments for five weeks and then move on to new pastures. Adult men care for the grazing cattle which are the major source of livelihood. Women are in charge of maintaining the portable huts, milking cows, obtaining water and gathering firewood. Their houses are of plastered mud or hides and grass mats stretched over a frame of poles. A fence of thorns surrounds each family's cattle yard and huts.

30. Their society has for long been so organized around cattle and warfare (for defense and for raiding others) that they find it hard to change to a more limited lifestyle. The purported benefits of modern life are often undesirable to the Samburu. They remain much more traditional in life and attitude than their Maasai cousins. Duties of boys and girls are clearly delineated. Boys herd cattle and goats and learn to hunt, defending the flocks. Girls fetch water and wood and cook.

31. **Social Organization.** The Samburu are a gerontocracy. The power of elders is linked to the belief in their curse, underpinning their monopoly over arranging marriages and taking on further wives. This is at the expense of unmarried younger men, whose development up to the age of thirty is in a state of social suspension, prolonging their adolescent status. The paradox of Samburu gerontocracy is that popular attention focuses on the glamour and

deviant activities of these footloose bachelors, which extend to a form of gang feuding between clans, widespread suspicions of covert adultery with the wives of older men, and theft of their stock.

32. **Economy.** Traditionally the Samburu economy was purely pastoral, striving to survive off the products of their herds of cows, goats, and for some, camels. However, the combination of a significant growth in population over the past 60 years and a decline in their cattle holdings has forced them to seek other supplemental forms of livelihood. Some have attempted to grow crops, while many young men have migrated for at least short periods to cities to seek wage work. Many work in Kenya's capital, Nairobi, as watchmen, while it is also popular to go to Kenya's coastal resorts where some work; others sell spears and beaded ornaments.

33. **Food and society.** Traditionally Samburu relied almost solely on their herds, although trade with their neighbors and use of wild foods were also important. Before the colonial period, cow, goat, and sheep milk was the daily staple. Oral and documentary evidence suggests that small stock were significant to the diet and economy at least from the eighteenth century forward. In the twenty-first century, cattle and small stock continue to be essential to the Samburu economy and social system. Milk is still a valued part of Samburu contemporary diet when available, and may be drunk either fresh, or fermented; "ripened" milk is often considered superior. Meat from cattle is eaten mainly on ceremonial occasions, or when a cow happens to die. Meat from small stock is eaten more commonly, though still not on a regular basis. Today Samburu rely increasingly on purchased agricultural products—with money acquired mainly from livestock sales—and most commonly maize meal is made into a porridge.[8] Tea is also very common, taken with large quantities of sugar and (when possible) much milk, and is actually a staple of contemporary Samburu diet. Blood is both taken from living animals, and collected from slaughtered ones. There are at least 13 ways that blood can be prepared, and may form a whole meal. Some Samburu these days have turned to agriculture, with varying results.

Maasai

34. Kenya's most well-known ethnic tribe, the Maasai is semi-nomadic people located primarily in Kenya and northern Tanzania. They are considered to be part of the Nilotic family of African tribal groups. The Maasai probably migrated from the Nile valley in Ethiopia and Sudan to Maasailand (central and south-western Kenya and northern Tanzania) sometime around 1600 AD, along the route of lakes Chew Bahir and Turkana bringing their domesticated cattle with them. The Maasai speak the Maasai language, an Eastern Nilotic language closely related to Samburu (or Sampur), the language of the Samburu people of central Kenya, and Camus spoken south and southeast of Lake Baringo. Maasai's population is about 684,000 and is located in the Rift Valley Province, Kajiado and Narok districts.

35. **Livelihood:** The Maasai are cattle and goat herders, their economy almost exclusively based on their animal stock, from which they take most of their food: meat, milk, and even blood, as certain sacred rituals involve the drinking of cow blood. Moreover, the huts of the Maasai are built from dried cattle dung.

36. **Cultural Profile:** In spite of their reputation as fierce warriors, Maasai culture revolves around their cattle. One of their spiritual beliefs is that their rain god Ngai gave all cattle to

the Maasai people, and therefore anyone else who possesses cattle must have stolen them from the Maasai. This has led to some fatal altercations with other tribes of the regions over the centuries when they attempt to reclaim their "property". Despite the growth of modern civilization, the Maasai have largely managed to maintain their traditional ways, although this becomes more challenging each year. Circumcision is performed on both sexes, with the elder men circumcising the teenage boys (who are not permitted to make a noise during the ceremony), and the elder women circumcising the teenage girls (for whom crying is permitted). Attempts by the Kenyan government to stamp out female circumcision have failed, primarily due to the fact that it is the Maasai women who defend the practice, not the men.

37. **Natural Environment:** The ability to graze their cattle over large territories, for example, has diminished considerably in recent years, due to increased urbanization and the increased privatization of land.

Traditional Artisanal Blacksmith

lnkunono Community of Samburu County

38. The Inkunono are a small population living among the Samburu and Rendille within Samburu and Marsabit districts. The views from the Samburu and Nkunono community indicated that the Nkunonos who are currently scattered around the villages within Samburu and Marsabit district are the remnants of the first peoples within the areas from whom the Samburu community ancestrally evolved.
39. The iNkunono culturally relied solely on blacksmith as a source of livelihood. The main tools produced from the artisanal occupation include: (i) cutting instruments: (Axes, household knives, circumcision knives, swords); (ii) security objects: Spear (Short for Morans and long one for Elders) and arrows. In addition, the Nkunono make ornaments which include: hand and foot bangles, necklaces, headgears. These objects are mostly destined for use by the dominant Samburu community for rituals and economic purposes. Currently, the Nkunono have started diversifying their sources of livelihood by embracing some economic activities practiced by their neighbours (Muchemi, 2015).

Annex 5: VMGs screening by National AIDS Control Council

REGION	COUNTY	CONSTITUENCY	NAME OF MARGINALIZED GROUP	AREA WHERE FOUND	ECONOMIC ACTIVITIES
	Tana River	Bura	Wailwana	Bura, Madogo & Mororo	
			Munyoyaya	Mbalambala, Mororo & Madogo	
			Waata	Sombo	
		Galole	Waata	Hola	
	Kilifi	Ganze	Wasanya	Midoina	
		Malindi	Wasanya (Boni)	Sabaki, Baricho	
		Bahari	Wasanya	Arabuko, Sokoke	
			Wapemba	Kamamah-Wendo wa Panya	
	Kwale	Kinango	"Wanyangulo"(Sanya)	Samburu Division, (Kilibasi,Silaloni,Busho)	
		Matuga	Sanya	Mbegani/Mkongani Location	
		Msambweni	Tswaka	Majoreni/Ishimoni	
			Wakifundi	Majoreni/Ishimoni	
	Lamu	Lamu West	Boni/Aweer	Jima Pandanguo Baragoni	
			Sanye	Mapenya (Shekale), mkunumbi Witu, Madagoni, Sendemke	
		Lamu East	Boni/Aweer	Milimani, Mangai, Basuba, Kiangwe, Mararani, Kiunga, Mkononi Buthei	
	Isiolo	Isiolo South	Waata	Garbatula, Kinna, El-Dera Modo Gashe	
		Moyale	Sakuye	Dabel Location, Dir-dima Sub Location, Golla Sub Location	
			Waata	Butiye Location Somake Location	
		North Horr	Daasanach Waata Deis	Chalbi District: Ilerett, North Horr, Kalacha Telesgei	
		Saku	Waata Konso	Marsabit Central: Divib Gombo, Dakabaricha, Qachacha	
		Laisamis	Elmolo	Loiyangalani (elmolobay)	

			Lkunono	Laisamis, Lontolio, korr, Gatab, Meville, Nairibi	
	Garisa	Dujis	Munyoyaya	Balich Village	
		Fafi	Munyoyaya	Bura	
		Lagdera	Gamuuns	Liboi	
			Bonieya	Shanta abaq	
			Reer Dumaal	Modogashi	
		Ijara	Boni Aweer	Bodhai Junction	
	Mandera	Mandera East	Gawawen	Neboi/Hunduthu	
			Warabei	Hararei/Hosle	
		Mandera West	Waata	Haradi	
		Mandera Central	Waata	Elhagarsu	
	Wajir	Wajir North	Gagabey	Bute	
		Wajir East	Hiir	Khorof-Harar/Wajiri Town/Hodhan	
			Ribi	Bula Burwako	
		Wajir West	Gagabey	Ganyure	
		Wajir South	Gagabey/Bon	Kibilay	
			Rer-Bahars	Bulla Kibilay	
		Kwanza	Dorobo/Sebei	Kaibei Location, Chepchoina	
	Baringo	Mogotio	Endorois	Koibatek District, Lake Bogoria and Maji Moto area	
		Baringo Central	Endorois	Marigat and Mochongoi Divisions	
			Sabor	Marigat (Kimalel location)	
		Baringo Central, Baringo North Baringo East	Ilchamus	Mukutani, Tangulbei Marigat & Kipsaraman	
	Trans Nzoia	Cherangany	Sengwer	Kabolet Forest, Kabolet Sub location, Makutano Location and Kaplamai Division	
	Turkana	Turkana South	Ngikebotok	Along the Banks of River Turkwel	
		Turkana Central Turkana South	Ichakun *(They are recently formed immigrants)*	Along the Banks of River Turkwel	
	Trans Nzoia	Saboti	Dorobos	Kiboroa and Kisawai location along Mt. Elgon Forest, Kiboroa Sub location, Saboti Division	

	West Pokot	Sigor	Sengwer	Seker, Lomut & Parua in Pokot Central Chepkono & Sonday in Pokot South	
		Kapenguria	Sengwer	Chemorngit Location, apuko Kopito, Lorsuk Kaplolmuo, Kamunono	
			Sengwer	Chepareria division, Kaibos Location, Talan locationemwochoi Kabolet and ch	
	Narok	Narok North	Ogiek	Nkareta, Sasimwani, Teketi, Cledeem, Topoti, Mbenek Dapshi, Orkuum le Saleita	
	Nakuru	Kuresoi	Ogiek	Kiptagich, Tinet, Ndoinet, Kuresoi	
	Samburu	Samburu West	Lkunono	Maralal, Tamiyoyi, Ngarjin Nchingei, lemisigiyo, Barsaloi, Lorengei	
			Ltorobo	Suguta Marimar Longewan Baawa	
		Samburu East	Sweii (Ndorobo)	Wamba, Ngilai along River Ngeny. Ngolgotim, Lodongkwe, Ndonyo wasin, Nondyo Nasipa	
	Narok	Narok South	Lkunono	Loita	
			Ogiek	Loloipangi	
			Ogiek	Sogoo, Enkaroni Lemek, Loita & Esinon	
	Nakuru	Eldama Ravine	Ogiek	Kiplombe & Mumberes	
		Molo	Ogiek	Nessuit Location Mariashon Mauche	
	Laikipia	Laikipia East	Yiaku	Doldol, sieku	
Western	Bungoma	Mt. Elgon	Ogiek	Kopsiro Division, Kapsokwony and Kaptama Division	Pastrolist Farmers

Annex 6: VMGF Consultation in Kiambu - Dorobo of Kinale

February 2 2016, No. of people consulted 21

Cohort	Issues/Challenges	Recommendation
Maternal Health Care Ante-natal Phase	• Lack of information on the importance of attending the clinics, ignorance and lack of money by some are the main reasons as to why women do not attend clinic. • Health facilities are located far away making it inaccessible for most women. The other readily available mode of transport in the area is the motorbike which might not be safe for a pregnant woman. • High poverty levels resulting to most pregnant women not being able to feed on a balanced diet which is essential for the baby they are carrying.	• Awareness creation to pregnant women on the importance of attending clinics as scheduled. • Construction of a hospital nearby. • Sensitizing pregnant women on the importance of well preparedness while pregnant in terms of savings and planning on the hospital to attend.
Natal Phase	• Uncooperative and rude nurses to mothers giving birth.. For example, in one of the public hospital the nurses tell mothers to go home and come the following day for the baby's first vaccination. When mothers plead with the nurses to let them spend the night there and come the following day they do not agree and they become harsh to the mother. Many women persevere since they do not have money to go to private hospitals. There are women who give birth at home. This mainly happens in cases of emergency such as; experiencing labour pains earlier than expected and lack of finances to go to the hospital. • Selfish gain by some private hospitals. They lack qualified personnel and equipment to carry out caesarean section (CS). After noticing a woman cannot deliver normally, they do not tell her but instead admit her, the mother ends up losing the baby and or her life.	• Construction of a health facility nearby for easy accessibility by pregnant mothers. Attending private hospitals where there is no harsh treatment by nurses. • MoH ensure nurses employed treat patients with dignity and especially women who have just given birth.
Post-natal Phase	• Mothers have poor support systems. They have to do a lot of house chores by themselves after being discharged from hospital. • Lack of emotional and physical support from most husbands. Only a few help in fetching water and buying foodstuff from the market. • High susceptibility to illnesses and body weakness. This is as a result of inability to feed on balanced foods recommended for breastfeeding mothers due to lack of money. • Reduced supply of breast milk as a result of not feeding well. Some mothers naturally lack milk completely after giving birth.	• Community Health Workers to do follow ups on mother's welfare after giving birth. Sensitizing men on the importance of supporting their wives during pregnancy and after giving birth. • Creating awareness to mothers on the importance of proper nutrition during breast feeding.
Child Health Care 0-28days	• Cold and flu as a result of not being warmly dressed. • Complementary feeding of the neonate at two weeks. Some mothers say they think the baby is not fully satisfied with breast milk only.	• • Proper examination be carried out on the neonate before being discharged from hospital. This to ensure no complications.

28days-5 years	• At the age of 1 year, mothers do not pay much attention to what the baby feeds on and so the baby may not be feeding on nutritious foods. • Bruises, swelling, fractures and burns when baby starts crawling and practicing to walk. • Some parents not taking their babies to school when they attain school attending age because of lack of school fees ignorance.	• Mothers need to pay more attention to the wellbeing of their babies even when they attain the age of one year and above.
6-12years	• Most children between these ages suffer from colds and diarrhea. • High indiscipline cases such as fighting sneaking away from home which may results to injuries and rape.	• Guidance should be offered to the children and correcting them rather than punishing them only.
Teenagers and Youth Teenagers	• Conflicts between the teenagers and their parents. • Early pregnancies among teenagers. • Practice of unprotected sex resulting to HIV and STIs cases among the teenagers. High cases of abortion being performed in the homes by other ladies who are experts in practicing that.	• Guidance and counseling sessions should be held in schools.
Youth	• Inability to afford sanitary towels. This results to some ladies missing school and embarrassment when they soil their clothes as a result of emergency periods. • Lack of medication to administer to students when they fall sick and a school nurse to offer medical attention to the students. Help is offered by fellow students and if the case is serious, the student is rushed to the hospital • Early pregnancies and STIs cases are rampant. • Abortion is being practiced at homes by ladies who are not medically trained. This is risky as it puts the life of the mother in danger. Inability to feed on a balanced diet because parents cannot afford it. Also in schools, the meals provided are not balanced resulting to lack of some nutrients in the body. • Lack of information regarding proper health care practices through trainings or seminars. • Unqualified school cooks who do not maintain hygiene standards. This could result to illnesses among students. Poor sanitation practices. There is no soap provided to wash hands after visiting the toilet and toilets are not properly cleaned. This can be dangerous especially with the cholera outbreak. • Inaccessibility to hospitals is difficult due to poor road network in the area. Understaffing medical personnel and lack of medicine in the hospitals.	• Sanitary towels to be availed in schools to help students who cannot afford a pack. • Contraceptives to be availed in schools and dispensaries for the youth who are sexually active. • Schools employ cooks who have undergone training and ensure they provide their medical certificates for them to get a job. • Assistance to be offered to students suffering from STIs. • Hospitals to be equipped with medicine and more qualified medical personnel. • Seminars to be held to enlighten the youth on how to observe proper health care practices. Reproductive health should be one of the topics tackled in depth.
Men	• Inaccessibility of health services due to poor roads full of pot holes and long distance to be covered.. The situation is made worse when it rains, the roads become impassable. This results to death of some especially the old as they are taken to the hospital for treatment.	• Government to assist in the construction of a good road network system. • Availing a health facility nearer the community members to help reduce distance covered.

	• High medical cost which most people cannot afford due to financial instability. Health practitioners tend to neglect them since they do not have money. • Lack of information by most people on proper health care and reproductive health, For instance, many men do not want to use, or their spouses to use family planning methods for fear that they will become infertile and their wives barren. • High susceptibility to diseases like pneumonia and flu because of the cold environmental conditions since the area is covered by a forest. During the rainy seasons, it is very cold.. • Poor housing conditions due to lack of money to build decent houses • Many cases of typhoid, malaria and diarrhea experienced in the area. This results from drinking untreated water from the river and boreholes. • Shortage of medicine at the health center. One can walk many km to the health center and go back home without any medication. • Poor services offered at the health centers. Ignorance and harsh treatment from the nurses. • Understaffing. The nearest health center has only two health attendants. This results to them not paying proper attention to a patient as they are in a hurry to attend to the next. • Lack of ambulances at the hospital and health centers which can be used in cases of emergency.	• Community members be trained on good health care practices and importance of family planning. This can be done through seminars and talks. • Free condoms should be availed in the dispensaries. • Increasing number of nurses and doctors in the dispensaries and hospitals. This will allow the patients to receive proper attention and good services. • Ambulances to be made available at the hospitals. • Introduce mobile clinics which can be accessible to many. • Be provided with water storage facilities and assisted in water treatment.

Annex 7: VMGF Consultation in Endorois, Baringo
February 13 2016; No. of persons consulted: 23

Cohort	Issues/Challenges	Recommendations
Maternal Health Care Antenatal phase	• Long distances to accessing health services, lack of finances and information are factors that contribute to mothers not attending ante-natal clinics. • Harassment by nurses in the health centers who talk rudely to the women. • Religious beliefs where some churches prohibit their congregants from going to the hospital. The practice has greatly increased in the region. Lack of information on the importance of pregnant women feeding well. .This results to many cases of anemia. • Women overworking even when they are almost due. Husbands rarely offer support. This results to complications later on. • Fear of the unknown. For example, afraid that their HIV status could be positive. This contributes to women not going for checkups. • Cultural beliefs that it is a taboo for a mother to get pregnant the same time with her daughter. If this happens the mother is embarrassed and does not seek medical help including ante-natal clinics. • Most women suffer from Malaria because of the areas climatic conditions.	• Creating awareness among women on the importance of attending clinics. • Have a health center built nearby with a maternity which is equipped such that an operation (C.S) can be carried without the mother having to go to a private hospital. • Introduce mobile and outreach clinics. This will encourage women to seek medical help. • Increase medical personnel in the already existing health centers who are well trained. • Sensitize men on the importance of their wives attending clinics when pregnant so that they can support them. • A campaign that promotes going to hospital should be carried out by doctors/ nurses and the community's administration in the churches that are against this practice. Ensure that all pregnant women have mosquito nets, even those who are in the interior and cannot access the hospital. • Awareness creation to mothers on importance of them knowing their HIV status. They can be advised on measures to take for the baby to remain HIV negative if they are positive. • Women should be encouraged to feed on balanced diet for their own health benefit and that of their baby.
Natal phase	• Excessive bleeding due to delay in the removal of placenta. This is common to mothers giving birth at home. • Accessibility to the hospitals results to mothers giving birth at home and alongside the road on their way to the hospital. Due to lack of proper medical attention, cases of infant and maternal mortality are common.. • Verbal abuse by nurses. • Women who have undergone FGM have prolonged and difficult labour.	• Women to be encouraged to avoid giving birth at home and go to the hospital. • Nurses should be trained on how to treat patients and if possible have nurses coming from their own community. • Have a programme in place which educates community members who valued FGM especially women on the risks it posses to girls. This will go a long way in eradicating this practice. • Have hospitals built nearby with a well equipped maternity.

Post-natal phase	• Shortage of food supply in the area contributes most women are not able to feed on nutritious foods while breastfeeding. This results to body weakness. • Bleeding and backache problems due to overworking before fully recovering. • Inability to afford sanitary towels after being discharged from the hospital. They end up using pieces of blankets which are readily available to them. This is risky as it can lead to infections. • For those who deliver at home, suffer from growth later on because the placenta is not properly removed. • Cultural practices where mother cannot take milk or milk product until the naming ceremony is undertaken after one month and is also not allowed drinking water until after one month. It is believed that taking water will weaken the joints and cause back ache.	• Encourage birth preparedness programme among couples. This will aid in women being able to feed well on nutritious foods for good health of the mother and baby. • Introduce mobile and outreach clinics which will help reduce distance mother has to walk to get medical help. • Women to be provided for enough sanitary towels which they can use after being discharged from the hospital. • Ensure that every hospital has an ambulance.
Child Health Care 0-28 days	• For women who give birth at home, most of the children do not receive the first BCG immunization. • Many cases of vomiting and diarrhea among neonates. • Infection of umbilical cord due to lack of proper hygiene. • Stomach problems as babies cry a lot. (Colic) • Some mothers lack adequate milk to breastfeed their babies.	• Introduce mobile and outreach clinics and increase number of well trained nurses. • High standards of hygiene to be maintained by mothers when handling their babies. This will help avoid vomiting, diarrhea and infections of the umbilical cord. • Increase supply of medicine in the hospitals. • Ensure nurses undergo proper training and are more careful when handling babies. • Emphasis to be put on the importance of mother feeding well because what she feeds on is what the baby will feed.
28days-5 years	• Children suffer from pneumonia and malaria as a result of the humid weather and anemia because of not eating fruits. • Stomach bloating a condition they refer to as “kalasa” which is caused by ant hills. • Children suffer from snakes bites since snakes are all over the place. • HIV cases among children. There are about 5 cases in every 100. • Fractures, swellings and burns because children are exploring the environment around them. • Poor immunization strategy. Mothers are told there should be a minimum of about 10 mothers in the hospital who have brought their children for immunization for the children to be attended to.	• To reduce cases of; Anemia- mothers should take it upon themselves to ensure that their children eat fruits every day, malaria- Mothers be given mosquito nets for their children and pneumonia- children be immunized against it. • Avail drugs in the area for immunizing against pneumonia as it is only found in Kimalel. • Introduce sprays or come up with mechanisms that can be used to chase away snakes within the home and school compounds • Parents should take more care of their children. • Treatment for snake bites to be readily available in the hospitals.
6-12 years	• Children this age can acquire some diseases and infections from school or from other children they interact with.	• Guidance and counseling to be offered by parents. • Parents take good care of their children. • Continue with awareness creation on risks of FGM.

	• Fractures and burns as they try out new things such as climbing trees, fighting among others. • Running away from home. Mostly girls who are susceptible to FGM. • Many indiscipline cases.	
Teenagers and Youth	• Lack of sanitary towels especially among students since most of them cannot afford. • The Female Genital Mutilation (FGM) practice has negative effects on the ladies. • Rape cases occur in the area. • Abortion practices. This is mostly done in the homes without a trained medical professional. • Early pregnancies cases among students. • Sexually Transmitted Infections (STI) is rampant among the youth such as syphilis, Hepatitis B and gonorrhea. • Inaccessibility to clean drinking water.	• Sanitary towels to be provided freely in schools • Create awareness on elders on the negative effects of FGM. • Action should be taken on the rape cases offenders. Sensitization should be done on the procedures to be taken after a rape ordeal has taken place • Allow the use of contraceptives especially to the youth who cannot abstain to avoid early pregnancies. Methods which protect from STIs. • Support to deliver safely and continue with school after giving birth should be offered to girls who become pregnant while in school. • The community to be provided for tanks and be taught on different ways of treating water.
Men	• Lack of quality health care facilities. • High poverty levels preventing many from seeking medical attention. • Ignorance by most people even on early signs of diseases and illnesses. • Poor sanitation • Regressive cultural beliefs. • Malnutrition and lack of immunization among children.	• Introduce a school feeding program • Mothers to ensure babies are well breastfed. • Employ qualified medical personnel in the hospitals. • Training on importance of promoting positive cultural practices only. • Construction of toilets. • Establishing a clear structure through which community members can be empowered.

Annex 8: VMGF Consultation in Samburu – Ilkonono, Dorobo and Samburu Community
February 11 2016, No. of persons consulted 34

Cohort	Issues/Challenges	Recommendations
Maternal Health Care Ante-natal stage	• Failure of most women to attend clinics because of long distances and lack of information on the importance of these clinic visits. • Deficiency of some nutrients as a result of not feeding on a balanced diet. For example, there are no greens included in the diet. They mainly feed on uji, milk, meat. • Overworking even when pregnant results to loss of mothers weight and also affects the growth of the baby in the womb. • Increased cases of anemia caused by lack of fruits and greens in their diet.	• Introduction of outreach and mobile clinics as this will encourage women to attend clinics. • Awareness creation on importance of attending ante natal clinics and mother feeding on a balanced diet. • Men should be encouraged to offer help and support to their spouses during pregnancy and immediately after delivery.
Natal stage	• Prolonged and difficult labour as a result of FGM and early marriages. • Excessive bleeding when giving birth at home. A lot of pain is experienced afterwards since there is no pain killer given unlike in hospital. • Challenged children, infant mortality, fistula and delay of placenta from coming out occur when women give birth at home. Lack of money to go to private hospitals where a caesarean section needs to be done since this service is not offered in the public hospital	• More seminars and trainings to be held campaigning against FGM practice and early marriages. • Mothers and traditional birth attendants to be sensitized on the importance of giving birth in hospitals and the risk associated with delivering at home. • Build more maternity hospitals especially in the interior regions. The only existing are found in Serara, Sereolipi and Ngarenarok. • Equip health centers with equipment to carry out operation and qualified doctors to carry out perform operations.
Post-natal phase	• Poor feeding habits by most mothers. They mainly feed on foods that are not balanced which include soup, porridge, meat and blood only. • Failure to attend post natal clinics to check on their healing process because hospitals are far away. • Body weakness and weak joints due to prolonged labour. • Regressive cultural practices. A woman cannot take water until after 4 days as it is believed it will affect the joints and cause back ache, one is given animal fat instead. This is risky because water is very essential for every human being.	• Encouraging proper feeding on a well-balanced diet among women breastfeeding. • Mobile and outreach clinics are introduced. • Sensitization on importance of attending post-natal clinics. • Scale up the fight against FGM and early marriages. • Emphasize on importance of drinking water and its benefits in the body.
Child Health Care 0-28 days	• They suffer diseases such as diarrhea, fever, and anemia. Body weakness of the neonates as a result of their mothers having had prolonged labour. • Most neonates are underweight. • Experiencing breathing difficulties. • Poor breastfeeding because the mother may not have adequate milk.	• Home hygiene should be maintained to avoid diarrhea. • Encouraging mothers to attend clinics and ensure immunization and treatment for any illness. • Proper ventilation in the houses.

28 days-5 years	• Children mainly suffer from diarrhea, pneumonia, anemia, kwashiorkor and high fevers. • Injuries since they are exposed to danger. • Low immunization because of the long distances to accessing these services and lack of awareness on its importance. • Negligence and abandonment of children by parents.	• Mothers ensure they maintain high hygiene practices. • Dangerous objects be kept out of reach of children and properly disposed. • Ensuring children receive proper nutrition. • Addition of mobile and outreach clinics. There is only one in Wamba. • Set up of children centers so that the abandoned children can find refuge. • Reinforcing the children's Act.
6-12 years	• They are highly exposed to T.B and pneumonia. • Malaria and anemia cases are rampant. • Cultural practices. When a one is injured or has some illness they are treated locally and do not go to the hospital. For instance; o Anemia- given animal blood. o Diarrhea- given animal soup with herbs. o Injuries- given animal fat o Fractures- treated with the bark of a tree.	• Mothers to feed their children on a well balanced diet. • Parents to take more care of their children and be concerned with their well being.
Teenagers and youth	• Lack of enough health facilities. • Lack of awareness on different health challenges and what can be done. • Shyness of opening up fully what challenge they are facing when they visit the health center especially if being treated by a doctor of the opposite sex. This is common with STIs cases. . • Shortage of enough trained health personnel. There is only 1 or 2 health worker for all health services. • Insufficient or lack of drugs at the health center. One is referred to the chemist to buy drugs. • Poor road networks resulting to inaccessibility to health services. • High poverty levels. • Shortage of equipment needed in the health center, e.g. machines for carrying out operations. • Language barrier. It becomes difficult for the patients who cannot speak any other language besides mother tongue to communicate with the health attendants who do not understand the local language . • The youth are not represented in the health facility's Board of Management. Nomadic lifestyle. • Corruption at the health centers. Some drugs do not get to the health centers.	• Improving the existing conditions and services at the health facilities. • Trainings/ workshops to be held for the youth to inform them on different health issues. • Establishment of youth friendly centers. • Government to increase number of health personnel in the health centers. • Government to supply sufficient drugs to all health centers. • Improvement of road infrastructure. • Every hospital to have an ambulance. • Reduction of medical cost at the hospitals. • The government should provide enough machines for carrying out different health procedures. • Health education to be offered in schools. • Introduction of mobile clinics and establishment of Community Units. • Have youth representation in the health committees.

		• The health care providers should stop corruption. Government should make a follow up on all the drugs disbursed.
Men	• Believe in use of Traditional herbs. • Long distance covered to reach health facilities.. Usually 20-30 KM. • Language barrier. This raises a need of having a translator from local language to swahili or English and vice versa which could lead to misinterpretations. • Nomadic lifestyle. This poses a challenge when they have to move to places where there are no health facilities. • Failure of the health professionals and community health workers to maintain confidentiality. • High illiteracy levels among the community members. • Lack of quality health services and drugs at the public health centers. This has resulted to over reliance in private hospitals which are costly.	• Ensure all government health facilities are properly equipped with necessary machines. • Trainings on health issues be held in the area. Build more health facilities close to the people. • Gender equity to be observed. The staff at the health facilities should be a representation of both genders. • Improvement of the road network system • Youth from the locality that have undergone nursing training be given first priority when vacancies come up at the health centers.

Annex 9: VMGF Consultation in Kwale – Wakifundi and Watswaka

February 15 2016, No. of persons consulted 26

Cohort	Issues/Challenges	Recommendations
Maternal Health Care Ante natal Phase	• ong distance to the health facility. Transport becomes a challenge. • Poverty. Lack of finances to pay for the services at the hospital. • Fear of undertaking some test such as HIV/AIDS. • Fear of palpation.	• Sensitizing women on the importance of knowing their HIV status. • Women to be trained on the available business opportunities. This will help them get a source of income to pay for the services during clinic visits.
Natal Phase	• Having to travel for long distance to get to the hospital or to the midwife. • Harsh treatment from the nurses. • Fear of being told they need to be operated. Most people cannot afford to pay • The episiotomy procedure is painful • Maternal and infant mortality.	• Measures to be put in place to ensure nurses treat women giving birth with respect and dignity. • Ensuring all equipment needed when a mother is delivering is availed in the hospital
Post-natal Phase	• Lack of awareness by mothers on importance of seeking post natal care. • Mothers not visiting hospital for post natal care services but rather consulting the midwife at home who might not have all the knowledge on how to deal with the health challenges encountered.	• Educating women on importance of going back to the hospital for checkup after delivery.
Child Health Care 0-28 days	• Religious beliefs require the mother to stay home for 40 days without going anywhere. • Long distance to accessing health facility for clinic visits.	• Introduce outreach clinics in the villages. • Mothers to be educated on importance of immunization of children.
28 days-5 years	• Having to travel long distance to take the children to the clinic. • Poor road transport network system.	• Health facility to be put up near the villages. • Before putting up a health facility, one must get permission from the owners of the land.
6-12 years	• Long distances to accessing health facility in case a child is sick and needs medical care.	• The children should be trained on health issues at school.
Teenagers and Youth	• Fear of other people, including doctors knowing their HIV status. • High poverty levels results to many people not seeking medical attention whenever they fall sick. • Lack of information on the importance of taking good care of their health and seeking health care services. • It is not easy to access health services since the health facilities are far away. • Poor road network. • The big gap in age differences between the doctor and the patient results to most youth not opening up fully. They also fear that if they disclose some information they might be reported to their parents.	• Awareness creation on importance of seeking treatment. • Doctors to maintain high levels of confidentiality. • Youth receive empowerment and support on starting small businesses. • The youth to volunteer as community health volunteers. • Parents make an effort of educating their children and the children also work hard in school. • Health facilities to be put up in the villages. • County government ensures that the roads are repaired and properly maintained.

	• Early marriages. Parents force their daughters to get married at a tender age especially to a man who is wealthy. • Alcoholism results to one not visiting the hospital even when sick as they only want to use the money they have to drink alcohol • Rape cases are rampant mainly because students have to walk for long distances to school and along the way, they are rape	• Use of contraceptives by the youth who cannot abstain to prevent spread of HIV, STIs and early pregnancies. • Ladies dress appropriately as this will reduce rape cases. • There should be a youth representative in the health care provider's team to whom the young people can easily open up to. • Sensitization to parents on the importance of allowing their children to study and avoiding marrying them of at a young age.
Men	• Health facilities being far away from the people. An approximate of 10 km. • Poor public relations among health workers.They ignore patients talking to them. • Lack of awareness on the importance of getting health care services. This results to mothers giving birth at home and people constructing houses with no toilets. • Embarrassment on getting a HIV test done, buying or picking a condom from the health center and an examination of private parts by a gynecologist or obstetrician especially of the opposite sex. • High poverty levels resulting to people not seeking health care services. • Having to queue and wait for long to be attended at the hospital because of; shortage of medical personnel, laziness of some and lack of proper systems in place to ensure effective delivery of services. • Fear of death for example when an operation is to be done. This results to many people not seeking for medical help. • Traditional beliefs such as witchcraft and therefore reuse to go to the hospital. • Large families resulting to limited resources to accessing health services. • Lack of enough equipment at the hospital.	• Introduce mobile clinics in the villages. • Ensure health care providers to be polite and MoH to follow up on those who are rude. • Creation of awareness on health issues. • Sensitize on the risks associated with one not knowing their HIV status and ensure confidentiality is maintained between the patient and doctor. • Members to be empowered with skills of carrying out businesses. • Ensure there is fairness at the hospital, the first to come should be served first. • Community members to be educated on the importance of family planning and its importance. • Number of equipment needed at the hospital should be increased.

Annex 10: VMGF Consultation in Reproductive Health (Family Planning)

Region	Issues/Challenges	Recommendations
Dorobo Kinale	• The main forms of contraceptives used in the area are; Pills, Injection, Coil and Implants. The commonly accepted one is the injection and that is what most people are using. • Pills are not so common because most people say they forget to use them. Coils and Implants are used by a very small percentage. • Most husbands are against their wives using the contraceptives. They say that they lower their libido. Women therefore use the contraceptives without involving their husbands in making that decision. • Teenagers are also using contraceptives a lot, getting them from the chemists.	• Trainings be offered on family planning because most people lack understanding and there are many misconceptions.
Samburu, Ilkonono and Turkana of Samburu County	• Among the Samburu community members, very few believe and use contraceptive. Majority belief that use of contraceptives results to bareness. Therefore the commonly used form of contraception is; Breastfeeding until the baby is big enough and Polygamy. After a woman has given birth, the husband goes to the other wife (wives) where his conjugal rights are met.	• Providing efficient family planning services. • Women to be sensitized on how contraceptives work. • Health centers to have specialized doctors who will pay attention and advice women on family planning practices.
Endorois of Baringo County	• The main methods used for family planning are; Breastfeeding, Pills, injections and the natural method. • A woman cannot have sex until after six months. Earlier on a belt was put around a mother's stomach after giving birth and whenever she had this belt the husband could not have a sexual intercourse with her until she had removed it whenever she felt ready. • Women in this community have refused to use the coil as they believe it causes cancer.	• Seminars to be held to train women on the different contraceptive methods and how they are used. Their advantages and disadvantages. • A short session was held after the discussions with the officer from MoH, where so many questions on family planning arose and the women were so attentive. Some of the questions asked include; • Is the IUD hazardous? Can contraceptives be used by ladies who have not given birth yet? How is it that a woman on contraception can become pregnant? • Avail the 3-5 year injection in hospital. Only the one for 3 months is found in hospitals.
Wakifundi and Watsawaka of Kwale county	• Fear to use as a result of rumors that contraceptives cause cancer and pressure. • Continuous bleeding. • Heavy bleeding when on menstruation. • Results to some women not receiving their monthly periods. • Some men do not want their wives to use contraceptives	• Sensitizing women on importance of family planning and having a family size that is manageable

Annex 11: VMGs Comments: National Disclosure Workshop

In Nairobi (Silver Springs Hotel) on March 21st, 2016 between 9:00 -13:30

Key Issues	Comment/question/concern	Response to comments/questions
Access to conventional Primary Health Care	1. The VMG communities in Mt. Elgon have had many challenges in regards accessing conventional health care services and hence rely on traditional medicine as such they are grateful for the programme.	-
Access to health facility	2. Most areas in Mt. Elgon are inaccessible (bad roads) and have no health care facilities. Is the programme going to include infrastructure development i.e. building facilities?	The programme does not focus on infrastructure development but rather on improving the existing infrastructure.
Staffing of local health facility with professional health staff within VMG areas	3. The deployment of health professionals in hardship areas (where most VMGs reside) is plagued by numerous challenges with most professionals transferring out of the areas shortly after deployment. Since the programme has training component, it was suggested that the programme train persons from the communities who can later be deployed to the areas since they are familiar with and are used to the prevailing conditions in the areas. It was also suggested that MoH should analyse the number of health workers who come from hardship areas and work on increasing that number.	The programme has a scholarship component for nurses and midwives that give priority to applicants from VMGs. The scholarship programme offers a total of 400 scholarships, 320 which will be given to applicants from 20 priority ASAL counties while the remaining 80 will be distributed among applicants from the VMGs from other counties across the country. The scholarship also give priority to female applicants with 2/3 of the scholarship set aside for females and 1/3 for males. The applicants have to meet the qualifications set by the nursing council. The MoH is working on a request to increase the number of scholarships from the current 400 to 800.
Utilisation of Traditional Health Knowledge	4. A participant wanted clarification on how the programme is going to integrate traditional knowledge and practices with modern medicine practices in the programme including traditional medicines, traditional birth attendants, traditional family planning methods and other practices	At this level the programme is in the planning stage and the implementing agency (MoH) will develop an implementation manual that will be done consultatively and will include clear plan/strategies for all aspects of the programme including the inclusion of indigenous knowledge (ITK) and traditional medicine practices and to what extent.
Provision of primary health care to areas faced with inter-tribal resource-based conflicts	5. The Ilchamus community, for example, have lived in conflict area over the last 10 year that have resulted in numerous challenges in access to basic services including health care services. In addition the area also suffers poor infrastructure and is hard to reach. The community representative sought for clarification on how the programme is going to address the issue and suggested that the programme include provision of mobile clinics to reach all people including those who are in hiding.	The actual activities of the programme will be dependent on the local context in the counties and as such each county will implement activities that would address its priority needs e.g. having mobile clinics

Representation of VMG in health governance structures	6. Concerned that the programme may go the same way as past programmes that haven't reached the intended targets. Suggested that there be representation of the VMGs at all levels of the programme management from the grassroots to the top to ensure that the VMGs are not overlooked	The indicators for monitoring the programme will be disaggregated to indicate what percentage of each indicator consists of VMGs and as such it will be possible to judge to what extent the project has reached the VMGs
Safety of vaccines	7. Expressed concern about rumours such as the safety of vaccines and the use of family planning which could affect the uptake of health services and wanted to know how the programme would address these issues.	The MoH ensures that any vaccines or FP methods administered through their facilities is safe for the consumers. The consumers have a right to safe services (vaccines and FP methods). The County government will set aside a budget for sensitizing the communities to alleviate fears and concerns arising from rumours and/or myths that affect the uptake of health services.
Integration of TBA in the health system	8. Traditional birth attendants play a vital role in the community especially since the community members have easy access to them. Suggested that the programme seek a way to integrate the TBAs in the programme.	The TBAs will be kept on board to work with MoH workers as birth companions and to assist in quick assessment and referral of cases.
Access of health service by persons with disabilities	9. Programme should ensure that the persons with disabilities are also included in the programme objectives	The project is intended for all people. The VMGF is an instrument to ensure that the VGMs are not excluded due to their small numbers, location or culture. As such the physically or mentally handicapped and other vulnerable groups would be included too.
Failure of the project to establish new health infrastructures and instead improve existing ones would further marginalize VMG as areas have no health facilities	10. The MoH was applauded for the initiative to reach all people and especially the VMGs with quality health care. However, it was noted that the objective of the programme was to improve 'existing facilities' and was concerned that this would further marginalize the VMGs since most of these communities do not have health facilities.	Although the programme will not focus on infrastructure development, there may be exceptions depending on the prevailing conditions of some areas.
	11. It noted that most VMG communities have deeply entrenched cultural practices that affect the people's uptake of health services and wanted to know how the programme would address such cultural dynamics.	The County government will set aside a budget for sensitizing the communities to alleviate fears and concerns arising from rumours and/or myths that affect the uptake of health services. The alternative medicine (traditional medicine and health practices) have not been adequately addressed in the framework. And so, due to cultural entrenchment the community members will always turn to traditional practices before seeking conventional medicine. Presently the MoH is working on policy

		and regulations to govern alternative medicine. Meanwhile, there is need for extensive consultation with the said communities to come up with ways to integrate traditional medicine with conventional medicine without compromising the quality of health care.
	12. It was noted that the VMGF has explained a grievance redress mechanism as one of the key components and wanted to know what were the anticipated conflicts or issues in the programme that warrants such focus on GRM.	The GHM is a tool again used to guide how to handle community complaints and resolutions. The anticipated conflicts and issues will vary from one area to another.
	13. Sought clarification on the involvement of the county government in the programme and was concerned that it may affect the effectiveness of the programme due to bureaucracy.	The programme will be implemented through the county government as is provided for in the constitution of Kenya (CoK). Any issues arising from the arrangement will be handled through the GRM. There are also VMG focal persons (County Nursing Officers) deployed by the MOH at the county level to ensure VMGs are not excluded. The focal persons were trained in February 2016 and 17 counties were represented.
	14. Sought clarification on whether the programme will be piloted first to test the effectiveness of the design.	-
Need for infrastructure development	15. Emphasised the need for infrastructure development since they have very few health facilities which is compounded by the ongoing conflict in the area	See response 2 and 10 above
VMG appropriate community strategy for opportunities like scholarship in medical schools	16. Pointed out that there is need for a more targeted communication strategy to reach the VMGs (e.g. about the scholarship opportunities) since most of them are in areas where they have no or limited access to mainstream media.	It was encouraged that every time the VMGs are corresponding with the Project they should indicate the aspect that they are vulnerable. They should not be silent about it.
Sharing of full VMGF report with VMGs	17. Requested that the full report be shared for further inputs since the presentation was only a brief summary.	The report will be shared
Infrastructure development improve access	18. Emphasized the need to include an infrastructure development component in the programme to ensure the communities without facilities are not excluded	See response 2 and 10 above
	19. Emphasized the need for infrastructure development component in the programme.	See response 2 and 10 above
Need for VMGs network for improve advocacy	20. Suggested that there be a network for the VMGs in order to strengthen their voice in articulating issues that the communities face.	The formation of a VMGs network is left to the VMGs and their leaders.
Scholarship to VMGs in professional fields	21. Inquired whether the scholarship opportunities could also be availed to students from VMGs who are already training in various institutions and struggling to meet the costs.	-

Appropriate communication strategy	22. Suggested that the communication strategy to specifically target the VMGs since Minority groups have no access to main stream media and suggested that the programme make use of the existing community leadership structures to pass on information	
Need for infrastructure development	23. Put emphasis on development of new infrastructure besides improving the existing ones that lack proper equipment to cater to the communities.	See response 2 and 10 above
	24. Reiterated that most VMGs also face challenges in accessing quality education resulting in most students from such communities attaining low grades. Enquired if the entry grades for such students could be lowered to give them opportunity to benefit from the scholarship	The qualifications for entry for the nursing programmes at the KMTC were already lowered to as low as practical for the scholarship and cannot be lowered any further.
Benedict (M&E Division MoH)	25. Emphasized that there is need for registration of births and deaths among the VMGs since the data is needed for more precise planning for health services in proportion to the population of the communities.	-
Access by pastoralist	26. The Samburu are primarily pastoralist and periodically move away with their livestock. How is the programme going to ensure that the communities on the move get the services?	See response to 5 above
Infrastructure development	27. Samburu region in general suffers communication problems due to lack of appropriate infrastructure which make reaching the communities difficult hence need for more targeted communication	
	28. Pointed out that intra-county disparities should be considered to ensure that the services are delivered in proportion to the needs of the communities.	
Infrastructure development	29. Emphasized on need for infrastructure development	See response 2 and 10 above
Scholarship opportunities for VMGs	30. Need for more targeted communication especially on scholarship opportunities	
Database for VMGs	31. Pointed out that there was need for mapping the VMGs which could help in ensuring that they are all reached and involved in the programme	There exists data on VMGs by the National Gender Commission and the National AIDS Council and it was suggested that the MoH links up with these institutions to obtain the data.

Annex 12: VMG List: National Disclosure Workshop

In Nairobi (Silver Springs Hotel) on March 21st, 2016 between 9:00 -13:30

12.1: Institutional Public Consultation

SNo	INSTITUTION	TYPE OF INSTITUTION
	VMG Institutions/IPOs from:	
	Ogiek	Community
	Dorobo	"
	Ii chamus	"
	Endorois	"
	Maasai	"
	Samburu	"
	Turkana	"
	Iikonon	"
	Watha	"
	Wakifundi	"
	Watswaka	"
	NGOs	CSO
	ERMIS Africa	"
	KMTC	Government
	MoH	"
	County Governments	"
	National Government	"
	World Bank	Observer

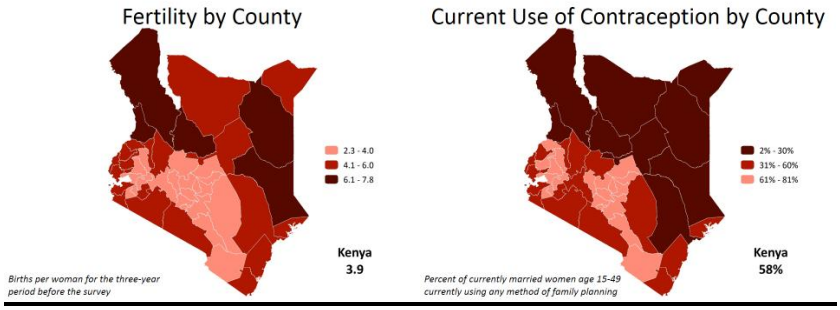
12.2 List of Participants during the In-Country National Public Consultation of Transforming Health Systems for Universal Care Project VMG Framework

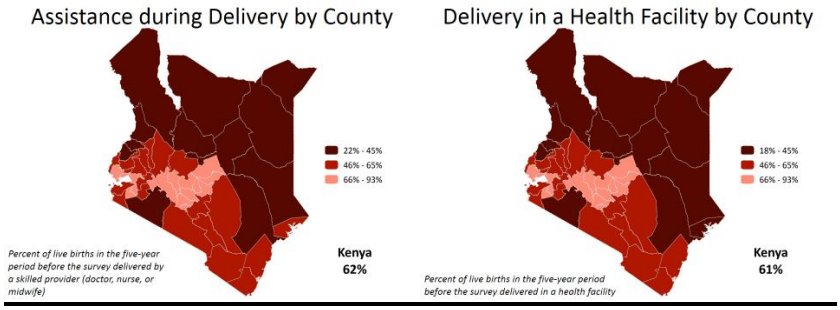
The list of participants during the in-country public Consultation of THS_UCP VMG Frameworks held on the March 21, 2016 was captured as follows[26]:

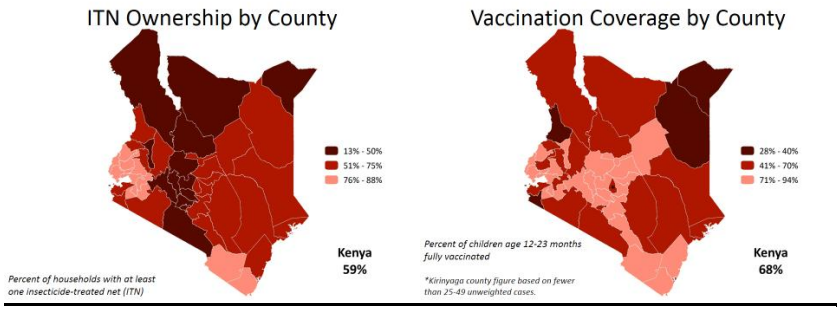
Serial No.	Name	Organization	Position	Email:	Phone No.	Signature
1.						
2.						
3.						
4.						
5.						
Etc.						

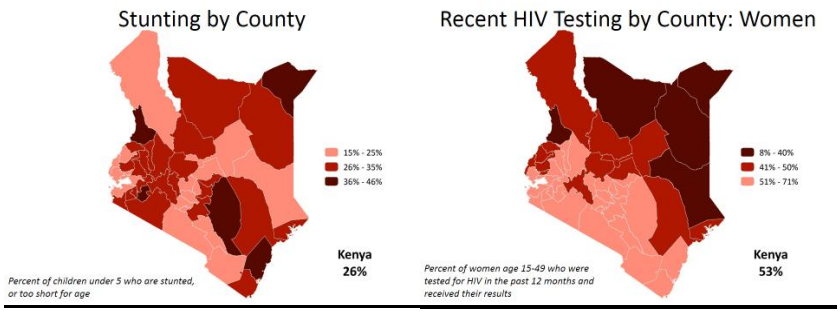
[26] It was attended by about 60 participants from 9 counties (Baringo, Kwale, Bungoma, Narok, Nakuru, Kiambu, Samburu, Nairobi, and Kilifi)

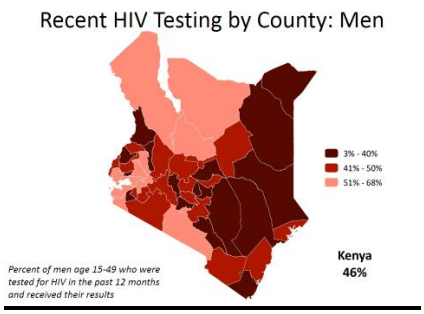
Annex 13: Kenya Demographic and Health Survey (KDHS - 2015)











Annex 14: Integration of Citizen Engagement

The Local Context for CE

1. CE underlines both the right and the corresponding responsibility of citizens to expect and ensure that government acts in the best interests of the people. Article 43 of the Kenya Constitution stipulates that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare. Integrating CE in health service delivery is about setting up systems to ensure that citizens have greater voice; that the health system is downwardly accountable to them; and that it responds to their needs.

2. From a county perspective, the County Governments Act, 2012 stipulates that governments should facilitate the establishment of structures for citizen participation (engagement) in the conduct of the activities of the county assembly as required under Article 196 of the Constitution.[27] This includes promoting and facilitating citizen participation in the development of policies and plans, and delivery of services in the county through strategies such as the evaluation of the performance of the county government and public sharing of performance progress reports. In this regard, CE fits in perfectly within the mandate of the Act; mainstreaming CE in the delivery of healthcare services will contribute to a county's goal to enhance citizen participation.

3. Currently, health care providers are contending with increasingly enlightened populations demanding answers on the quality of and access to health care services they are entitled to receive. The traditional approach to service delivery has been supply-side driven with little or no input from the demand-side. Moreover, there has been minimal collaboration with stakeholders to engage citizens in addressing the challenges that the health sector faces.

How CE will Contribute to the PDO

4. CE will contribute to achievement of the PDO through: (i) improved demand for health services as a result of enhanced community participation in decision-making and management processes; (ii) improved governance as a result of strengthened health facility governance structures; (iii) empowered communities as a result of functional community units and increased community participation in health service delivery; and (iv) improved quality of health services as a result of feedback systems and GRM.

5. It is proposed that practical CE activities are undertaken at both county and health facility levels based on the MOH's Implementers' Manual for Social Accountability in the Health Sector: for County Health Managers and Other Health Stakeholders, published in 2014. This coupled with the CHS, are, ideally, the blueprint for CE activities in the health sector. For the county level, the county governments and CHMTs are critical in leading the process.

Proposed CE Activities

6. Activities will be centered on the three components of CE.

[27] Republic of Kenya. 2012*The County Governments Act, 2012*. Edited by the Republic of Kenya. Nairobi: National Council for Law Reporting.

a. **Information sharing.** The extent to which health and operational information is made publicly and interactively available. Through CHS structure, the Project will seek to enhance information sharing for transparency on health care delivery and management.

b. **Community participation.** This is primarily hedged on the CHS, and specifically, establishment of new community units and improved functionality of existing ones as well as establishing CBM mechanisms while also strengthening existing mechanisms such as inviting community representatives on the boards and management committees of health facilities.

c. **GRM.** The extent to which feedback and GRM are available at the community level and whether/how the feedback loop is closed. The health system does not have an established and systematized GRM. The Project will seek to establish this where health service users can submit feedback and grievances on health services including malpractice and corruption issues building on existing CHS structures such as CHWs.

7. The proposed CE activities are expected to be undertaken by two key actors: (i) CHMTs who should ideally appoint a focal person for CE from within the team to guide the process; and (ii) health facilities at all levels of care – who are expected to have their CHEWs as the CE focal persons at facility level. The proposed activities are listed in Table below.

Table. Proposed CE Activities at CHMT and Facility Levels

Responsibility	Activities
CHMT	*Management* ▪ Conduct training of trainers for all county-level CE focal persons and stakeholders. The overall goal of the training will be to enhance the capacity of CHMTs and stakeholders on integration of CE approaches. ▪ Appoint CE focal persons within the CHMT who will provide leadership in the integration of CE in delivery of services ▪ Build capacity of health care providers through forums such as Continuous Medical Education and sensitise communities on CE through forums such as dialogue days ▪ Include the CE agenda in all forums where stakeholders are being engaged particularly during program formulation ▪ Ensure exit interviews are conducted in all health facilities annually with the involvement of community representatives such as CHC members and/or CHWs ▪ Carry out supervision of the integration of CE at all levels of health care provision in the county and ensure the integration is reflected in the performance contracting and appraisal for health workers; both incentives and sanctions should be established to support the process *Information Sharing* ▪ Publicise through media (television, radio, newspapers) (i) funds disbursements per facility in the county, including performance based funding, partner funding, and user fees subsidies; (ii) at least two major successful community activities such as dialogue or action days where community members have participated and benefited in one way or another, (iii) patients' rights and responsibilities in health services;28 and (iv) health-related community events *Community Participation* ▪ Support the establishment of functional community units ▪ Pilot CBM primarily using community scorecards as a tool of monitoring health facility performance. CBM involves drawing in, activating, motivating, capacity building and allowing the community and its representatives e.g. community representatives such as Board/HFMC members, CHC members and CHWs or community based organisations (CBOs), to directly give feedback about the functioning of public health services. The community monitoring process involves a partnership between healthcare providers and managers (health system); the

[28] Based on the 2013 Patients' Charter: 2. Ministry of Health: Kenya National Patients' Rights Charter. Nairobi: MOH; 2013.

Responsibility	Activities
	community and CBOs/NGOs. The emphasis of CBM should be laid on the developmental spirit of 'fact-finding' and 'learning lessons for improvement' rather than 'fault finding'. *GRM* ▪ Set up a phone number through which citizens can call or send short messages to highlight their complaints ▪ Support the establishment of effective GRMs in all levels of health care delivery wherein the following measures are put in place, (i) multiple complaint uptake locations channels, (ii) fixed procedures for complaint resolution are documented illustrating prompt and clear processing guidelines (including reviewing procedures and monitoring systems), and (iii) an effective and timely complaint response system to inform complainants of the action taken
Health Facilities (Led by the In-Charge)	*Information Sharing* ▪ Have the Service Charter prominently and publicly displayed in Kiswahili and/or relevant vernacular language; the Charter should include all user fee charges ▪ Display information, quarterly, on funds received and expenditure on the facility's board ▪ Display information on working hours, services provided and outreach activities on the facility's board ▪ Display names and phone contact information of Board/HFMC members ▪ Display information on last date supplies received from drugs supply agencies such as KEMSA. *Community Participation* ▪ Through the facility's HEW, support the management of community units such that they are functional ▪ Regularly conduct dialogue and action days to share information with the community ▪ Include in the facility AWP priorities identified, during these dialogue and action days and/or any other forums ▪ Plan outreach activities based on community feedback regarding preferred locations and services provided ▪ Ensure the Board/HFMC meets at least quarterly ▪ Submit minutes of Board/HFMC meetings to the sub-CHMT *GRM* ▪ Have a complaint box available. The box should be placed strategically, locked, and include pen and paper ▪ Display the phone number in the service charter and sensitise community members on its existence ▪ Identify trusted community members, outside of Board/HFMC members, and assign them to receive grievances that community members are not comfortable writing or calling about; post their names and contacts on the board ▪ Log all complaints and corresponding action taken in a complaint register

Annex 15: List of Groups that could meet Criteria for OP 4.10

Table 15.1: VMGs Present in THS-UC Project Operational Area that could meet the criteria of OP 4.10

Name	Other Names (derogatory)	Estimated Population[1]	Livelihood[1]	Counties[1]
1. Dorobo	Dorobo	10,000	HG /Farmers	Kiambu (Lari – Kambaa area) Wamba
2. Sengwer	Charangany	50,000	HG/Farmers	Trans-Nzoia;
3. Ogiek	Dorobo	40,000	HG/Farmers	Nakuru, Baringo, Narok, Koibatek, Nandi, Naivasha, Bungoma
4. Waatha	Wasanye	13,000	HG/Farmers	Kwale; Kilifi
5. Wasanye	Sanye		Farmers/Fishing	Kwale; Kilifi
6. Wakifundi	Washuyu	3,500	Fishing, Mangrove traders	Kwale
7. Watswaka			Fishing, Mangrove traders	Kwale
8. El Molo		2,900	Fishing	Samburu
9. Ilchamus		33,000	Fishing/Farmers/ Livestock Keeper	Baringo
10. Endorois	Dorobo	60,000	Fishing/Farmers/ Livestock Keeper	Baringo
11. Rendille		62,000	Pastoralists	Marsabit
12. Gabra			Pastoralists	Marsabit
13. Samburu			Pastoralists	Samburu
14. Ilkonono			Blacksmith	Samburu
15. Maasai		666,000	Pastoralists	Narok (wmbaa)
16. Aweer	Boni		Hunter-gatherers /fishing	Lamu
17. Dassanach	Shangila		Pastoralist	Marsabit
18. Emolo			Fishing and peasant pastoralist	Marsabit
19. Borana				
20. Turkana				
21. Somalia				

Source: ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012

Table 15.2: Other potential groups that the project should validate their characteristics

Potential VMGs	Locality to conduct the screening
1. Malakote /	Mombasa
2. Munyoyae /	Mombasa
3. Wanyasa / Malawi	Mombasa
4. Makonde	Mombasa
5. Wafrere – people from frere town in Mombasa	Mombasa
6. Nubian	all counties
7. Riba (people eating dead camel)	Mandera
8. Rirbahar (people of the ocean)	Mombasa

9. Corner tribe	Mandera
10. Deis	Marsabit (shores of lake Turkana in Ilelet)
11. Orma	Tana river
12. Pokomo	Tana river
13. Werdei (Tana river)	Tana river
14. Gal jiil (Gar – foreigner/pagan/camel, Jiil –love) isolated village	Mandera, Wajir, Garissa,

Source: MoH consultations and ERMIS Africa Ethnographic Survey of Marginalized Groups, 2005-2012

Table 15.3: Other potential groups that the project should validate their characteristics include

REGION	COUNTY	CONSTITUENCY	NAME OF MARGINALIZED GROUP	AREA WHERE FOUND	ECONOMIC ACTIVITIES
Coast	Tana River	1.Bura	Wailwana	Bura, Madogo & Mororo	Farming, Fishing
			Munyoyaya	Mbalambala, Mororo & Madogo	Casual Labor Farming
			Waata	Sombo	Farming Casual Labor
		2. Galole	Waata	Hola	Casual Labourers
	Kilifi	3. Ganze	Wasanya	Midoina	Hunting & Gathering
		4. Malindi	Wasanya (Boni)	Sabaki, Baricho	Hunting and Gathering
		5. Bahari	Wasanya	Arabuko, Sokoke	Hunting and Gathering
			Wapemba	Kamamah-Wendo wa Panya	Fishing
	Kwale	6. Kinango	"Wanyangulo"(Sanya)	• Samburu Division, (Kilibasi,Silaloni,Busho)	Farming and Hunting
		7. Matuga	Sanya	Mbegani/Mkongani Location	Farmers
		8. Msambweni	Tswaka	Majoreni/Ishimoni	Fishing/Farming
			Wakifundi	Majoreni/Ishimoni	Fishing/Farming
	Lamu	9. Lamu West	Boni/Aweer	Jima Pandanguo Baragoni	Hunters and Gatherers
			Sanye	Mapenya (Shekale), mkunumbi Witu, Madagoni, Sendemke	
		10. Lamu East	Boni/Aweer	Milimani, Mangai, Basuba, Kiangwe, Mararani, Kiunga, Mkononi Buthei	
Eastern	Isiolo	11. Isiolo South	Waata	Garbatula, Kinna, El-Dera Modo Gashe	Pastoralists

		12. Moyale	Sakuye	Dabel Location, Dir-dima Sub Location, Golla Sub Location	• Semi Nomads • Hunters
			Waata	Butiye Location Somake Location	• Unskilled Labourers • Blacksmith • Mixed Farmers • Charcoal Burners
		13. North Horr	Daasanach Waata Deis	Chalbi District: Ilerett, North Horr, Kalacha Telesgei	Pastoralists Fishing
		14. Saku	Waata Konso	Marsabit Central: Divib Gombo, Dakabaricha, Qachacha	• Hunters & Gatherers • Blacksmith
		15. Laisamis	Elmolo	Loiyangalani (elmolobay)	Fishing
			Lkunono	Laisamis, Lontolio, korr, Gatab, Meville, Nairibi	Black smith Pastrolist
North Eastern	Garisa	16. Dujis	Munyoyaya	Balich Village	
		17. Fafi	Munyoyaya	Bura	
		18. Lagdera	Gamuuns	Liboi	Casual Labourers
			Bonieya	Shanta abaq	Casual Labourers
			Reer Dumaal	Modogashi	Hunters
		19. Ijara	Boni Aweer	Bodhai Junction	
	Mandera	20. Mandera East	Gawawen	Neboi/Hunduthu	
			Warabei	Hararei/Hosle	
		21. Mandera West	Waata	Haradi	
		22. Mandera Central	Waata	Elhagarsu	
	Wajir	23. Wajir North	Gagabey	Bute	Blacksmith
		24. Wajir East	Hiir	Khorof-Harar/Wajiri Town/Hodhan	
			Ribi	Bula Burwako	
		25. Wajir West	Gagabey	Ganyure	
		26. Wajir South	Gagabey/Bon	Kibilay	
			Rer-Bahars	Bulla Kibilay	Black smith
North Rift	Baringo	27. Kwanza	Dorobo/Sebei	Kaibei Location, Chepchoina	• Bee Keeping • Farming • Animal Keeping
		28. Mogotio	Endorois	Koibatek District, Lake Bogoria and Maji Moto area	Pastrolist and Small Farming activities
		29. Baringo Central	Endorois	Marigat and Mochongoi Divisions	Pastrolists Peasant Farming

			Sabor	Marigat (Kimalel location)	Pastrolists
		30. Baringo Central, 31. Baringo North 32. Baringo East	Ilchamus	Mukutani, Tangulbei Marigat & Kipsaraman	Pastrolists
	Trans Nzoia	33. Cherangany	Sengwer	Kabolet Forest, Kabolet Sub location, Makutano Location and Kaplamai Division	Hunters & gathers Small Farming & Pastrolist Bee Keeping
	Turkana	34. Turkana South	Ngikebotok	Along the Banks of River Turkwel	Small Scale Farming
		35. Turkana Central 36. Turkana South	Ichakun *(They are recently formed immigrants)*	Along the Banks of River Turkwel	Small Scale Farming Basketry
	Trans Nzoia	37. Saboti	Dorobos	Kiboroa and Kisawai location along Mt. Elgon Forest, Kiboroa Sub location, Saboti Division	• Farming • Bee Keeping • Cattle Keeping
	West Pokot	38. Sigor	Sengwer	Seker, Lomut & Parua in Pokot Central Chepkono & Sonday in Pokot South	Farming Livestock
		39. Kapenguria	Sengwer	Chemorngit Location, apuko Kopito, Lorsuk Kaplolmuo, Kamunono	
			Sengwer	Chepareria division, Kaibos Location, Talan locationemwochoi Kabolet and ch	Farming Honey harvesting Dairy
South Rift	Narok	40. Narok North	Ogiek	Nkareta, Sasimwani, Teketi, Cledeem, Topoti, Mbenek Dapshi, Orkuum le Saleita	• Farming • Livestock
	Nakuru	41. Kuresoi	Ogiek	Kiptagich, Tinet, Ndoinet, Kuresoi	• Farming • Livestock Rearing • Honey Tapping
	Samburu	42. Samburu West	Lkunono	Maralal, Tamiyoyi, Ngarjin Nchingei, lemisigiyo, Barsaloi, Lorengei	• Black smith • Livestock • They have Councillors
			Ltorobo	Suguta Marimar	Livestock

				Longewan Baawa	Farming Honey Tapping
		43. Samburu East	Sweii (Ndorobo)	Wamba, Ngilai along River Ngeny. Ngolgotim, Lodongkwe, Ndonyo wasin, Nondyo Nasipa	Livestock Keeping
	Narok	44. Narok South	Lkunono	Loita	Black Smith
			Ogiek	Loloipangi	Hunters & Gatherers
			Ogiek	Sogoo, Enkaroni Lemek, Loita & Esinon	Farming & Livestock
	Nakuru	45. Eldama Ravine	Ogiek	Kiplombe & Mumberes	Farming Cattle Keeping
		46. Molo	Ogiek	Nessuit Location Mariashon Mauche	Bee Keeping Farmining Livestock
	Laikipia	47. Laikipia East	Yiaku	Doldol, sieku	Hunters and Gatherers Game Ranchers
Western	Bungoma	48. Mt. Elgon	Ogiek	Kopsiro Division, Kapsokwony and Kaptama Division	Pastrolist Farmers

[ii] OP 4.10 Footnote 7: 'Collective attachment' means that for generations there has been a physical presence in and economic ties to lands and territories traditionally owned, or customarily used or occupied, by the group concerned, including areas that hold special significance for it, such as sacred sites. 'Collective attachment' also refers to the attachment of transhumant/nomadic groups to the territory they use on a seasonal or cyclical basis.