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Acronyms

CACC- Constituency AIDS Control Committee
CBO -  Community Based Organization
CHWS  Community health Workers
DMOHs District Medical Officers of Health
EAPHLN - East Africa Public Health Laboratory Networking
EMMS - Essential Medicines and Medical Supplies
FGD - Focus Group Discussions
HFMC - Health Facilities Management Committees
HSSF- Health Sector Support Fund
IPs - Indigenous Peoples
IPPF- Indigenous Peoples Planning Framework
IDSR- Integrated Disease Surveillance and Response
ITNS  Insecticide Treated nets
JAPR  Joint AIDS Program Review
KDHS - Kenya Demographic Health Survey
KHSSP- Kenya Health Sector Support Project
KEPH - Kenya Essential Package for Health
KEMSA - Kenya Medical Supplies Agency
KNASP - Kenya National AIDS Strategic Plan
MARPS Most At Risk Populations
MCH Mother Child Health
MOPHS- Ministry of Public Health and Sanitation
NACC National AIDS Control council
NHSSP - National Health Sector Strategic Plan
NGO - Non-Governmental Organization
NASCOP- National AIDS & STIs Control Programme
PHO Public Health Officers
TBA   Traditional Birth Attendants
TOWA – Total War against AIDS
VMPP - Vulnerable and Marginalized People’s Plan
VMPPF - Vulnerable and Marginalized Peoples Planning Framework
Acknowledgments

This work would not have been complete without the support of many people and institutions. Multiface Research and Development Centre would like to acknowledge the support received from the Ministry of Public Health and Sanitation staff, particularly the Swap Secretariat at Afya House, various District Medical Officers of Health (DMOH), Public Health Officers (PHOs), Medical Supretendants and Health workers in the facilities which were visited during this exercise. We would also like to acknowledge the support of the NACC headquarters and their regional offices for the support provided in mobilization of the VMPs to participate in this study.

The study team would like to particularly single out the significant support provided by the various CACC coordinators in mobilizing the VMG community members to participate in this exercise. The staff of the East African Public Health Laboratory Network helped to provide the contacts and facilitated meetings with its staff in the different sites which were visited by the consultancy team.

We also acknowledge the support provided by the partners including the World Bank staff who accompanied the consultancy team during the site visits and consultations. The consultative meetings at AFYA house before, during and after the site consultations significantly enriched the process of developing the Vulnerable and Marginalized Peoples Plans (VMPPs) and the consultancy team would like to acknowledge their contribution in successful completion of this exercise. Of great importance is the sacrifice by the Vulnerable and Marginalized Populations who volunteered their precious time to provide information to the consulting team during the data collection exercise.

In compiling this report, we have taken care to represent the views of all the respondents correctly and accurately. We hope that the entire process and the final plans will help the VMPs to enhance their accessibility to and utilization of health services.

Erick O. Nyambedha, PhD
Team Leader and Lead Consultant
Executive Summary

Despite the fact that Kenya has registered overall improvement in most health outcomes, there are still notable inequalities in access to health care based on geographic, socio-economic and gender dimensions. Consequently, Kenya has developed the Indigenous Peoples Planning Framework (IPPF) in order to comply with the World Bank’s operational policy on Indigenous Peoples. Projects developed within this framework are expected to provide opportunities and mechanisms for Indigenous Peoples to participate and benefit from the project activities in their areas, through appropriately developed actions plans which are responsive to their cultural conditions.

A broad objective of this exercise was that The Ministry of Public Health and Sanitation (MOPHS), through its projects: the Kenya Health Sector Support Project (KHSSP), the East African Public Health Laboratory Network (EAPHLN) and the Total War Against AIDS (TOWA) project under the National AIDS Control Council (NACC), sought to jointly develop, separately implementable Vulnerable and Marginalized Peoples Plans (VMPPs) to increase the accessibility of health services to the Vulnerable and Marginalized Populations (VMPs). Specifically, the exercise sought to establish the (i) extent to which the Indigenous Peoples (IPs) are benefiting from the three projects, (ii) the barriers to accessing services provided under the three projects and (iii) to develop action plans which provide implementers with practical measures to guide implementation, monitoring and evaluation of IPs benefits from the project activities given the geographical, financial and socio-cultural factors.

Information was collected from thirteen communities in eight Counties/Districts. The 13 communities were: Sengwer, Ngikebotook, IL Chamus, Endorois, Sabor, Ogiek, Konso, LKunono, IL Waana/Malakote, Waata, Boni/Aweer, Saanye and Munyoyaya. Qualitative data collection instruments covering all the relevant thematic areas identified from the ToRs and anchored on each project’s vulnerable and marginalized peoples planning framework were utilized. Data was collected through consultations with the VMPs and other stakeholders to obtain information regarding whether the (i) VMPs benefit from the three projects, (ii) barriers to access and utilization as well as benefiting from the projects and (iii) the recommendations on how to enhance their ability to benefit. The data collection included; a desk review, Focus Group
Discussions (FGDs), In-depth interviews with key Informants (KII) and narratives from project beneficiaries. Fieldwork was conducted among 13 out of 22 VMPs identified by the Ministry of Public Health and Sanitation (MOPHS). Data was analyzed using the ethnographic methods of content analysis. This included an examination of emerging themes and categorizing them into summaries relevant for the development of action plans for each of the three projects.

Findings: Overall, the results showed that most VMPs do not have adequate access to health services under KHSSP, they neither participate in the local health care decision making as well as in the activities of the TOWA grants mainly due to lack of capacity. Poverty, discrimination, low levels of education as well as lack of information significantly contributed to the poor accessibility to and utilization of health services. Harmful socio-cultural practices were also noted to be prevalent. Furthermore, the findings revealed that there were no functioning grievance complaints mechanisms that could strengthen governance, representation and oversight through which social accountability could be strengthened among the VMPs to enhance accessibility to and utilization of health services. Based on these findings, three separate Vulnerable and Marginalized Plans (VMPPs) have been developed with an aim of enhancing access to basic health services including laboratory testing and diagnosis and increased participation of the VMPs in the TOWA grants (See Annex VII). The VMPPs made recommendations in the following areas based on the following thematic areas; community empowerment, promotion of good and desirable health practices, making health services affordable, ensuring that health facilities serving the VMP communities have adequate medicines and supplies as well as equipment and infrastructure; and enhancement of social accountability to strengthen governance, representation and information flow to the VMPs with regard to health services delivery.

The main recommendations included the following:  
i) There is need to enhance awareness of the existing health services among the VMG communities  
ii) Improve utilization of available services by promoting positive health care seeking behavior  
iii) Put in place plans to enhance access to health services in the communities by adopting the pro-poor strategies in health financing,  
iv) Social Accountability mechanisms should be put in place to enable proper strategies for grievance resolution and a monitoring mechanism,  
v) Build the capacity of the VMG communities to participate in health activities,  
vi) Address the identified gaps in HIV/AIDS
service provision among the VMG populations and vii) Enhance service delivery, equipment and infrastructure of East African Public Health Laboratory Network.
1 Introduction

1. After a period of stagnant and even deteriorating health indicators, Kenya has recently made some significant progress. Overall, most health outcomes in Kenya now compare quite favorably with its East African neighbors. Nevertheless, there are serious health status challenges remaining. Inequities in health in Kenya continue to have geographic, socioeconomic and gender dimensions. Maternal mortality remains high with the maternal mortality ratio (MMR) officially estimated to be around 530 per 100,000 live births. The total fertility rate is 4.6 births per woman. This is a slight decrease from the rate of 4.9 ten years ago. Neonatal mortality is a particular concern and 6 out of 10 infant deaths occur during the first 28 days of life. According to the Kenya Demographic Health Survey (KDHS) 2008 findings, 35 percent of Kenyan children are stunted, while 14 percent are severely stunted raising serious concerns about chronic malnutrition.

2. The Constitution of the Republic of Kenya (Republic of Kenya, 2010) has entrenched the right to health for every Kenyan through Article 43 (1) (a) which states that ‘every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare’. In Article 56 (e), the Constitution has further recognized the right to health of minority and marginalized groups in the country by stating that “the State shall put in place affirmative action programs designed to ensure that the minorities and marginalized groups have reasonable access to water, health services and infrastructure; and participate and are represented in governance and other spheres of life respectively.” This study on the Kenya Health Sector Support Project (KHSSP); the Total War against AIDS Project (TOWA) and the East Africa Public Health Laboratory Network (EAPHLN) is one initiative the government and the World Bank to address the healthcare services needs of the Vulnerable and Marginalized Groups (VMGs) (World Bank, 2010, 2007 2006a, 2006b,2006c, 2005).

3. Kenya’s national health goal to provide access to and utilization of health services by all citizens is commendable, however pockets of poverty as well as socio-culturally and geographically disadvantaged communities persist (MOPHS, 2010, 2009). Consequently, the Kenya Health Sector Support Project (KHSSP) has developed the Indigenous Peoples Planning Framework (IPPF) to comply with the World Bank’s operational policy on Indigenous Peoples (World Bank, 2006b). Projects developed within this framework will provide opportunities and mechanisms for Indigenous Peoples, also recognized as the vulnerable and marginalized groups, to participate and benefit from the project activities in their geographical areas, through appropriately developed action plans which are responsive to their cultural conditions.

The World Bank has funded the Total War against AIDS (TOWA) to help fight HIV/AIDS in Kenya in collaboration with the National AIDS Control Council (NACC) and the East African Public Health Laboratory Network (EAPHLN) to enhance accessibility to quality laboratory services for the cross-border populations.
4. The Kenya Health Sector Support Project (KHSSP) aims to improve delivery of essential health services for Kenyans, especially the poor. The Total War against AIDS Project (TOWA) aims to expand the coverage for targeted HIV/AIDS preventive and mitigation services. The East Africa Public Health Laboratory Networking (EAPHLN) project aims to increase access to quality public health laboratory services for diagnosis and surveillance of TB and other communicable diseases.

5. Although these three projects do not anticipate negative impacts on Vulnerable and Marginalized Groups (VMGs), the World Bank Operational Policy (OP4.10) Indigenous Peoples has been triggered for all three projects to ensure pro-active steps are taken for such groups to benefit from the project. Each of the projects has a Vulnerable and Marginalized Peoples Planning Framework (VMPPF) focusing on a pro-active approach that ensures VMGs is included, mainly through effective targeting and/or assistance in preparing sub-projects. VMGs have been identified and the next step is to translate the frameworks into concrete plans. It is generally envisaged that the Vulnerable and Marginalized Populations do not have access to these services in a similar way to other ethnic communities in Kenya.

2 Objectives of the Study:

6. The overarching objective of the study is to ensure that the health needs of local Vulnerable and marginalized groups\(^1\) (VMGs) are addressed in a participatory and meaningful way. The consultancy worked towards ensuring a coordinated health sector approach to meeting the specific health needs of VMG working through the three projects. Specific Objectives of the assignment were to:

   a) undertake free, prior and informed consultations with local vulnerable and marginalized groups on access to health/HIV services provided under the three projects;

   b) support the three implementing agencies to develop project specific Vulnerable and marginalized peoples Plans (VMPPs) in cooperation with the local vulnerable and marginalized ethnic groups, that will enable such groups in the project areas access benefits from each project equitably and in a culturally appropriate manner.

7. The consultant facilitated joint consultations with selected VMGs for all three projects to support development of project specific VMPPs based on the existing VMPPF. Considerable social analysis has already been undertaken on IPs in Kenya under a number of Bank funded projects including these three operations. Therefore, a broad social assessment on the same groups would add little value. Instead, the study adopted a more focused consultation with select VMGs covering at least 13 areas known to have underserved and marginalized populations focusing on access to health services at levels 1-3 including access to HIV related services, and specialized laboratory services for TB and other communicable

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\(^1\) Note that different countries may adopt other terms to refer to “indigenous peoples” – for example, vulnerable and marginalized ethnic groups, tribal groups or local minorities.
diseases. This will ensure planning better coordinated delivery of health and HIV services that are responsive to the needs of VMGs and also save time, minimize repetition, and community fatigue with research including effective management of community expectations. Thirteen communities in 9 districts within 8 counties were selected.

3 Approach

8. The consultancy followed the same 4 step approach for each of the three health projects

   a) To assess whether VMG are included or excluded through the existing project
   b) To document what and how existing support is being provided to VMG
   c) To identify how the existing project can expand and improve support to VMG through the existing mechanism and activities already in the plan.
   d) To recommend any additional/new work through the existing project, where appropriate

4 Background to the Vulnerable and Marginalized Communities

9. According to the African Commission on Human and Peoples’ Rights (ACHPR, 2003) document entitled “Report of the African Commission’s Working Group of Experts on Indigenous Populations (IP)/Communities”, the Indigenous Peoples (IPs) also identified as the ‘vulnerable and marginalized people’ are those populations whose cultures and ways of life differ considerably from the dominant society; are under threat, and in some cases face extinction. Their survival depends on access and rights to their lands and the natural resources; they suffer from discrimination as they are regarded as less developed and less advanced than other more dominant sectors of society and often live in inaccessible regions and suffer from various forms of marginalization, both politically and socio-economically.

The scope of the study is national; however the assessment was conducted in ten sites, clustered into 5 groups (See Map one in annex III), spread across the country in mapped areas home to Indigenous People. The Ministry of Public Health defined and mapped 22 VMG communities in the whole country (See List in Annex IV). Out of these, free and informed consultations were held with 13 VMGs during the site visits. The 13 VMG communities that were visited included the Sengwer, Ngikebotook, Endorois, Sabor, IL Chamus, Ogiek, Konso, LKunono, Munyoyaya\textsuperscript{2}, Waata, Wasaanye, Boni, and Aweer. Table 2 in annex IV shows the locations by country and district of the 22 communities, including the 13 communities covered in the study. Other communities that have been listed as the Vulnerable and Marginalized Communities in a screening done by the Ministry of Public Health and Sanitation but were not visited include; Gawawen, Daasanach, Deis, El-Molo, Sakuye, Dorobo/Il torobo, Gagabey/Bon, Rer-Bahars and Yiaku. Annex III Map 1 shows the Location of Health Facilities versus Marginalized Groups/Communities Disparity Analysis by County.

\textsuperscript{2}The Malakote also live in Madogo and were among the respondents that participated in the FGDs with the Munyoyaya VMG.
10. The level of education among the VMGs is generally low and a hindrance to effective flow of information as well as negatively affecting their participation in development activities. The low levels of education has made it difficult for the majority of the VMG communities to access formal employment and therefore many do not have any regular source of income. This has made the surrounding communities who are better educated to dominate over them while the VMG communities see themselves as inferior and refer to themselves as “jamii duni wenyе wamejитenga” to mean discriminated communities that live in isolation. These feelings of isolation and inferiority have escalated their lack of access to health services and participation in other projects such as the TOWA one. However, 8 of the 13 VMGs who were visited had community members who had accessed secondary school education as was mentioned in Focus Group Discussions with Sengwer, Endorois, ILChamus, Ogiek, Ngikebootok, Konso, Malakote and while among the Munyoyaya there was one person who had graduated from a University.

11. Quite often, the few who are educated in this community migrate to live away and therefore do not participate in most community activities, leaving the villages with people who have very low levels of education. Among the Sengwer, in the Kabolet Forest in Cherenganyi hills there was one young lady who was trained as a social worker and works at the Kapsara hospital as a casual. Her presence in the hospital has helped to attract the Sengwer to the hospital because they feel one of their own is working in the hospital and can empathize with their health problems.

12. Ten communities out of the 13 who were visited mentioned that they were trying to adopt farming because natural resources to sustain fishing; hunting and gathering as well as pastoralist livelihood are difficult to sustain. These included; the Sengwer, Endorois, ILChamus, Sabor, Ogiek and the Konso, Aweer/Boni, Waata, Saanye and Ngikebootok. They are however, facing problems of lack of farm inputs and recurrent crop failure due to unpredictable weather, which perpetuates poverty and cases of malnutrition in their communities. Among the VMG communities which are pastoralists, cattle rustling have perpetuated poverty levels, leaving them with no other form of livelihood.

13. All the 13 VMGs who were studied except Ngikebootok and Konso communities live in places which lack infrastructure in general but specifically public transport to functional health facilities. In some places, the terrain cannot allow the use of motorcycle as a means of transport. A major issue that is common among these groups is domination by other majority communities. Consequently, there is bias in receiving information regarding most government services and opportunities. Lack of access to information has made it difficult for these communities to benefit from the public and private sector as well as civil society organizations. In places where NGOs are operating such as among the Konso and Lkunono, the target has been the general population living in the areas, hence all the opportunities have gone to the dominant communities, who use their numerical and other socio-economic supremacy to benefit from the resources, to the disadvantage of the VMGs living in their midst.
5 Background and Scope of the Study

14. The three projects that are the focus of the study include; (i) Kenya Health Sector Support Project (KHSSP) which seeks to improve delivery of essential health services for VMGs; (ii) the Total War against AIDS Project (TOWA) aimed at expanding the coverage for targeted HIV&AIDS preventive and mitigation services for the VMGs; and (iii) the East Africa Public Health Laboratory Network (EAPHLN) whose objective is to increase access to quality public health Laboratory services. Data obtained from this study will be used to jointly develop separate implementable Vulnerable and Marginalized Peoples Plans (VMPPs) for the three World Bank sponsored projects.

15. The Kenya Health Sector Support Project (KHSSP) is implementing the National Health Sector Strategic Plan II (NHSSP). The KHSSP is being implemented by three agencies namely (i) Ministry of Medical Services (MOMS) that has responsibility for Health Financing Reforms and District Hospital Referral improvements (ii) Ministry of Public Health and Sanitation (MOPHS) that has primary responsibility for the Health Sector Service Fund (HSSF) and (iii) Kenya Medical Supplies Agency (KEMSA) that is responsible for procurement of Essential Medicines and Medical Supplies (EMMS) and related reforms. The project has two main components.

a. **Component I - Effective and Transparent implementation of the Kenya Essential Package for Health (KEPH) through HSSF grants and performance strengthening (US$46 million):** This component supports the effective and transparent implementation of the Kenya Essential Package for Health (KEPH) through (i) HSSF grants and performance strengthening and (ii) improving the governance and stewardship role of the Ministries of Health, including support for health financing reforms and improvements in referrals and strengthened Monitoring and Evaluation.

b. **Component II: Availability of Essential Health Commodities and Supply Chain Management Reform (US$ 54 million):** This component seeks to increase the availability of essential medicines and medical supplies (EMMS) and assure quality with reforms in supply chain management and related capacity building. This component is intended to bring sustained relief to the frequent shortages and stock-outs of health commodities by building-up a reasonable buffer stock of EMMS at Kenya Medical Supplies Agency (KEMSA) as well as reforms to make procurement and the supply chain system more efficient, transparent and effective.

16. Both components support improvements in health sector governance, accountability and performance with an overall aim of enhancing access to and utilization of basic and quality health services for Kenyans. In summary, KHSSP was designed to ensure the following:
• Improved recovery of malnourished children and their lactating mothers;
• Increased access to and utilization of out-patient services; and
• Efficient supply of essential drugs through KEMSA.

17. The Total War against AIDS Project (TOWA) aims to expand the coverage for targeted HIV&AIDS preventive and mitigation services. TOWA has two components.
   a. The first component deals with strengthening governance and co-ordination, including capacity building of beneficiaries in the use of grant funds and support for program implementation. This component will make financial resources available to civil society, public and private sector and research institutions.
   b. The second component focuses primarily on the civil society and private sector with results based proposals and activities. TOWA will also be responsible for: (i) Raising awareness on HIV&AIDS and (ii) Support to PLWHA.

18. The East Africa Public Health Laboratory Networking (EAPHLN) aims to increase access to and utilization of quality public health laboratory services. The project strategically focuses on cross border districts within the country (Wajir, Kitale, Busia, Malindi and Machakos) as well as cross border countries. For example, Kenya is currently faced with an increase in refugee population from neighboring countries such as Somalia and South Sudan with unstable health programs. The project is designed to enhance the capacity of national and regional health centres of excellence in the provision of accurate and appropriate information on diagnosis and surveillance of Tuberculosis and other communicable diseases. Further, it will facilitate rapid and effective communication of laboratory information; and capacity building of healthcare workers to improve diagnosis of diseases.

6 Objectives of the Assignment

19. The overall objective of the study is to ensure that the health needs of local vulnerable and marginalized groups (VMGs) are addressed in a participatory and meaningful way. The specific objectives are to:

   a. Undertake free, prior and informed consultations with local vulnerable and marginalized groups on access to health/HIV services provided under the three projects;

   b. To develop project specific Vulnerable and marginalized peoples Plans (VMPPs) in cooperation with the local vulnerable and marginalized ethnic groups, that will enable such groups in the project areas access benefits from each project equitably and in a culturally appropriate manner.

   c. Advise if additional Call for Proposals (CFP) for the VMG groups is necessary and if so in which geographic area, and in which area of service.
7 Study Approach

7.1 Approach

20. The study adopted a four-step approach for each of the three health projects namely:

- Assessment of whether VMG are included or excluded through the existing project and the TOWA Call for Proposals (CFPs);
- Documentation of what and how existing support is being provided to VMG;
- Identification of how existing project can expand and improve support to VMG through the existing mechanism and activities already in the plan i.e. addressing the gaps in access to and utilization of health services); and
- Recommendations on any additional/new work (new CFPs under TOWA) through existing project, where appropriate.

7.2 Study Methods and data collection

21. The study was conducted between August and September 2012 in the following counties where VMG had earlier been identified to live: Trans Nzoia, Turkana, Baringo, Nakuru, Marsabit, Tana River, Lamu and Kilifi. An additional, key informant was interviewed to provide information about the East African Public Health Laboratory Project in Wajir. In total, the study conducted consultations with 13 VMGs.

22. The study used various methods to obtain requisite ethnographic data, which included desk review, key informant interviews, focus group discussions, narratives and observations. Initial entry into the field was done through the contacts that were given by the three partners in the project: The Kenya Health Sector Support Project (KHSSP), Total War against AIDS (TOWA) and the EAPHLN. The consulting firm contacted the regional Co-coordinators for NACC, EAPHLN officers and District Medical Officers of Health (DMOHs) in the regions where VMGs were to be visited. NACC regional Co-coordinators and (DMOHs) provided the contacts of the Constituency AIDS Control Co-coordinators (CACCs) and in some cases, the public health officers (PHOs) helped to mobilize the community members who participated in the Focus Group Discussions (FGDs), Key Informants and a few cases where the narratives were obtained.

a. **Desk Review** was used to provide background information to the study and to inform refinement of data collection instruments in close consultation with the reference persons for each of the three projects under the study. The documents reviewed relate to the design, implementation and monitoring of the three projects and include the World Bank’s Indigenous Peoples Policy, Indigenous Peoples Framework IPPF for the three projects, the National Health Sector Strategic Plan II (NHSSP II), Effective and Transparent implementation of the Kenya Essential Package for Health (KEPH), Kenya Health Sector Support Project (KHSSP)
documents, Kenya National AIDS Strategic Plan (KNASP), the Joint AIDS Program Review (JAPR) and TOWA project among other documents.

b. Key Informant Interviews were conducted with reference persons for the three separate projects (CACC Coordinators, Public Health Officers and Laboratory Technologists in charge of hospitals, nursing officers in charge of health facilities, medical supreidents and DMOH in the study sites). Other respondents identified were opinion leaders among the VMGs and included the local politicians, religious leaders, local provincial administration officials and Community Health Workers. Six out of 13 VMG communities reported to have registered CBOs which were not active. However, NGO activities were reported in 3 (LKunono, Konso, Ngikebotook) out of 13 VMG communities that were visited.

c. Focus Group Discussions which are disaggregated by sex were held with different VMG communities in the study sites. The findings indicated that age is not a barrier to the achievement of the principle of homogeneity and free discussions during the FGDs because of the dominant concept of ‘wazee’ to mean all the men including young men who are married, and ‘wamama’ which means all women, both young and who are married. Both categories of ‘wazee’ and ‘wamama’ are considered to provide views which are representative of the whole community among the VMGs who were visited. Each FGD comprised 8-12 women or men. Altogether, a total of 26 FGDs were conducted in 13 VMG communities. There was no FGD in Wajir because information was obtained from Key Informant Interviews only by phone. The FGDs were conducted by the consultants during the field visits. The FGDs for the women respondents were moderated by a female member of the team experienced in conducting the FGDs, while those among the men were conducted by a male member of the team who is also experienced in Focus Group Discussions. The FGDs were recorded to ensure accuracy by the note takers during these discussions. In a few cases, where the VMGs could not communicate in either English or Kiswahili, a local interpreter was identified to help in the translation. The Focus Group Discussions provided the bulk of the data on which this report is based.

d. Narratives were derived from individual VMGs who were willing to share their experiences in seeking or utilizing the services provided by the three projects in their respective areas. The study obtained a relevant narrative from each of the three VMG communities (Annexes 1-3).

e. Direct observation was useful in triangulation and verification of the information that was obtained from the other methods of data collection.
7.3 Data Analysis

23. The data was transcribed using a computerized transcription machine to produce texts for analysis. The data collected was analyzed using the ethnographic methods of content analysis by examining emerging themes and categorizing them into summaries that are relevant for the development of action plans for each of the three projects. The focus was on identification of gaps in access to and utilization of health services to inform the development of vulnerable and marginalized people’s plans for each project. The emerging analytical themes were collapsed into major actionable points for the three projects (KHSSP, TOWA and EAPHLN).

7.4 Scope and Limitations

24. Data collection in this study was conducted using short ethnographic methods that aimed at collecting qualitative data to provide explanations on why the VMG communities are not able to benefit from basic health and HIV/AIDS services under Kenya Health Sector Support Project (KHSSP), Total War Against AIDS (TOWA) and the East African Public Health Laboratory Network (EAPHLN). The study primarily aimed at providing insight on how these communities can be assisted to benefit from the services provided in the three projects through affirmative action in a culturally appropriate way. The data obtained therefore provides an in-depth understanding of the reasons why these communities cannot access and utilize health services in the same way as other communities in Kenya. However, the data cannot be used to draw statistical inferences and generalizations on behalf of the VMGs because of the limitations of the ethnographic data. Secondly, the study team could not travel to Wajir and other parts of North Eastern Province due to security concerns in the region because of Al Shabaab insurgency and banditry activities at the time of the data collection.

8 Findings of the Study

24. This section presents the summaries of findings from the free and informed consultations that were conducted with the VMGs in the sites that were visited as well as the information obtained from a key informant from in Wajir. The results are presented in several sections: The first section reports the overall health problems that the VMGs identified to be prevalent in their areas and for which they expressed concern for either lack of or inadequate health services. The remaining three sections provide summaries of the themes identified during the data analysis according to the three projects: The Kenya Health Sector Support Project (KHSSP) project, The Total War against AIDS (TOWA) project and the East African Public Health Laboratory Network (EAPHLN) project. Recommendations for possible actions that are only within the scope of these projects have been identified to improve accessibility to and utilization of the health services. These are provided at the end of a summary for each of the projects.
25. Below are the major health problems that were identified during discussions with the VMGs. These health problems are not necessarily presented in the order of their prevalence. However, the most pressing health problems identified among the VMGs include; Malaria, HIV/AIDS, Typhoid, Tuberculosis, Malnutrition and Snake bites.

   a. **Malaria** is a major disease that was mentioned by 12 out of 13 VMG communities visited. Most of the VMGs have small houses and because of this, men stay out in the open and only come into these houses late in the night after the women have prepared meals and all the children have eaten and ready to sleep. This exposes them to mosquito bites despite the provision of nets to some VMG communities. In addition, the nets provided are not enough for everyone in the house. This means that not everyone sleeps under the insecticidal treated nets (ITNs). Malaria was mentioned as a health problem among 12 out of 13 VMGs who were visited.

   b. **HIV&AIDS** was reported as a big problem in most of the VMG communities, with high levels of stigma. HIV&AIDS is not discussed freely in these communities across sex differences. The VMGs reported that most Traditional Birth Attendants (TBAs) were exposed to HIV infection because of the practice of conducting deliveries without protective gloves. In other VMGs, condom distribution has not progressed well because of the attitudes and religious beliefs. HIV/AIDS was mentioned among 12 out of 13 VMGs who were visited.

   c. **Snake bites** were mentioned in 8 out of the 13 VMG communities. The snakes were reported to be very poisonous and have resulted in high case fatality rates. The snakes enter the houses at night in search of rats and water. The structure of the houses makes it easy for them to get access. Among the Endorois in Lake Bogoria, about 100 families who lost their loved ones due to snake bites have reportedly been compensated by the Wildlife Services (KWS).

   d. **Malnutrition** was mentioned in 8 out of the 13 VMG communities visited and mainly affects children and their lactating mothers. The VMGs who participated in the Focus Group Discussions attributed this problem to lack of food due to poor or no crop harvest and high levels of poverty associated with cattle rustling, dwindling natural resources for hunting and gathering and their transitioning from pastoralist, hunting and gathering as well as fishing lifestyle to settled agricultural life of which they still lack essential farm inputs.

   e. **Typhoid**: Mentioned in 11 out of the 13 VMG communities who were visited

   f. **Diarrhea**: Mentioned in 7 out of the 13 VMG communities visited

   g. **Brucellosis**: Mentioned in four VMG communities out of the 13 who were visited

   h. **Tuberculosis**: Mentioned in nine VMG communities out of the 13 who were visited

   i. **Cancer**: Mentioned in four VMG communities out of the 13 who were visited

   j. **Pneumonia**: Mentioned in five VMG communities out of the 13 who were visited

   k. **Common skin diseases**: Mentioned in three VMG communities out of the 13 who were visited
1. **Other health related problems identified were**: allergy, eye problems, cancer, Liver cirrhosis, blood sugar, blood pressure, kidney problems, pneumonia, anemia, heart problems, and environmental health problems, lack of pit latrines and water related health problems.

The above information is presented in a table below

### Table 8.1: List of health ailments identified by communities

<table>
<thead>
<tr>
<th>Name of VMG community</th>
<th>Malaria</th>
<th>HIV/AIDS</th>
<th>Snake bites</th>
<th>Malnutrition</th>
<th>Typhoid</th>
<th>Diarrhea</th>
<th>Brucelosis</th>
<th>Cancer</th>
<th>Pneumonia</th>
<th>Common skin diseases</th>
<th>TB</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sengwer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Ngikebotook</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>IL Chamus</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Endorois</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sabor</td>
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<td>X</td>
<td>-</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Ogiek</td>
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<td>-</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Konso</td>
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<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
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<td>X</td>
</tr>
<tr>
<td>Lkunono</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
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<tr>
<td>Munyoyaya</td>
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<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>IL Waana/Malakote</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>X</td>
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<td>-</td>
</tr>
<tr>
<td>Waata</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>X</td>
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</tr>
<tr>
<td>Boni/Aweer</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>-</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Sanye</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>X</td>
<td>X</td>
<td>-</td>
</tr>
</tbody>
</table>

### 8.2 The Kenya Health Sector Support Project (KHSSP)

#### 8.2.1 Findings on the KHSSP

##### 8.2.1.1 Accessibility to and utilization of health services

26. *Distance from most of the VMG communities visited to the nearest health facility ranges between 17-40 Kilometers.* Most of the VMG communities were in areas that are inaccessible. The accessibility to health services in such areas is further hindered by factors such as distance, impassable rivers, swamps and cost of transport. The IL Chamus, for example, spend an average of Kshs.600 for transport expenses to take the pregnant women in labour to deliver at Marigat district hospital; while the Waata community in Madogo of Tana
River spends an average of Kenya shillings 2,000 on transport hire to take their sick to the Provincial hospital in Garissa. It was reported that most deliveries are conducted at home because of these challenges. Poverty was identified as a factor limiting the accessibility to health services at level 1-3 in most of the VMG communities.

27. There were built and complete health facilities that have not been equipped while in other sites there were health facilities, mostly dispensaries that had not been completely built.

28. Low levels of awareness on the existing health services were noted among the VMG community. This was compounded by the fact that the VMG communities live in places which do not have access to functional health facilities due to the fact that there are health facility structures in some VMG communities that are not operational as was the case among the IL Chamus and Boni/Aweer, the strong belief on the effectiveness of traditional herbs which are found for free in the villages yet in the health facilities, one has to pay in order to obtain access. Very few people therefore go to the health facilities and many are unaware of the existing services. Low levels of awareness can also be attributed to low levels of education and the socio-economic activities of the VMG communities which make them to spend a lot of time in the bush hunting and fishing thus limiting their interaction with the larger surrounding communities. Among the Sengwer in the Cherenganyi Hills, people perceive all diseases to be malaria caused by the types of crops they eat, fruits and sometimes drinking tea which is believed to cause malaria. They therefore apply herbs to vomit. Vomiting after applying herbs is considered to be a healing process for people suffering from malaria. One of them thus explained during an in-depth interview; ‘Mimi situmii dawa za hospitali’ meaning ‘I don’t use medicine from hospitals’.

29. Out of the 13 communities that were studied, 10 of them reported that they receive malaria treatment services in the hospitals although only 4 of the thirteen communities reported having been provided with the Insecticide Treated Nets (ITNs). Five communities reported having access to maternity services for hospital deliveries while only 4 out of the 13 communities reported that there are HIV/AIDS services in the health facilities close to where they live. Only one community, the Konso reported that all the health services that they need are provided in Marsabit district hospital.

30. All VMGs who were studied reported that deliveries are conducted at home for some of the members of the community. This is because the hospitals are far, difficult to reach and expensive whenever transport is available. Cases of deliveries on the way to health facilities are rampant as was reported among the Sengwer, Sabor, IL Chamus, Endorois and Ogiek. In a few cases, deliveries are conducted at home by the Traditional Birth Attendants due to cultural beliefs and practices. Among the Ngikebotook in Turkana South district, the community does not prefer taking pregnant women to deliver in hospitals because of traditional rituals that are performed during child birth, such as the use of a common spear or knife to cut the umbilical cord of a new born baby boy or girl respectively and application of traditional herb as well as birth ceremonies. In these communities, it was reported that a new born can only be taken to the hospital two weeks after delivery, resulting in the new born missing some immunization. At the Katilu health centre, a facility with a catchment area of
22,278 people and which serves the Ngikebotook community, there was a maternity wing which had beds but without patients. The Ngikebotook community members also prefer not to take pregnant women to the hospitals because of lack of female health workers to conduct deliveries, water and shortage of lighting at the hospital, water and food among other factors. A key informant explained thus:

Men in our community do not allow women to deliver in the clinic because they want to perform traditional rituals and apply herbs. The umbilical cord of the male baby is cut using a common spear in the community while the one for the female baby is cut using a common knife in the community. They only allow women to go to the hospital after two weeks from the time of delivery.

31. In addition, the VMGs interviewed pointed out that some community members prefer not to take pregnant women to hospital because they are not comfortable with male staff conducting deliveries. This was particularly reported among the Boni/Aweer who do not like their women to be delivered by men and that some women have undergone FGM and therefore feel stigmatized being delivered by young men who are outsiders. Among the Ogiek community, it was reported that the TBAs do not prefer gloves even if they are provided with some because they keep long nails which they use as surgical blades to cut the umbilical cord of the new born.

32. Cultural beliefs and practices that were identified as barriers to accessibility to health services included; the beliefs and practices around deliveries for pregnant women in some communities, beliefs in the efficacy of traditional herbs, beliefs and stigma associated with the relationship between Tuberculosis and HIV/AIDS.

33. The knowledge, attitudes, practices and behaviour (KAPB) with regard to HIV&AIDS and disease prevention at community level is generally very poor. There are few indigenous people trained as health workers but who are not working in the local health facilities. Some health workers perceive the VMGs as being difficult to help and that the strained relationship between the health workers and the VMG communities presents a barrier to accessibility to health services. All the VMGs interviewed preferred to have their own indigenous people trained and posted as health workers in the surrounding health facilities.

34. The government is encouraging opportunistic testing for most diseases reported to the hospital, which is now accepted by most communities visited by the study team. This results in mothers visiting family and ante-natal services knowing their sero-status more than the men in the community.

35. Language barrier between health workers at the health facilities was cited as a communication problem because most of the health workers do not come from the community. Some of the VMGs reported being discriminated against by the local health workers. This was reported among the Sengwer, Sabor and Ogiek communities. The Sengwer were uncomfortable going to the Kapsara district hospital which is about 17 Km
away for fear of being arrested as they are generally perceived by other communities as cattle rustlers, at the same time they hear rumours that HIV/AIDS prevalence is high among their members who have been tested at the Kapsara district hospital but no intervention in the community.

36. **The site visits and consultations showed that in five VMG communities out of the 13 that were visited, health facilities were closed for longer periods of time because of lack of health workers.** This was observed in health facilities that serve the IL Chamus, the Sabor, Endorois, Ogiek and the LKunono. In the Endorois community, for example, it was reported that the only health worker in the facility had a habit of closing the facility when allegedly going for a seminar or to conduct outreach services. In the Ogiek Nessuit dispensary, the health worker can be away for a period extending over two months.

37. **All the VMG communities interviewed apart from the Konso and Boni/Aweer communities reported a lack of essential drugs in the health facilities, laboratory services and complained of reported compromised quality of services to the VMGs.** The shortage of drugs in the health facilities has resulted in most of the VMGs buying drugs from commercial outlets. The health workers who were interviewed reported inconsistent supply of drugs by KEMSA partly due to lack of full implementation of the pull system and controversies regarding the gazettement of some health facilities as the main cause of lack of drugs in the health facilities where VMGs live.

38. **There is resistance on the use of family planning services by the women because of perceived side effects and lack of support from the men.** It was mentioned by the women, for instance, that men always raised complaints that use of family planning services reduces ‘warmth’ from the women. In other cases, VMGs are opposed to family planning because they believe they are a minority and would like to have many children so that they can fill their land but not to be occupied by the dominant communities surrounding them as well as the fact that they believe the religious teachings do not allow family planning. Among the Lkunono community in Laisamis, the men reportedly practice the natural method of family planning of ‘withdrawal’ or extended period of absence from home when the wife is breastfeeding because they fear the side effects of family planning pills. A community member among the Ogiek thus explained during an in-depth interview;

> Why are we being asked to practice family planning so that other people from outside the community can come and occupy our land? We do not want to be continuously referred to as minorities.

39. **There were no HIV&AIDS services in 11 out of 13 the VMG communities that were visited.** Stigma is still high and people are not volunteering information on their HIV status because of fear of isolation by the community members.
8.2.1.2 Outreach Services

40. **In communities where the outreach services are conducted, they were reported to be erratic and mainly inclined towards immunization of children.** Outreach services only conducted in seven out of 13 VMG communities that were visited. Most of the VMG communities reported that the only outreach service which could reach their communities was the polio immunization services. In some of the communities, the outreach services were reportedly conducted monthly such as among the Sengwer, Endorois, Malakote and Waata; while in two others Lkunono and IL Chamus, the services are provided twice in a month. Among the Ngikebootok the outreach services are irregular and occasionally provided by the World Vision. It was also reported that the contact time with the communities is very limited. For instance, among the Sengwer, the outreach services were reportedly provided for three hours from 12.00 noon to 3.00 p.m. every last Thursday of the month at the Sengwer Cultural Centre, which cannot be accessed by community members from Kabolet Forest because of distance and poor road network.

41. **All VMG communities where outreach services are provided perceive them to be meant for women and children only.** During the focus group discussions (FGD) with the men, they expressed their willingness to seek healthcare services if they were fully integrated and not only focusing on women and childcare. Key informant interviews confirmed that the perception that outreach services are for women and children emanated from the announcements by the village elders who call them “clinic for women and small children”. It was also observed that the services are limited to MCH due to lack of drugs.

42. In four out of 13 VMG communities (Malakote, Waata, Endorois and Sengwer) the outreach services were provided by the nearest government health facilities. In two others, these services Lkunono and IL Chamus were provided by the missionaries. Among the LKunono and IL Chamus communities, for example, these outreach services are provided by the Laisamis and Marigat Catholic Parishes respectively.

8.2.2 Recommendations for improved access to and utilization of health services for the VMGs

43. **There is a need to enhance awareness of the existing health services among the VMG communities by enhancing the health promotion activities through the use of CHWs, the CHEWs and the public health officials in order to address the problems related to low levels of awareness and demand for health services as well as promote prevention and control of diseases among the VMG communities.**

44. **There is a need to put in place plans to enhance access to health services in the communities by adopting the pro-poor strategies in health financing through waiver system targeting the poor community members among the VMG communities.** In addition, there is a need for enhanced outreach programs to enable VMG populations in far places from the health facilities to access health services.

45. **Ensure the regular and sustained supply of essential drugs to the health facilities** that can be used to treat common health problems identified among the VMGs.
46. *Encourage the participation of VMG representatives in the health management structures* as well as the participation of VMG community members in health promotion activities such as the involvement of TBAs among the activities to enhance hospital deliveries among the VMG communities. This can be done through effective linkage between the CHWs, CHEWs and members of VMG who are TBAs.

47. *Social Accountability mechanisms should be put in place to enable proper strategies for grievance resolution and a monitoring mechanism* on how the grievances by the VMG communities regarding health services are addressed. Social accountability mechanisms in these communities should ensure the creation of special slots for VMG representatives at all levels of local health facilities and management boards within the counties where the VMG live.

48. *Build the capacity of the VMG communities and their elected representatives in Health facility management committees* in governance, leadership roles, team synergy/building, advocacy and complaints handling.

49. *There is a need to conduct sensitization through the participation of CHWs on the effects of some cultural practices on the overall health of the VMG communities.* This can be done through the Community health units in the villages as well as in the churches, community social events and the chiefs’ barazas.

### 8.3 The Total War against AIDS Project (TOWA)

#### 8.3.1 Findings on TOWA

50. *There was evidence of lack of information about TOWA within the VMGs.* Seven out of 13 VMG communities who were visited (Sengwer, Sabor, LKunono, Waata, Sanye, Boni Ngiebotook) do not have information about the TOWA project. On the other hand, the Endorois, IL Chamus, Konso and Ogiek communities received the information on the Call for Proposals (CFPs) only when it was too late to respond. In some cases, the CACC committee members and some prominent community leaders who have access to the TOWA Call for Proposals (CFPs) are reported to invite people in their networks. This was reported among the Sengwer of Kapenguria and IL Chamus in Marigat.

51. There are existing registered community based organizations (CBOs) among the VMG communities but the majority of them are not focusing on HIV&AIDS due to stigma. Only one self-help group among the Sengwer in Cherenganyi is focusing on HIV&AIDS prevention work but its activities are confined on awareness creation.
52. Out of 13 VMG communities visited, only four have benefited from the TOWA call for proposals. The VMG communities which have been funded are the Ngikebotook, Ogiek, LKunono and Endorois. The CACC Coordinators in those constituencies explained that the few groups that have been funded were given special consideration but if left to compete with other groups would not be able to receive any funding.

53. All CACC members are selected based on the criteria provided by NACC. Such a criterion selects elite members of the community such as the pastors and the councilors who reportedly spearhead the interests of their friends and majority voters, in total disregard of the minority groups. A CACC coordinator in one of the VMG communities intimated that some religious and political leaders only serve their own interests in the CACC.

54. All VMG groups and their members do not know how to write proposals for the TOWA funds. A few who have approached skilled people for assistance in this area have not been able to raise the Kshs. 5,000 or more demanded by those writing the proposals for them.

55. The criteria set for qualifying for the TOWA funds cannot be attained by most of the existing CBOs in the majority of the VMG communities. For example, the requirement of one year of experience in conducting HIV&AIDS activities; having an active and operational account for the group for the past six months; the number of people to be reached by the project and in some cases, those people living with HIV&AIDS (PLWHA) scares away many potential beneficiaries of the project. The other major challenge is the issue of focusing on thematic areas and limiting the number of words to be used in responding to the CFPs. These were major obstacles to the communities as they are limited by low literacy and education levels.

56. According to a key informant in some communities such as the Ogiek, their representatives do not like attending meetings when no allowances are paid. However, a Focus Group Discussion with the Ogiek members showed that they would be willing to attend meetings if they are convinced that their interests as minority groups will be genuinely addressed.

57. There is a general lack of interest among the VMG communities to respond to CFPs by donors and the government agencies. This has resulted from many years of disappointment due to lack of feedback, follow-up and consistency in project management. Consequently, the VMG communities are apathetic and find it difficult to respond these CFPs.

58. There is misinformation among all the VMG communities that the TOWA funds are for PLWHA only and that other people who have not been tested are not legible to apply.

59. The Ogiek community reported lack of proper mechanisms for disposal of condoms. They explained that, children sometimes get access to the used condoms and play with them. This has resulted in resistance by the community members regarding the use of these condoms in the community. In other communities such as among the Boni/Aweer, Waata, Lkunono and IL Chamus, condom stigma is still very high and can potentially cause challenges for condom promotion.
8.3.2 Recommendations on how to help VMGs to benefit from TOWA CFPs

60. There is a need to address issues pertaining to limited capacity among the VMG communities to participate in HIV/AIDS control and prevention activities. This would enhance knowledge about HIV/AIDS and create awareness at community level.

61. There is a need to address the identified gaps in HIV/AIDS service provision among the VMG populations such as enhancing counseling and testing services, condom promotion, stigma reduction as well as initiating support services for PLWHAs.

62. There is a need to introduce and put in place social accountability mechanisms to ensure proper handling of grievances and complaints regarding the provision of HIV/AIDS related services among the VMG populations. This would include training of elected VMG representatives in the CACC communities in governance, leadership and effective representation.

63. There is a need to put up a proper monitoring and evaluation mechanism for all HIV/AIDS activities among the VMG communities that can in addition be useful in monitoring the effectiveness of the grievance resolution mechanisms put in place.

64. There is a need to build the capacity of the VMG communities to compete and benefit from future funding for HIV/AIDS activities in their communities through their registered groups among the VMG communities.

65. VMGs should be assisted to form groups in Liaison with Ministry of Gender, Children and Social Development. The formation of such groups and their subsequent participation in the TOWA CFPs should be based on the local prevailing levels of fight against HIV/AIDS contexts.

8.4 The East African Public Health Laboratory Network (EAPHLN) project

8.4.1 Findings on the EAPHLN

66. The EAPHLN is situated in five cross-border locations in the country (Machakos, Malindi, Wajir, Kitale and Busia). For purposes of this study, only three of these were studied – Kitale (Trans Nzoia West district); Malindi (Coast Province) and Wajir County (North Eastern Province). The study team visited two of the locations (Kitale and Malindi). Information regarding the third laboratory was obtained through a telephone interview and an in-depth discussion with a Key Informant during a visit to Nairobi.
67. The EAPHLN in Kitale district hospital has purchased microscopes and Gene-Xpert equipment to be used for diagnostic and research for tuberculosis work. It also supports logistics such as purchase of chemicals and reagents that are useful in improving bacteriology department in the laboratory. It has also supported training of laboratory personnel on disease surveillance and integrated them as team members in outbreak investigation. Through the support of the EAPHLN, the integrated disease surveillance has been strengthened through regular training and cross-border and inter-district disease surveillance. However, the location of this laboratory is out of reach for most of the VMG communities and those VMGs who were interviewed in this study had not heard about the existence of the EAPHLN. The Sengwer community, for instance, live more than 40 kilometres away from the facility and 20 kilometres from the nearest Kapsara district hospital, which makes access to the services to be very difficult. Further, the use of the laboratory and disease surveillance is sometimes hampered by the administrative barriers, for example, inter-districts protocol.

68. In Malindi, the study team observed that the microscope and Gene-Xpert equipment that were purchased by the EAPHLN are all in use. It was also learnt that the World Bank has purchased a Safety Cabinet for the laboratory safety work, which was yet to be delivered to the hospital. It was reported by the laboratory in charge that chemicals and reagents, particularly those used for microbiological work had been purchased by the World Bank for use in the hospital. The study team was also shown a list of reagents and chemicals that had been forwarded to the Bank and which they had accepted to supply. It was reported that the laboratory is integrated in disease surveillance and undertakes outreach services on a quarterly basis using funds from the World Bank. The team identified a major gap in the use of the recording register where tests that are being done using the Gene-Xpert equipment were not disaggregated by location of the patients who had been tested. This makes it difficult to identify the location of disease outbreaks in case they occur for prompt response.

69. A lot more has been done in Wajir County compared to other EAPHLN visited by the study team. In Wajir County, it was learnt that there is good political by the area elected leaders, ministry of health officials and the provincial administration. For example, the Gene-Xpert equipment was commissioned by the area member of parliament (MP), which gave the World Bank project very good publicity. The district has also received a Land Rover, which has been used in many areas for disease surveillance and even for obtaining other urgent supplies such as laboratory reagents and blood for use in the local hospital. Through the EAPHLN funding, the district has employed two degree and four diploma holders to work in the hospital. This has enabled the laboratory to work 24 hours. The laboratory has bought four (4) computers and strengthened water bacteriology and bio-safety. It has trained staff on computer usage and bought local computer devise (LCDs) for use in the trainings. In this community, the leadership has ensured that any World Bank supplies are commissioned by the government, with the involvement of local communities.

70. Despite the efforts put in place by the EAPHLN through the World Bank funding, no mobilization and sensitization of the Laboratory project has been done for the health workers and health management boards in the sites that were visited.
71. All the VMG communities experience big challenges with transportation of specimens to the major hospitals because of distance to the laboratory.

72. No efforts were identified during the site visits for the EAPHLN network to create awareness and linkages among the VMG populations who are targeted by the project as well as lack of mechanisms to reach the cross-border VMGs either through joint meetings with the health management teams across the borders or through the use of private agencies through the public-private partnerships in the cross border disease surveillance to reach a greater population of VMGs.

73. The laboratory system does not have provisions for responding to emergency testing needs because it depends on the general hospital referral system which is slow. VMGs complained that it is expensive to get laboratory results if such results are to be obtained from the EAPHLN because of waiting for one or more weeks and spending money on arranged transport to inquire from the nearest health facility if the results have come. The laboratories were only able to be accessed by the VMGs who are reached through the World Bank funded outreach programmes. There were no mechanisms to reach the VMG populations that lived far from the major health facilities where those laboratories are situated.

74. The laboratories generate a lot of bio-hazardous waste, which poses a disposal problem since most of the hospitals do not have sufficient incinerators. In Wajir County, for instance, the district hospital where the EAPHLN is situated the incinerator is very small and cannot cope with waste generated by increased by workload from the laboratory.

75. There was no evidence in three laboratories where data was collected on the use of modern communication technology for data transmission of health information for improved disease surveillance among the VMG communities as well as cross-border communities in the region. However, literature available on the activities of the EAPHLN indicates existence of such services.

76. There are a very limited number of computers for the EAPHN project. In all the project sites visited, there was not linkage between the staff of the project and the rest of the hospital where disease surveillance is done.

77. The few computers for the EAPHLN are not used effectively by the staff of the project due to inadequate training on how these can be used for disease surveillance.

78. There was no evidence of cross-border meetings for disease surveillance and data sharing among the VMGs.
8.4.2 Recommendations on how to increase accessibility and utilization of EAPHLN services

79. There is a need for awareness creation about the existence of the EAPHLN project among the VMG communities. This can be done through the use of CHWs, CHEWs and the use of community health units as mechanisms for creating awareness and demand for laboratory services.

80. The EAPHLN should establish mobile laboratory to enhance access to testing services for the identified health problems facing the VMG communities. In this regard, awareness on outreach services should focus on all people in the VMG communities and not women and children alone as is the case presently.

81. There is a need for a multi-pronged capacity building efforts to build the capacity of laboratory staff in IT skills and descriptive epidemiology while the Community Health Workers should be trained in disease surveillance, be empowered and facilitated to become EAPHLN local agents for improved referral system at the community level.

82. There is a need to put in place mechanisms to address the gaps in interventions for laboratory services with regard to access, equity and utilization of Laboratory services by the VMG communities as well as ensure that there is proper disposal of waste generated by the laboratory services in all the places where either the satellite or major laboratories are situated for enhanced environmental health.

8.4.2.1 Social Accountability

83. There is deep routed mistrust between the VMGs and the local administration. This was particularly observed among the Ogiek, Sengwer, Boni/Aweer and Waata communities. The view was corroborated by key informants, mainly the CACC coordinators in some of the sites visited. The other issue which featured prominently was the common practice among the majority communities masquerading as VMGs whenever opportunities arose so as to benefit from targeted funding to as was reported among the Sengwer, Konso, Waata, IL Waana and Ogiek communities.

84. Most VMGs do not have appropriate mechanisms for raising grievances when they failed to receive quality healthcare services. Some of the community members interviewed such as the Konso, Sabor, IL Chamus and Endorois intimated that they channel their grievances to the local provincial administration but do not have anywhere else to go if they are not assisted at those levels.

85. Most of the VMG communities do not have advocacy groups or other structures that can facilitate advocacy of their healthcare rights. The Ogiek and Sengwer communities reportedly had advocacy groups but which lacked capacity to lobby and advocate for their rights.
8.4.2.2 Participation in local healthcare and governance

86. VMG community participation in health care decision-making was not uniform. Some of the communities such as the LKunono, Ngikebotook, Sabor, Endorois, IL Chamus, reported that they have representatives in the local health centre management committees. However, some of the representatives were not elected by the local community but were reportedly appointed by influential people in the district health management boards. This was reported by the IL Chamus and Endorois communities in Baringo County. The Ogiek, Sengwer and Konso communities complained that they did not have representatives in the local health management boards.

87. Information from the FGDs corroborated the KII that the views of the local leaders had not been taken into account regarding decisions on healthcare service provision in the VMGs. Some of the complaints advanced by the communities included prolonged closure of health facilities due to absence of health workers, unprofessional staff members some of whom were reportedly using abusive language to patients, perennial shortage of drugs and laboratory reagents. This issue was particularly raised by the Ogiek in Molo district whose nearest health facility does not have water and only operates on week days between 9 am and 4pm because the officer in charge lives in Njoro.

88. Other issues that were raised by the VMG communities relate to lack of training on governance issues, especially lobbying and advocacy on their health rights. This was more evident in communities such as the Boni/Aweer in Lamu who see the health workers in the health facility management committee as their bosses and therefore difficult to question their decisions and only ratify.

89. There was no evidence of public-private partnership in the provision of services as well as mechanisms for sustainable solutions for basic delivery of health services to the VMGs, particularly those living in difficult to reach areas and who expressed difficulty in accessing health through the existing public health delivery system.
9 References


Annex 1: Narratives

VULNERABLE AND MARGINALIZED GROUPs – NARRATIVE

It was a sunny morning on September 10, 2012. I was meeting with a group of women from the Munyoyaya community on an assignment which was aimed at assessing the health status of the community which is categorized as Vulnerable and Marginalized community. I got an opportunity to talk with Muslima (not her real name). Muslima is a Munyoyaya woman and hails from one of the Vulnerable and Marginalized communities that were the focus of our study in Madogo, Tana River District. She is a community mobilizer and belongs to one of the women groups in the community. I gathered through my conversation with her that she was a third wife in her first marriage. In this marriage, the first co-wife had six children, while the second had three. During this marriage, Muslima lost two babies: the first as a still birth and the second died after three months of delivery. She got the second baby through operation at Garissa Provisional General Hospital. In her present marriage, now eight months old, she is also a third wife.

Muslima struck me as very friendly lady, easy to get along with. I asked her if she would mind discussing information that would be considered personal.

“What is so personal? When I lost my babies, people knew about it, I am in my second marriage, my former husband knows and everybody who matters to me also knows…all these are in the public domain and I see no reason why I should not share with you if you are interested”

Encouraged by this positive response, I felt comfortable to ask her several questions regarding access to health services including use of laboratory services, knowledge about HIV and other health related issues in the community. A glowing smile accompanied her response whenever I posed the next question to her. Sometimes, both of us would break into laughter, whenever she answered a question in an interesting and humorous manner or she would detect humor and laugh at some of the questions which I asked her.

“So, how often did you attend ante-natal clinic during your first pregnancy?” I asked her.

“I went there twice, in the seventh month and the eighth month. Then the ninth month, I delivered a still baby boy.”

“What did the hospital say was the cause of the still birth?”

“No, it was at home” she said. She explained how she started feeling the labour pains in the early part of the night and then the Traditional Birth Attendant was called in.

“I must admit she tried her best. She is a real expert whom the women trust in our community. But in this case, the baby was simply not coming out. My husband, together with three other people who had gathered around to give support, where necessary, was waiting outside. They left only after being informed of the bad news.

“Have you ever sought health services of whatever nature since the loss of your first child?”

“No, when I have a headache or some malaria, I simply go to the shops and buy some pain killers or I go to the pharmacy and I explain what I am suffering from. They sell very good tablets for malaria”, she added.

“What about your second born?” I asked her.

“Oh, that one? I conceived after 10 years”.

I...
“Were you using any family planning services?” I asked her while trying to explain to her what family planning means.

“No, in fact my husband was very supportive. He would tell me that he still loved me without any child but I insisted that I should have one. So, he would give me money whenever I wanted to go and consult a herbalist. We visited many of them. Finally, I got pregnant when I was not expecting it at all”.

‘I was overwhelmed with happiness. But I was cautious. I did not want to lose the baby again. I therefore decided to try ante-natal clinic at Garissa hospital. I got a baby girl through operation at Garissa Provincial Hospital. She was a very healthy baby and weighed 3.5 kilogrammes.’

Muslima paused for sometime and I thought that she was waiting for me to finish writing my notes. But when I asked her the next question, she told me that her happiness was very short lived. The baby started crying continuously after six hours of birth.

“I stayed in the hospital for the next one month, after which I was discharged. But I returned to the hospital after three days because there she would sometimes be sedated and sleep for a few hours. That is how I spent my life, in and out of hospital, until she passed on. The cries never stopped until she died. When she was examined, she was found to be severely disabled - a defective colon, brain and everything. The doctors said even if the baby lived for long, she would not have sat or walked in her life.”

“Turning to your current marriage, what discussions have you held with your husband regarding getting a baby?” I asked her.

“We have not talked about children yet. But I have been asking him for money to see a renowned witch doctor and he gives me. I suppose, if he refuses he thinks I might get annoyed.”

“What about going to hospital to test and find out the possible reasons for these health problems?

“I have not gone”, she told me.

‘Why?’ I asked her.

“No big reason”, she added. “I have just not gone.”

“Are you thinking of doing so any soon?” I insisted

“I might, but sometimes the expenses are discouraging. The costs for the tests are very prohibitive. In addition, most of the tests can only be performed in Garissa… and you know Garissa is about 20 kilometers from here. You need good preparation in terms of money for transport and also payment for tests.” She added rather pensively.

“Now, about the HIV&AIDS activities, are they conducted in this area?” I asked

“No, most of the groups fear that if they carry out the HIV &AIDs activities then people will think they are suffering from the same.” She answered

“But in your opinion, does such HIV&AIDS exist in this community?” I asked her.

“Definitely, but nobody will admit. For me, I attended a seminar once and was taught on what the signs and symptoms are and I have seen people die in the community with similar manifestations.”

“So, how do you think your community can be helped to prevent further HIV infections?” I asked her.
“The hospital knows the number of those suffering from the disease because these days, one cannot be tested for any other illness unless an HIV test is done first. The pregnant women have no choice either because all types of tests are done.”

Muslima was very passionate that her community needs to be targeted specifically in HIV&AIDS activities. She explained how most of the women in her community are not able to read and write; do not have the skills to mobilize and organize themselves for a development activity and cannot be able to respond to funding request by sponsors and donors. She added that the men are in an equally difficult situation because of having a lower health seeking behaviour compared to the women.

(VMPPs Study, September 2012)

(A) TOWA NARRATIVE

Swahili impressed me as a very sociable person. He struck me one who is in his mid-forties. During the Focus Group Discussions (FGD) he introduced himself a man with three wives, the youngest being only three months old in the marriage.

We discussed many aspects of health, which he shared very freely.
“Now, about the HIV&AIDS activities, are they conducted among the Sengwer people?” I asked.
“No, most of the groups fear that if they carry out the HIV &AIDs activities then people will think they are suffering from the same.” he answered

“But in your opinion, does HIV&AIDS exist in this community?” I asked.
“Definitely, but nobody will admit, he explained. He looked down, up and into some space before he gave told me his personal feelings about the pandemic. He explained how he watched a relative die, in denial, while insisting that he had been bewitched. I tried to get him counseled but he asked me to keep off, arguing that I knew those who had bewitched him.

Both of us looked at each other and I was about to ask him another question when he said:
‘For me, I attended a seminar once in Nairobi and was taught on what the signs and symptoms are and I have seen people die in the community with similar manifestations, Swahili added.”

“So, how do you think your community can be helped to prevent these HIV infections?” I asked.

“The hospital knows the number of those suffering from the disease because these days, one cannot be tested for any illness unless an HIV test is done first. The pregnant women have no choice because all types of tests are done on them.”

Swahili was very passionate that his community needs to be targeted specifically in HIV&AIDS activities. He explained how most of the women in his community are not able to read and write; do not have the skills to mobilize and organize themselves for a development activity and cannot be able to respond to funding request by sponsors and donors. He added that the men are in an equally difficult situation because of having a poor health seeking behaviour compared to their female counterparts.

“So, how can we address these challenges, I asked him?
Swahili explained that his community is very unfortunate because most of the people are not aware about HIV. He said that they only hear of calls for proposals on TOWA when the deadline is well over.

“Are there some people that have tried their luck at any one time, I asked.
Those who tried had inside information. Even the requests for funding were written for them because most of them do not understand that kind of business, he explained. He was also quick to add that his community needs a lot of awareness on HIV, otherwise it will perish.

- VMPPs Study, September 2012
Annex II: Instruments of Data Collection

A: FOCUS GROUP DISCUSSIONS GUIDE FOR THE THREE PROJECTS

i) Level of awareness of existing Health and Laboratory services among the VMGs
   • Awareness regarding range of services provided at levels 1-3 and existence of HSSF.
   • Awareness of laboratory services for the VMGs
   • Awareness of TOWA activities eg call for proposals
   • Probe in all cases to document mechanisms for creating awareness and their effectiveness as well as possible indigenous institutions culturally appropriate for awareness creation among the VMGs (KHSSP, TOWA and EAPHLN projects)

   Probe for recommendations of culturally appropriate mechanisms for awareness creation including use of indigenous institutions among the VMGs, Availability of health workers and laboratory personnel to treat minor illnesses, health promotion and carry out laboratory tests for illnesses.
   • Availability of health workers to treat minor illnesses and to carry out health promotion (Probe to document the cultural appropriateness of strategies for health promotion among the VMGs and the priority diseases for health promotion) (KHSSP).
   • Types of illnesses for which the VMGs have been tested in the Laboratories (Probe to document the illnesses that have unmet testing needs and the priority illnesses within the service range of EAPHLN project)

ii) Availability of health services including outreach services, HIV/AIDS related services and existence of any mobile Laboratory services provided to the VMGs.
   • Whether outreach services are provided to habitations for the VMGs in a culturally appropriate ways taking into consideration gender and age variations (Probe to document the type and frequency of the provision of such services and whether there is a need for improvement of the service delivery including suggestions on priority areas)
   • What HIV/AIDS related services and information are provided to the community (Probe to document information about consistent supply of TB drugs and condoms to the VMGs, provision of LLTNs in malaria endemic areas as well as efforts to reduce higher risk sexual behaviour and infections consistent with the cultural settings of the VMGs and their priorities for health service delivery and efforts to support and improve the quality of life of PLWHA (TOWA)
   • Existence of mobile Laboratory facilities to the community.(Probe to document whether mobile laboratory facilities sufficiently address the requirements of the internal migration of the VMGs (EAPHLN)

iii) Whether services provided under the three projects and their delivery arrangements are sensitive and responsive to the specific needs of VMGs
   • Are service providers and service delivery arrangements in health facilities at level 1-3 sensitive and responsive to the specific needs of VMGs (Probe to document what are the most urgent needs of VMGs including their nutritional needs, whether the existing service delivery arrangements are responsive to the specific needs of the VMGs, cost and feasibility of the services, effectiveness of drug supplies by KEMSA and suggestions on how the current service delivery arrangements can be improved to enhance accessibility (KHSSP)
• How do the health seeking behaviour of the VMGs influence the effectiveness of the health services delivery (access and utilization) and what needs to be done to improve the health services delivery for VMGs.

• Are staff from local agencies providing HIV/AIDS prevention and mitigation services sensitive and responsive to the specific needs and requirements of VMGs (Probe to document services provided by CSOs/CBOs/NGOs, what are their priority needs for support, cost and feasibility of the services and how to make their services more sensitive and responsive to the specific needs of the VMGs in light of their health seeking behaviour)

• Are there any civil society organizations supporting the VMGs and what kind of support do they provide including support to address stigma related to some communicable diseases and how the CSOs can be strengthened to support the VMGs to access the laboratory services (EAPHLN). Probe for the priority needs/diseases for which support is critical and how such support can be provided.

iv) Participation of VMGs in program planning for the three projects
• Extent to which VMGs program planning at their nearest levels 2 or 3 health facilities, the share of VMGs in the health facility management committees and community health committees (Probe for problems related to governance competence for the VMGs and suggestions for strengthening governance including participation in the assessments with regard to KEMSA supplies (KHSSP)

• How the indigenous peoples themselves participate in sensitization and surveillance of diseases through their own indigenous institutions (Probe suggestions on how indigenous peoples’ access to laboratory services can be increased and whether there are surveillance sites to monitor hot spots for disease transmission (EAPHLN)

v) “Social Accountability” mechanisms for the three projects including existing grievance complaints mechanisms and awareness by the VMGs that they can complain.
• Existing grievance complaints mechanisms and how to apply them to the three projects KHSSP, TOWA and EAPHLN (Probe to document the perceived effectiveness of existing grievance complaints mechanisms for the three projects, and suggestions on how those grievance complaints mechanisms can be strengthened to suit the conditions of VMGs)

• Whether VMGs are aware where they can complain if they find deficiency in services/lack of responsiveness to their specific needs with regard to the three projects; KHSSP, TOWA and EAPHLN (Probe to document how the VMGs have been made aware of their rights to complain if at all the complaint mechanisms do exist.

vi) Capacity building needs of key service providers for the three projects and how such efforts can improve service delivery and responsiveness to the VMGs
• What are the capacity building needs for the three projects in terms of priority (Probe for capacity building/sensitization of key service providers to improve service delivery and responsiveness of providers to essential health services at community, facility and district levels –KHSSP,

• The kind of support/capacity building initiatives that VMGs need from regional facilitating agencies (RFAs) to ensure VMGs can submit proposals in the next and last CFP under TOWA (Probe for the capacity building needs of CACCs, CSO/CBO/FBO and how CACC structures would facilitate the mobilization of VMGs through Constituency Stakeholders’ Fora and suggest Community Pillars among the VMGs
• What are the existing gaps for laboratory services for VMGs in the districts that EAPHLN project is supporting (Probe for identified gaps and perceived effectiveness of laboratory staff and additional skills that VMGs would like laboratory staff to have in order to improve their service delivery.

B: KEY INFORMANT INTERVIEW CHECKLIST (Key stakeholders)

i) Level of awareness of existing Health and Laboratory services among the VMGs

- Awareness regarding range of services provided at levels 1-3 and existence of HSSF.
- Awareness of laboratory services for the VMGs
- Awareness of TOWA issues?
- Probe in both cases to document the cultural appropriateness of existing awareness creation and whether there are indigenous institutions that can be used to create awareness with regard to existing health and laboratory services.
- What would one recommend as a culturally appropriate mechanism for creating awareness on health issues among the VMGs (Probe for reasons for the given answer)

ii) Availability of health workers and laboratory personnel to treat minor illnesses, health promotion and carry out laboratory tests for illnesses

a. Availability of health workers to treat minor illnesses and to carry out health promotion (Probe to document the cultural appropriateness of strategies for health promotion among the VMGs) (KHSSP).

b. Types of illnesses for which the VMGs have been tested in the Laboratories (Probe to document the illnesses that have unmet testing needs within the service range of EAPHLN project)

iii) Availability of health services including outreach services, HIV/AIDS related services and existence of any mobile Laboratory services provided to the VMGs.

a. Whether outreach services are provided to habitations for the VMGs in culturally appropriate ways taking into consideration gender and age variations (Probe to document the type and frequency of the provision of such services and whether there is a need for improvement KHSSP).

b. What HIV/AIDS related services and information are provided to the community (Probe to document information about consistent supply of TB drugs and condoms to the VMGs, provision of LLTNs in malaria endemic areas as well as efforts to reduce higher risk sexual behaviour and infections consistent with the cultural settings of the VMGs and efforts to support and improve the quality of life of PLWHA (TOWA).

c. In your view, what would you consider to be culturally appropriate ways of promoting HIV/AIDS prevention efforts among the VMGs (TOWA)

d. Existence of mobile Laboratory facilities to the community. (Probe to document whether mobile laboratory facilities sufficiently address the requirements of the internal migration of the VMGs (EAPHLN).

iv) Whether services provided under the three projects and their delivery arrangements are sensitive and responsive to the specific needs of VMGs

a. Do you think service providers and delivery arrangements in health facilities at level 1-3 are sensitive and responsive to the specific needs of VMGs (Probe to document what are the priority and most urgent needs of VMGs including their nutritional needs, whether the existing service
delivery arrangements are responsive to the specific needs of the VMGs, cost and feasibility of the services, effectiveness of drug supplies by KEMSA and suggestions on how the current service delivery arrangements can be improved to enhance accessibility (KHSSP).

b. How do the health seeking behaviour of the VMGs influence the effectiveness of the health services delivery and what needs to be done to improve the health services delivery for VMGs.

c. Are staff from local agencies providing HIV/AIDS prevention and mitigation services sensitive and responsive to the specific needs and requirements of VMGs (Probe to document services provided by CSOs/CBOs/NGOs, what are their priority needs for support, cost and feasibility of the services and how to make their services more sensitive and responsive to the specific needs of the VMGs)

d. Are there any civil society organizations supporting the VMGs and what kind of support do they provide including support to address stigma related to some communicable diseases and how the CSOs can be strengthened to support the VMGs to access the laboratory services (EAPHLN). Probe for the priority needs/diseases for which support is critical and how such support can be provided.

v) Participation of VMGs in program planning for the three projects

a. How do VMGs participate in program planning at their nearest levels 2 or 3 health facilities, what share do they (VMGs) have in the health facility management committees and community health committees (Probe for problems related to governance, competence for the VMGs and suggestions for strengthening governance including participation in the assessments with regard to KEMSA supplies (KHSSP)

b. What efforts are in place for the indigenous peoples to participate in sensitization and surveillance of diseases through their own indigenous institutions (Probe suggestions on how indigenous peoples’ access to laboratory services can be increased and whether there are surveillance sites to monitor hot spots for disease transmission (EAPHLN)

vi) Which of the VMGs have not been reached under the TOWA Call For Proposals (Probe to document reasons why such VMGs were not reached under the TOWA Call for Proposals and what steps have been put in place or need to be put in place to effectively reach them under the next TOWA Call For Proposals)

vii) Are there any VMGs who were awarded contracts under the CFPs for providing HIV/AIDS prevention and mitigation services specifically focusing on VMGs (Probe to document the features that enabled them to be awarded and how other VMGs can also be helped to obtain an award)

viii) Do the VMGs have access to bed nets (only in malaria endemic areas) and where did they get the bed nets from? Probe to document whether they properly and consistently use the bed nets and how they perceive the use of bed nets in their households/or challenges they face when using the bed nets.

ix) “Social Accountability” mechanisms for the three projects including existing grievance complaints mechanisms and awareness by the VMGs that they can complain.

- Are there existing grievance complaints mechanisms and how to apply them to the three projects KHSSP, TOWA and EAPHLN (Probe to document the perceived effectiveness of existing grievance complaints mechanisms for the three projects, and suggestions on how those grievance complaints mechanisms can be strengthened to suit the conditions of VMGs)
• Are VMGs aware of where they can complain if they find deficiency in services/lack of responsiveness to their specific needs with regard to the three projects; KHSSP, TOWA and EAPHLN (Probe to document how the VMGs have been made aware of their rights to complain if at all the complaint mechanisms do exist.

x) Capacity building needs of key service providers for the three projects and how such efforts can improve service delivery and responsiveness to the VMGs

- What are the capacity building needs for the three projects (Probe for capacity building/sensitization of key service providers to improve service delivery and responsiveness of providers to essential health services at community, facility and district levels – KHSSP,
- The kind of support/capacity building initiatives that VMGs need from regional facilitating agencies (RFAs) to ensure VMGs can submit proposals under the next and last CFP under TOWA (Probe for the capacity building needs of CACCs, CSO/CBO/FBO and how CACC structures would facilitate the mobilization of VMGs through Constituency Stakeholders’ Fora and suggest Community Pillars among the VMGs
- What are the existing gaps for laboratory services in terms of priority for VMGs in the districts that EAPHLN project is supporting (Probe for identified gaps and perceived effectiveness of laboratory staff and additional skills that VMGs would like laboratory staff to have in order to improve their service delivery.

C: NARRATIVES CHECKLIST FOR VMGs

i) Level of awareness of existing Health, HIV and Laboratory services among the VMGs

- Are you aware of the range of services provided at levels 1-3 and existence of HSSF in health facilities in your area (Probe to document how they were made aware and the mechanisms currently in place to make them aware)
- What would you suggest as the best way to create awareness regarding availability of health services at levels 2 and 3 in your area (Probe reasons for the given answer and its relevance in enhancing access and utilization of health services among the VMGs)
- Are you aware of laboratory services that are provided in laboratories in your area (Probe to document how they were made aware and the mechanisms currently in place to make them aware)
- What would you suggest as the best way to create awareness regarding availability of laboratory services in your area (Probe for reasons for the given answer and its relevance in enhancing access to health services among the VMGs)
- Are you aware of any HIV/AIDS services, as well as the provision of bed nets and supply of TB drugs in this area? (Probe to document the level of awareness, how they were made aware and the mechanisms currently put in place or that need to be put in place to enhance awareness and utilization of such services by TOWA)

ii) Availability of health workers and laboratory personnel to treat minor illnesses, conduct health promotion and carry out laboratory tests for illnesses

a. Are health workers available to treat minor illnesses and to carry out health promotion activities in your area (Probe to document the cultural appropriateness of strategies for health promotion among the VMGs and whether their activities have created impact) (KHSSP).
b. What are the types of illnesses for which people are tested in the laboratories in this area? (Probe to document the illnesses that have unmet testing needs within the service range of EAPHLN project)

iii) Availability of health services including outreach services, HIV/AIDS related services and existence of any mobile Laboratory services provided to the VMGs.
   a. Are the outreach services are provided to habitations where you people live in culturally appropriate ways taking into consideration gender and age variations (Probe to document the type and frequency of the provision of such services and whether there is a need for improvement -KHSSP)
   b. What HIV/AIDS related services and information are provided to the community where you live (Probe to document information about consistent supply of TB drugs and condoms to the VMGs, provision of LLTNs in malaria endemic areas as well as efforts to reduce higher risk sexual behaviour and infections consistent with the cultural settings of the VMGs and efforts to support and improve the quality of life of PLWHA (TOWA)
   c. In your view, what would you consider to be culturally appropriate ways of promoting HIV/AIDS prevention efforts among the VMGs (TOWA)
   d. Are there mobile Laboratory facilities in the community where you live? (Probe to document whether mobile laboratory facilities sufficiently address the requirements of the internal migration of the VMGs and reasons behind the response given or whether they need the mobile laboratory services (EAPHLN).

iv) Whether services provided under the three projects and their delivery arrangements are sensitive and responsive to the specific needs of VMGs
   a. Do you think service providers and delivery arrangements in health facilities at level 1-3 are sensitive and responsive to the specific needs of your community?(Probe to document what are the most urgent needs of VMGs including their nutritional needs, whether the existing service delivery arrangements are responsive to the specific needs of the VMGs, effectiveness of drug supplies by KEMSA and suggestions on how the current service delivery arrangements can be improved to enhance accessibility of health services given the health seeking behavior of the VMGs (KHSSP)
   b. Are staff from local agencies providing HIV/AIDS prevention and mitigation services sensitive and responsive to the specific needs and requirements of your community?(Probe to document services provided by CSOs/CBOs/NGOs and how to make such services more sensitive and responsive to the specific needs of the VMGs given their health seeking behaviours (TOWA)
   c. Are there any civil society organizations supporting your community and what kind of support do they provide including support to address stigma related to TB and some communicable diseases and how the CSOs can be strengthened to support your community to access the laboratory services (EAPHLN).

v) Participation of VMGs in program planning for the three projects
   a. How does your community participate in program planning at their nearest levels 2 or 3 health facilities, what share does your community have in the health facility management committees and community health committees (Probe for problems related to governance, competence for the VMGs and suggestions for strengthening governance including participation in the assessments with regard to KEMSA supplies to the health facilities (KHSSP)
b. What efforts are in place for your community to participate in sensitization and surveillance of
diseases through your own indigenous institutions Suggest names of such indigenous institutions
(Probe suggestions on how indigenous peoples’ access to laboratory services can be increased
and whether there are surveillance sites to monitor hot spots for disease transmission (EAPHLN)

vi) Are you aware of any group in your community who were awarded contracts under the CFPs for
providing HIV/AIDS prevention and mitigation services specifically focusing on communities
around (Probe to document the views of VMGs on how their community members managed to get
the awards and why other groups did not get and how they can be assisted to get the contracts.

vii) Do members of your community have access to bed nets (only in malaria endemic areas) and where did
they get the bed nets from? Probe to document whether they properly and consistently use the bed
nets and how they perceive the use of bed nets in their households/or challenges they face when
using the bed nets.

viii) “Social Accountability” mechanisms for the three projects including existing grievance complaints
mechanisms and awareness by the VMGs that they can complain.

- Are there existing grievance complaints mechanisms and how to apply them to the three projects
  KHSSP, TOWA and EAPHLN (Probe to document the perceived effectiveness of existing
grievance complaints mechanisms for the three projects, and suggestions on how those grievance
complaints mechanisms can be strengthened to suit the conditions of VMGs)
- Are your community members aware of where they can complain if they find deficiency in
  services/lack of responsiveness to their specific needs with regard to the three projects; KHSSP,
  TOWA and EAPHLN (Probe to document how the VMGs have been made aware of their rights
to complain if at all the complaint mechanisms do exist.
Annex III: Map 1
Location of Health Facilities versus Marginalized Groups /Communities Disparity Analysis by County
Annex iv: Terms of Reference

Terms of Reference (TOR) for Preparation of a Vulnerable and Marginalized Peoples Plan (IPP) for
Kenya Health Sector Support Project (P074091)
Kenya East Africa Public Health Laboratory Networking Project (P111556)
Kenya Total War Against AIDS Project (P081712))

Background

1) After a period of stagnant and even deteriorating health indicators, Kenya has recently made some significant progress. Overall, most health outcomes in Kenya now compare quite favorably with its East African neighbors. Nevertheless, there are serious health status challenges remaining. Inequities in health in Kenya continue to have geographic, socioeconomic and gender dimensions. Maternal mortality remains high with the maternal mortality ratio (MMR) officially estimated to be around 530 per 100,000 live births. The total fertility rate is 4.6 births per woman. This is a slight decrease from the rate of 4.9 ten years ago. Neonatal mortality is a particular concern and 6 out of 10 infant deaths occur during the first 28 days of life. According to the Kenya Demographic Health Survey (KDHS) 2008 findings, 35 percent of Kenyan children are stunted, while 14 percent are severely stunted raising serious concerns about chronic malnutrition.

2) The Kenya Health Sector Support Project (KHSSP) aims to improve delivery of essential health services for Kenyans, especially the poor. The Total War against AIDS Project (TOWA) aims to expand the coverage for targeted HIV/AIDS preventive and mitigation services. The East Africa Public Health Laboratory Networking (EAPHLN) project aims to increase access to quality public health laboratory services for diagnosis and surveillance of TB and other communicable diseases. Although these three projects do not anticipate negative impacts on Vulnerable and Marginalized Groups (VMGs), the World Bank Operational Policy (OP4.10) Indigenous Peoples has been triggered for all three projects to ensure pro-active steps are taken for such groups to benefit from the project. Each of the projects has a Vulnerable and Marginalized Peoples Planning Framework (VMPPF) (see attachments 1,2,3) focusing on a pro-active approach that ensures VMGs are included, mainly through effective targeting and/or assistance in preparing sub-projects. VMGs have been identified and the next step is to translate the frameworks into concrete plans.

The Kenya Health Sector Support Project

3) **KHSSP:** The health sector in Kenya is currently implementing the National Health Sector Strategic Plan II (NHSSP II) with the goal of reducing the health inequalities and reversing the downwards trend of the health impact and outcome indicators in Kenya. To support the implementation of NHSSP II and accelerate efforts being made by Kenya to achieve the MDGs (Millennium Development Goals) within the sector-wide framework, the World Bank has recently approved financing for the Kenya Health Sector Support Project (KHSSP) in the amount of US$ 100 million equivalent over a period of 48 months starting October 1, 2010. The specific development objectives of the project are to: (a) improve the delivery of essential health services for Kenyans especially the poor; and (b) improve the efficiency of the planning, financing and procurement of pharmaceuticals and medical supplies.

4) The project is being implemented within NHSSP II and the Sector Wide Approach Framework and the majority of the funds will be channeled through the Joint Financing Agreement (JFA) pools that have been established for the Health Sector Services Fund (HSSF), Hospital Management Services Fund, and Human Resources for Health, Commodities and Capacity Development/TA. The JFA sets out the jointly agreed terms and procedures for the Kenya Sector Wide Program (SWAp) including, coordination,
planning, decision-making, funds flow and implementation. The JFA requires effective and transparent systems for financial management, procurement, governance, reporting, and auditing. The KHSSP funds will flow through the JFA pools for the HSSF and procurement of essential commodities, although some funds will be managed outside the JFA mainly focusing on capacity building and system strengthening.

5) The KHSSP is being implemented by three agencies namely (i) Ministry of Medical Services (MOMS) that has responsibility for Health Financing Reforms and District Hospital Referral improvements (ii) Ministry of Public Health and Sanitation (MOPHS) that has primary responsibility for the Health Sector Service Fund (HSSF) and (iii) Kenya Medical Supplies Agency (KEMSA) that is responsible for procurement of Essential Medicines and Medical Supplies (EMMS) and related reforms. The project has two main components:

a) **Component I - Effective and Transparent implementation of the Kenya Essential Package for Health (KEPH) through HSSF grants and performance strengthening (US$46 million):** This component supports the effective and transparent implementation of the Kenya Essential Package for Health (KEPH) through (i) HSSF grants and performance strengthening and (ii) improving the governance and stewardship role of the Ministries of Health, including support for health financing reforms and improvements in referrals and strengthened Monitoring and Evaluation.

b) **Component II: Availability of Essential Health Commodities and Supply Chain Management Reform (US$ 54 million):** This component will fund the increased availability of essential medicines and medical supplies (EMMS) and assure quality with reforms in supply chain management and related capacity building. This component is intended to bring sustained relief to the frequent shortages and stock-outs of health commodities by building-up a reasonable buffer stock of EMMS at Kenya Medical Supplies Agency (KEMSA) as well as reforms to make procurement and the supply chain system more efficient, transparent and effective.

**The Total War against AIDS project (TOWA)**

6) The project has two components which include:

a) **Component I: Strengthening Governance and Coordination Capacity,** which would support the continued development of (i) the coordinating function of the National AIDS Control Council (NACC); (ii) the monitoring and evaluation framework of the Kenya National AIDS Strategic Plan (KNASP); and (c) capacity building of beneficiaries in the use of grant funds.

b) **Component II: Support for Program Implementation:** This component would make financial resources available to civil society, public sector, private sector, and research institutions, focusing on initiatives in line with the KNASP, responding to priorities identified by the Joint AIDS Program Review (JAPR). The component would include subcomponents and essential commodities.

7) The **component II** focuses primarily on the civil society and private sector, with result-based proposals and activities. Proposals from the private sector, civil society organizations, research institutions and universities would be invited in a focused and structured manner through the mechanism of Call for Proposals. The focus will be on results, not on inputs. The prioritized result areas will be determined annually within the framework of the KNASP and based on areas identified as priorities in the JAPR. Proposals will be assessed and selected on the basis of their expected results, using a set of clear rules and criteria. Target populations and interventions are selected within the framework of the KNASP, according to priorities set by the JAPR. Priorities will be given to: (i) interventions with the largest impact in
preventing further spread of HIV; and (ii) target populations who are most susceptible to infection or most affected already.

8) Such populations include, but are not necessarily limited to: (i) OVC; (ii) highly mobile populations (truck drivers, migrant workers); (iii) women (including widows); (iv) the youth (including young girls); (v) workers in small and medium-sized enterprises, micro-enterprises, and the informal sector; (vi) people with disabilities; (vii) people exposed to sexual violence; (viii) Men Having Sex With Men (MSM); and (ix) Intravenous Drug Users (IDU). While CfP rules and criteria prioritize information-based interventions and implementers with a history of good performance, they will also: (a) allow for innovations; as well as (b) give new, inexperienced, but legitimate organizations with potential, a chance to prove them.

9) At the time of preparation, the TOWA project identified the vulnerable population to include (Women, Youths, WSMSE, OVC, and Mobile Populations) and MARP’s (CSW’s, MSM, IDU’s). In the process of project implementation it was realized that the existing framework was not adequately addressing the Indigenous Peoples. The World Bank’s Operational Policy (OP) 4.10 Indigenous Peoples requires that when groups that meet the criteria of the policy are identified in a project impact area -- steps be taken to ensure that (a) the project does not negatively impact them and (b) that they benefit from the project. This IPP is thus developed with the aim of enhancing the application of the WB OP 4.10 to the VMGs already identified in the IPPFs prepared by the GoK for the three World Bank financed projects.

10) The project is expected to have positive effects such as raising awareness on HIV/AIDS and other priorities that might emerge from the JAPR. The only potential adverse effects that might affect the IP’s would be possible omissions in benefits sharing. The VMPP will look carefully at how to take this into account within the qualification criteria for the call for proposals.

The East Africa Public Health Laboratory Network (EAPHLNP)

11) While progress has been made in laboratory-based surveillance of some disease (polio, measles, HIV/AIDS and meningitis) little progress has been made in the early detection of other epidemics such as multi-drug resistant tuberculosis (MDR-TB). The numbers of new TB cases in Africa in the 1990s, fuelled by the AIDS pandemic, are on the rise as is related mortality rates. Laboratory services are an essential support service for the efficient delivery of quality health services.

12) The project supports public health laboratories in 5 cross border areas i.e. Kitale (Trans Nzoia West), Busia, Wajir East, Machakos and Malindi Districts to improve diagnosis and access to specialized laboratory services and improved disease control and outbreak confirmation. The project has three components including: (i) Laboratory networking for specialized diagnostic and disease surveillance preparedness through specialized and satellite laboratories; (ii) training in diagnosis of TB, communicable diseases, surveillance and laboratory management; and (ii) joint operational research and knowledge sharing. The resurgence of TB in Africa has been fuelled by the spiraling of HIV epidemic with 2.8 million new TB cases and roughly 735,000 deaths annually. While progress has been made in laboratory-based surveillance of some diseases (polio, measles, HIV/AIDS and meningitis) -- little progress has been made in the early detection of other epidemics such as drug resistant tuberculosis. Laboratory services

3 The term “Vulnerable and Marginalized Groups” is being used in place of Indigenous Peoples” at the request of the Government of Kenya to reflect constitutionally-sanctioned terminology in the 2010 constitution. Use of this terminology does not mean or imply any change in the substance or scope of the Bank’s policy OP4.10 regarding Indigenous Peoples and its application in Kenya.
are an essential support service for the efficient delivery of quality health services. The Ministry of Public Health and Sanitation (MoPHS) will have overall responsibility for EAPHLN project implementation and within this Ministry, the Department of Disease Prevention and Control (DDPC) has been designated as the project coordinating unit to lead Kenya’s activities. The project will use a model of promoting an integrated model for providing diagnostic services in cross border areas that cuts across diseases.

Rationale for a Vulnerable and Marginalized Peoples Plan (VMPP):

13) There have been recent consultant projects which have informed the IPPFs. These include the joint Vulnerable and Marginalized Peoples Planning framework (VMPPF) for the East Africa Public Health Laboratory Networking project. The Kenya Health Sector Support Project has an existing IPPF to address health coverage issues that may affect vulnerable groups in the health sector. (These projects went to Board May 25, 2010 and June 29, 2010 respectively). In addition, a Social Assessment for the Natural Resources Management (NRM) Project was prepared in May 2010 which provides broad information on location, social structures, IP groups’ characteristics, etc for the Mt Elgon and Cherangany Hills areas. Also, an Environmental and Social Management Framework (ESMF) was prepared for the East Africa Public Health Laboratory Networking Project for Kenya, Tanzania, Rwanda and Uganda (January 2010).

14) While the EAPHLN project will focus on five rural districts in cross border areas of Kenya, the KHSS and TOWA projects are national initiatives and beneficiaries include all population groups in the country. The initial screening indicated that vulnerable Indigenous Peoples (IP) are likely to be present in, or have collective attachment to the project areas that may benefit from the project. The persistent inequalities highlight the need to improve access and use of essential health and HIV services by other marginalized populations in the country. All three projects prepared an Indigenous Peoples Framework (IPPF) and the proposed assignment is to support development of specific Vulnerable and Marginalized Peoples Plans (IPPs) for each project consistent with the World Bank’s Indigenous Peoples Policy (OP 4.10).

Objectives of Assignment

15) The overarching objective of the assignment is to ensure that the needs of local Vulnerable and marginalized groups\(^4\), (VMGs) are addressed in a participatory and meaningful way. The consultancy will work towards ensuring a coordinated health sector approach to meeting the specific health needs of VMG working through the three projects. Specific Objectives of the assignment are to:

a) undertake free, prior and informed consultations with local vulnerable and marginalized groups on access to health/HIV services provided under the three projects;

b) support the three implementing agencies to develop project specific Vulnerable and marginalized peoples Plans (VMPPs) in cooperation with the local vulnerable and marginalized ethnic groups, that will enable such groups in the project areas access benefits from each project equitably and in a culturally appropriate manner.

16) The consultant would facilitate joint consultations with selected VMGs for all three projects to support development of project specific VMPPs based on the existing VMPPF. As explained in the rationale, considerable social analysis has already been undertaken on IPs in Kenya under a number of Bank funded projects including these three operations. Therefore, a broad social assessment on the same groups would

\(^4\) Note that different countries may adopt other terms to refer to “indigenous peoples” – for example, vulnerable and marginalized ethnic groups, tribal groups or local minorities.
add little value. Instead, these TORs propose a more focused consultation with select VMGs covering at least 10 areas known to have underserved and marginalized populations focusing on access to health services at levels 1-3 including access to HIV related services, and specialized laboratory services for TB and other communicable diseases. This will ensure planning better coordinated delivery of health and HIV services that are responsive to the needs of VMGs and also save time minimize repetition and community fatigue with research including effective management of community expectations.

Approach

17) The consultancy will follow the same 4 step approach for each of the three health projects

a) To assess whether VMG are included or excluded through the existing project
b) To document what and how existing support is being provided to VMG

c) To identify how the existing project can expand and improve support to VMG through the existing mechanism and activities already in the plan.

d) To recommend any additional/new work through the existing project, where appropriate

Scope of Work

18) The scope is National; however the assessment will be conducted in ten sites, clustered into 5 groups (Table 2, G1-G5), spread across the country in mapped areas home to Indigenous People.

Work Program

19) Desk Review: The Consultant will undertake a desk review of legal summary and include a map of the location of indigenous peoples in the vicinity of the selected sites/locations, other relevant documents from projects being supported by the Bank or other institutions. (See Annexes 2-5). **It is important that the Consultant is aware not only of the goals and objectives of the project but of the project components to ensure that the VMPP activities are undertaken in a manner consistent with rest of the project, or are complementary. The budget need not be large, but should be reasonable and sufficient for carrying out the proposed activities.**

20) **Joint focused Consultations:** The consultant will undertake joint focused consultations for all three projects building on existing VMPPFs addressing the special needs of each project as described below:

a) **Health Sector Support Project: Access to the Kenya Basic Health Care Package** (access to a clinic, prenatal care, maternity ward, under 3 and 5 immunization, outreach services). Some issues to consider include:

i) To what extent are VMGs aware of services provided at levels 1-3 and Health Sector Services Fund?

ii) Are there community health workers in place providing health promotion and treatment for minor ailments?

iii) Whether outreach services are provided to habitations where VMGs reside? Which ones and how often?

iv) How accessible are the health facilities to VMGs for providing clinic, family planning, prenatal care, skilled child birth, immunization and care for sick children under 5 years?

v) Are service providers and service delivery arrangements sensitive and responsive to their specific needs?
vi) To what extent do VMGs participate in the program planning at their nearest levels 2 or 3 health facility? What is the share of VMGs in the Health Facility Management Committees and community health committees? Membership of VMG in the Governance structures HFMC?

vii) What are the existing grievance complaints mechanism and how can they be applied and/or enhanced in the project?

viii) Are VMGs aware of where they can complain if they find deficiency in services/lack of responsiveness to their specific health needs?

ix) What are the capacity building/sensitization of key service providers – at community, facility and district levels to improve service delivery and responsiveness of providers to essential health services?

b) TOWA – Focus on access to HIV/AIDS related services

Some issues to consider include:

i) Which of the VMGs have not been reached under the TOWA Call for Proposals (CFPs)? (The consultant will look at 4 previous CFPs to see if CSOs from locations where VMGs are located have submitted and proposal and if it was awarded a grant)

ii) What HIV/AIDS related services and information are provided to the community?

iii) Has any VMG been awarded contracts under the CFPs for providing HIV/AIDS prevention and mitigation services specifically focusing on VMGs?

iv) Is the staff from local agencies providing HIV/AIDS prevention and mitigation services sensitive and responsive to the specific needs and requirements of VMGs?

v) Do the VMGs have access to bed nets (only in malaria endemic areas)? Where did they get the bed nets from?

vi) What support/capacity building initiatives would VMGs need from regional facilitating agencies (RFAs) to ensure VMGs can submit proposals under the next and last CFP under TOWA5.

vii) Specifically, the consultant will suggest appropriate tools and capacity building needs for Constituency AIDS Control Committees (CACCs) and CSO/CBO/FBO on how to apply the tool as well as spell out how the identified VMGs in each constituency will be targeted through CACC structures at the constituency level. For example, how to mobilize VMGs through the Constituency Stakeholders’ Fora that brings together the players in the National Response of HIV and AIDS and in the Community Pillars as identified in the successive Kenya National AIDS Strategic Plans.

c) EAPHLNP- Access to Laboratory Services

Some issues to consider include:

i) What laboratory facilities are the VMGs aware of?

ii) Have they been tested for any illness? If so which ones? (Cholera, Meningitis, MDR-TB, influenza, polio or any other diseases?)

iii) Are there any mobile Laboratory services provided to the community?

iv) What can be done to increase IPs access to Laboratory facilities?

v) Are there any civil society organizations supporting the VMG’s? What kind of support is being provided?

vi) Are there surveillance sites to monitor hot spots for disease transmission with the VMG’s population?

vii) What is the existing gap for laboratory services for VMG’s in the districts that EAPHLN project is supporting?

5 The last Call For Proposals is in May 2011 for TOWA.
21) The Consultant will undertake required field visits to conduct a targeted social analysis to focus on issues of access to health services. It will validate initial findings from recent social assessment on and whether indigenous peoples have special needs relative to the overall population. S/he will also consult the project implementing agency and other stakeholders (ministries, champions, and affected people) about the proposed plan and any changes that would make the plan more effectual.

22) The consultant will review the commitment made in the 3 project related IPPFs (See Attachment 3: Summary of commitments of the VMPPF and confirm which commitments are achievable. Communities will be informed of those which cannot be achieved and why during the consultations as part of free, prior and informed consultations.

23) The consultant will propose interventions to the Project Implementation Teams and the TTL for follow-up and implementation purposes within the frameworks of the three projects. The methodology for each activity needs to be cleared with the Task Team Leader prior to the action.

24) The Consultant will carry out the task in close collaboration with the three project teams.

25) The Consultant will ensure that implementation arrangements for carrying out specified tasks as identified in the VMPPs during implementation are undertaken.

26) The Consultant will prepare three separate VMPPs – one for each project, utilizing a participatory approach and referring to the additional guidance offered in the Bank Operational Policy (OP4.10). He/She will summarize the key monitoring and performance indicators, identify monitoring arrangements, and ensure that all VMPPs’ activities have responsible institutions and a budget. In cases where the name of the VMGs is highly sensitive to the authorities in the country, the consultant may propose and discuss alternative names for the document. Within the Bank it is considered an IPP for clarity and consistency with OP 4.10, but for disclosure purposes it may be titled something else (such as a strategy or outreach component).

27) The TTL will oversee submission of the VMPPs disclosure in-country in the Bank’s InfoShop after the IPP has been approved by the Implementing Agency and the World Bank. Appropriate disclosure can include summaries in public libraries, “available upon request” in newspapers, or other means considered adequate by the consultant and Borrower.

28) The Consultant will keep a record of all consultation meetings (date, time, information presented, participants, concerns, suggestions) and give them to the implementing agency and Task Team Leader.

10.1.1 Outputs

29) The outputs of this consultancy will be:

a) Three separate Vulnerable and Marginalized Peoples Plans (VMPPs) with a focus on increasing access to health services provided under each project. The Plans will include baseline data (mapping of where such groups are and their populations, priority health concerns, documentation of current reach and coverage of health services provided under each project; recommendations to increase access, reach to health services for each project; strategy for local participation in decision-making throughout planning, implementation, including any measures for strengthening implementation capacity and institutional arrangements (agreements) with agencies that are not necessarily implementing the rest of the project, and evaluation, development or mitigation activities, implementation schedule, monitoring and evaluation, and a budget line from the project;
b) *a summary of the free, prior, and informed consultations* undertaken;

c) *A detailed description of a grievance resolution mechanisms* for three projects building on existing mechanisms in the health sector

d) *A detailed timetable and procedure for disclosure of the VMGP (IPP)* in country and in the World Bank’s InfoShop in English or the national language and fully explained in local dialect or language that the indigenous communities can understand.

**Guiding Principles**

90. The Consultant must bear in mind that:

  e) *The VMPP should be prepared in tandem with project’s implementation plan.* In many cases, proper protection of the rights of indigenous people will require the implementation of special project components that may lie outside the primary project's objectives as identified by the consultant where possible.

  f) *The key step in project design for the VMPP is the preparation of a culturally appropriate development plan* based on full consideration of the options preferred by the indigenous people affected by the project. Studies should make all efforts to anticipate adverse trends likely to be induced by the project and develop the means to avoid or mitigate harm. The institutions responsible for government interaction with indigenous peoples should possess the social, technical, and legal skills needed for carrying out the proposed development activities. Implementation arrangements should be kept simple. They should normally involve appropriate existing institutions, local organizations, and nongovernmental organizations (NGOs) with expertise in matters relating to indigenous peoples. Local patterns of social organization, religious beliefs, and resource use should be taken into account in the plan's design. Development activities should support production systems that are well adapted to the needs and environment of indigenous peoples, and should help production systems under stress to attain sustainable levels.

  g) *The VMPP should avoid creating or aggravating the dependency of indigenous people on project entities.* Planning should encourage early handover of project management to local people. As needed, the plan should include general education and training in management skills for indigenous people from the onset of the project.

**Qualifications**

30) Must have capacity to work in Kenya including registration and offices in necessary. Demonstrated experience in Socio-Anthropological work with VMGs, provide information indicating that they are qualified to perform the services (brochures, description of similar assignments), availability of appropriate skills among staff and logistical capacity. The team leader should be a person with an advanced degree in Social Sciences; assisted by a a public health expert and a Social Scientist both with strong background in respective research methodologies. In addition the social scientist should be well versed in community development work.
Consultancy Arrangements

31) The Consultant will work on the IPP over a period of 60 working days as detailed in a comprehensive activity schedule. Table1: Action Plan

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timetable</th>
<th>Outputs</th>
<th>Delivered by when?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preparation of VMPP timetable and work plan</td>
<td>After two weeks of start of consultancy</td>
<td>Final Inception Report</td>
<td>Four weeks after contract signing date</td>
</tr>
<tr>
<td>2 Site visits and meetings</td>
<td>Ongoing throughout length of consulting assignment</td>
<td>Summary Reports</td>
<td>Bi-weekly reports</td>
</tr>
<tr>
<td>3 Draft reports</td>
<td>Within 2 weeks of completion of site consultations</td>
<td>Report (draft)</td>
<td>Within 2 weeks of completion of site consultations</td>
</tr>
<tr>
<td>4 Consultations on report (draft) including dissemination workshop and meetings</td>
<td>Two weeks</td>
<td>Summary of consultations and feedback</td>
<td>Delivered with the final report</td>
</tr>
<tr>
<td>5. Final report</td>
<td>End of consultancy</td>
<td>Final Report delivered with summary of consultations</td>
<td>End of consultancy</td>
</tr>
</tbody>
</table>

Budget

Institutional Arrangements

32) The Consultant will be supervised by the Ministry of Public Health and Sanitation. Under the arrangements for free, prior, and informed consultations, the Consultant should ensure that the consultations are coordinated closely with local district health authorities and community leaders of the VMPs. The ministry shall make available the relevant project appraisal documents, related VMPPFs. The World Bank OP 4.10 can be accessed at:

Table 2: Vulnerable Minority and Marginalized (Indigenous Peoples) in selected districts in Kenya

<table>
<thead>
<tr>
<th>Constituencies</th>
<th>Large District</th>
<th>IP’s</th>
<th>Areas</th>
<th>Economic Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Baringo North</td>
<td>2. Baringo</td>
<td>IL-Chamus</td>
<td>L. Baringo</td>
<td>Fishing / Livestock</td>
</tr>
<tr>
<td>5. Marsabit</td>
<td>Daasanach</td>
<td>Munyoyaya</td>
<td></td>
<td>G2</td>
</tr>
<tr>
<td>Waata</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Konso</td>
<td></td>
<td>Marsabit (Dub</td>
<td></td>
<td>G3</td>
</tr>
<tr>
<td>Deis</td>
<td></td>
<td>gobba, Qachacha</td>
<td></td>
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<tr>
<td>El-molo</td>
<td></td>
<td>Garb-tula</td>
<td></td>
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<tr>
<td>Lkunono</td>
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</tbody>
</table>

**Notes:**
- **G2** indicates semi-nomadic pastoralists and fishing.
- **G3** indicates semi-nomadic pastoralists, farming, fishing.
<table>
<thead>
<tr>
<th>Region</th>
<th>District</th>
<th>Sub-District</th>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Bura G4</td>
<td>8. Tana River</td>
<td>Waata</td>
<td>Farming, small livestock</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sombo</td>
<td>Casual work, Farming, Fishing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Balambala (TR)</td>
<td>Beekeeping, farming, brickmaking, Sand harvesting</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Bura</td>
<td>Rice farming, fishing</td>
<td></td>
</tr>
<tr>
<td>13. Wajir North</td>
<td>9. Wajir</td>
<td>Gagabey /Bon</td>
<td>Farming, small livestock</td>
<td></td>
</tr>
<tr>
<td>14. Wajir East</td>
<td></td>
<td>Bulla Kibilay (Habaswein sub-district)</td>
<td></td>
<td></td>
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<tr>
<td>15. Wajir West</td>
<td>Rer-Bahars</td>
<td>Wajir Town</td>
<td>Blacksmiths</td>
<td></td>
</tr>
<tr>
<td>16. Wajir Solth</td>
<td>10. Turkana</td>
<td>Ngikebootok</td>
<td>Hunting, Fishing and growing Sorghum</td>
<td></td>
</tr>
<tr>
<td>17. Narok South</td>
<td>11. Laikipia</td>
<td>Yiaku</td>
<td>Livestock, game ranching</td>
<td></td>
</tr>
<tr>
<td>18. Narok North G5</td>
<td></td>
<td>Doldol, Siek,</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>West Pokot: Serewo, Chepareria, Sook</td>
<td>(Ancient Hunter-gather) Farming and livestock</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Pokot Central: Seker and Lomut</td>
<td></td>
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<tr>
<td></td>
<td>Region</td>
<td>Type</td>
<td>Activities</td>
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<tr>
<td>21. Matuga</td>
<td>Kwale</td>
<td>Boni</td>
<td></td>
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<tr>
<td>22. Kinango</td>
<td></td>
<td></td>
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<tr>
<td>15. Malindi</td>
<td></td>
<td>Boni</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>23. Lamu West</strong></td>
<td><strong>G4</strong></td>
<td><strong>Boni/Aweer</strong></td>
<td>Majengo, Mangai, Kiunga, Kiduruni</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(Ancient Hunter-gather) –farming,</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>fishing</td>
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</tr>
<tr>
<td>16. Lamu</td>
<td></td>
<td></td>
<td>Sanye</td>
<td></td>
</tr>
<tr>
<td>24. Bahari</td>
<td></td>
<td>Boni</td>
<td>Hunter-gathers</td>
<td></td>
</tr>
<tr>
<td>25. Mt Elgon</td>
<td></td>
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<tr>
<td>18. Mt Elgon</td>
<td></td>
<td>Ogiek</td>
<td></td>
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<tr>
<td>26. Molo</td>
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<td></td>
</tr>
<tr>
<td>27. Kuresoi</td>
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<tr>
<td>19. Nakuru</td>
<td></td>
<td>Ogiek</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>28. Eldama Ravine</strong></td>
<td><strong>29. Mogotio</strong></td>
<td><strong>Koibatek</strong></td>
<td>Ogiek, endorois</td>
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<td>G1</td>
<td></td>
</tr>
<tr>
<td>21. Tran zoia</td>
<td></td>
<td>Sengwer</td>
<td>Hunter-gather)</td>
<td></td>
</tr>
<tr>
<td>30. Cherangany</td>
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<tr>
<td>32. Kwanza</td>
<td></td>
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<tr>
<td>33. Saboti</td>
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</tbody>
</table>

**Attachment 1**

Vulnerable /Marginalized Peoples Planning Framework for the Total War Against AIDS Project – KENYA/(IPPF)

**Attachment 2**

Vulnerable /Marginalized Peoples Planning Framework from the Kenya health SWAp and the regional health Systems and TB Support Project – KENYA

**Attachment 3**
Summary of commitments of the VMPPFs
<table>
<thead>
<tr>
<th>Health SWAp</th>
<th>TOWA</th>
<th>EA Public Health Laboratory Networking Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aims to improve service delivery at levels 1-3 through direct cash transfers to facilities and improved supply of essential medicines</td>
<td>TOWA works with civil society to promote HIV awareness with focus on prevention</td>
<td>Networking of Labs in 5 cross border areas to improve access to specialized laboratory services and improved disease surveillance – increase diagnosis, surveillance, alb work</td>
</tr>
<tr>
<td>Scope is nationwide but pilot in 8 districts first</td>
<td>Nation wide</td>
<td>Wajir East, Malindi, Kitale, (TransNzoia West), Busia and Machakos</td>
</tr>
<tr>
<td>Limited list of IPs</td>
<td>Long list of IPs</td>
<td>Limited list of IPs</td>
</tr>
<tr>
<td>Sub projects will be screened and implemented with associated IP in agreement with IP community</td>
<td>CACCs to mobile the IPs and invite them to the Constituency Stakeholder’s fora</td>
<td></td>
</tr>
<tr>
<td>There will be consultations and participation of IPs during the design and implementations to ensure their needs met</td>
<td>Social Assessment: to find out demographic status, socio economic data – poverty level, food security, education levels and access to health services, inst structures, governance capacities</td>
<td>SA will be done EMP will be done to be disclosed with IPs in affected area</td>
</tr>
<tr>
<td>Annual work programs from the MOPHS will clearly describe activities proposed to serve IPs</td>
<td>Engage IPs: in CFP - IPs to be invited to the community pillars as identified in the KNASP where stakeholders meet to identify gaps, review progress, share experience. Establish IP Screening team, Establish IP Coordination Committee to ensure IP in NACC structure mechanisms participation</td>
<td>There will be consultations and participation of IPs during the design and implementations to ensure their needs met Annual work programs from the MOPHS will clearly describe activities proposed to serve IPs</td>
</tr>
<tr>
<td>There will be consultations and participation of IPs during the design and implementations to ensure their needs met</td>
<td>Establish a dispute resolution and grievance mechanism that IPs can access.</td>
<td></td>
</tr>
<tr>
<td>The project will support capacity development of district officials and facilities committees to sensitize them of their need to consult, screen and monitor for IPs</td>
<td>Capacity building of the CACCs, CS/CBO/FBO on how to apply the tool</td>
<td>The project will support capacity development of district officials and facilities committees to sensitize them of their need to consult, screen and monitor for IPs</td>
</tr>
<tr>
<td>Summary of Commitments made in VMPPFs</td>
<td></td>
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<tr>
<td>Health SWAp</td>
<td>TOWA</td>
<td>EA Public Health Laboratory Networking Project</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Annual progress report will</td>
<td>Monitoring – IP project monitoring Team</td>
<td>Assignment of institutional resps for monitoring,</td>
</tr>
<tr>
<td>assess extent that IPs are</td>
<td>trained to use community based project</td>
<td>training district officials,</td>
</tr>
<tr>
<td>reached and are benefitting</td>
<td>report COBPAR</td>
<td></td>
</tr>
<tr>
<td>from the annual national program.</td>
<td></td>
<td>Annual progress report will assess extent that</td>
</tr>
<tr>
<td>Esp Ogiek, Dorobo and Sengwer.</td>
<td></td>
<td>IPs are reached and are benefitting from the</td>
</tr>
<tr>
<td>Annual supervision report to assess</td>
<td></td>
<td>annual national program. Esp Ogiek, Dorobo</td>
</tr>
<tr>
<td>project impact on the IPs</td>
<td></td>
<td>and Sengwer. Annual supervision report to assess</td>
</tr>
<tr>
<td></td>
<td></td>
<td>project impact on the IPs</td>
</tr>
<tr>
<td></td>
<td>Budget – for proposals and capacity</td>
<td></td>
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<tr>
<td></td>
<td>building but none for SA and screening</td>
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</tbody>
</table>

Suggestions -- Next Steps

- **Screening**: At project level while Bank to confirm with Government the IP groups screened for Kenya

- **All three projects undertake a joint Social Assessment**: building on existing and planned SAs.
- The consultant to undertake social analysis /survey focused on IP groups access to health with a focus on (i) accessing financial resources by civil societies in the areas for implementation of prioritized intervention in the Joint Annual program review (JAPR)
- To what extent the IPs are aware of services provided and participate in the program planning?
- Whether service providers and service delivery arrangements are sensitive and responsive to their specific needs?
- Whether they are aware where they can complain if they find deficiency in services/lack of responsiveness to their specific need

**Focus of the VMMC Plans should be on health services access.** Need to capture specificity of each project – specific actions based on assessment

- The Task Team is best-placed to determine which areas and communities will be covered under a Plan, but the activities, as we understand, would be focused on access to basic health services.
- Identify top IP HIV needs/concerns and propose actions to be taken to support IPs to submit proposals under the next and last Call For Proposals under TOWA
- Identify how to increase IPs access to Labs facilities and to basic health care under the Laboratory and health SWAp projects. The last Call For Proposals is in the next few months for TOWA

- Follow up consultation /assessment after a year to see to what extent recommended actions have been implemented and whether the IPs perceive a qualitative
<table>
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<tr>
<td>TOWA</td>
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<tr>
<td>EA Public Health Laboratory Networking Project</td>
</tr>
</tbody>
</table>

Identify capacity building/sensitization of key service providers -- at district and facilities level
Annex V: LIST OF KEY INFORMANTS AND DATES OF INTERVIEWS

1. Sengwer Community CACC member`-20/08/2012
2. CACC Coordinator, Cherengany -21/08/2012
3. Public Health Technician (Trans Nzoia East) -23/08/2012
4. DASCO- Trans Nzoia East -20/08/2012
5. DMLT –Trans Nzoia East -20/08/2012
6. DPHO-Trans Nzoia East -20/08/2012
7. Nutritionist- Kapsara Hospital -21/08/2012
8. Nursing Officer-Kapsara District Hospital -21/08/2012
9. Home Based Care Coordinator- Kapsara District Hospital -21/08/2012
10. Medical Superintendent Kapsara District Hospital-21/08/2012
13. Laboratory Technologist, Malindi District Hospital- 15/09/2012
14. Disease Surveillance Officer, Wajir -22/09/2012
15. District Public Health officer/CACC Cordinator- Bura East-10/09/2012
17. Assistant Chief- Kabolet I forest- 20/08/2012
18. CACC Coordinator- North Horr -5/09/2012
20. Chief-Sabor Location -25/08/2012
21. CACC Coordinator- Molo -26/08/2012
22. CACC Coordinator- Turkana South -22/09/2012
23. CACC Coordinator- Lamu West -13/09/2012
24. CACC Coordinator- Laisamis -05/09/2012
25. Community Health Worker- Bura constituency -11/09/2012
27. Area Councillor- Ogiek Nessuit -26/08/2012
28. Area Councillor IL Chamus- Marigat -24/08/2012
29. Chief- Ogiek Nessuit location-26/08/2012
30. District Medical Officer of Health- Marigat -24/08/2012
31. District Public Health Officer- Marigat -25/08/2012
32. CACC Coordinator- Baringo Central -25/08/2012
33. Pastor- Marigat division -24/08/2012
34. Assistant Chief- El dume sub-location -24/08/2012
35. Pastor- Katilu location- 22/08/2012
36. Area councilor –Katilu location (South Turkana)-22/08/2012
Annex VI: Places, communities visited and Dates during the VMPPs Study

1. Trans Nzoia East –Cherenganyi (Kabolet Forest)- Sengwer -20/08/2012
2. Trans Nzoia East District hospital- 21/08/2012 and 23/08/2012
3. Turkana South – Katilu (Banks of river Turkwel)-Ngikebootok -22/08/2012
5. Molo –Ogiek Nessuit Location-Ogiek – 26/08/2012
10. Malindi district hospital -16/09/2012
Annex VII: Final Vulnerable and Marginalized Peoples Plans (VMPPs)

REPUBLIC OF KENYA

MINISTRY OF PUBLIC HEALTH AND SANITATION

FINAL VULNERABLE AND MARGINALIZED PEOPLES PLANS (VMPPs) FOR KENYA
HEALTH SECTOR SUPPORT PROJECT (KHSSP)

PRESENTED BY:
MULTIFACE RESEARCH AND DEVELOPMENT CENTRE
P.O. BOX 54-40100, KISUMU

MARCH 2013
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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</thead>
<tbody>
<tr>
<td>EAPHLN</td>
<td>East African Public Health Laboratory Network</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Heath Worker</td>
</tr>
<tr>
<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<tr>
<td>HFMC</td>
<td>Health Facility Management Committee</td>
</tr>
<tr>
<td>TOWA</td>
<td>Total War Against AIDS</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non Governmental Organizations</td>
</tr>
<tr>
<td>CSOs</td>
<td>Civil Society Organizations</td>
</tr>
<tr>
<td>DMOH</td>
<td>District Medical Officer of Health</td>
</tr>
<tr>
<td>KHSSP</td>
<td>Kenya Health sector support project</td>
</tr>
<tr>
<td>VMGs</td>
<td>Vulnerable and marginalized groups</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune-deficiency Virus</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CBOs</td>
<td>Community Based Organizations</td>
</tr>
<tr>
<td>NACC</td>
<td>National Aids Control Council</td>
</tr>
<tr>
<td>WB</td>
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<tr>
<td>HCT</td>
<td>HIV Counseling and Testing</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with AIDS</td>
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<tr>
<td>MGCSD</td>
<td>Ministry of Gender, Children and Social Development</td>
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</tbody>
</table>
The Vulnerable and Marginalized Peoples Plans for the Kenya Health Support Project (KHSSP) are derived from field visits and consultations that were held with the Vulnerable and Marginalized Communities in Kenya between August and September 2012. The plans aim at enhancing access to and utilization of basic health services for the Vulnerable and Marginalized Populations (VMPs) within the framework of Kenya Health Sector Support Project (KHSSP). The plans will specifically help to address such health issues as health promotion, provision of outreach services, frequent stock out of essential drugs in health facilities, address gaps in pro poor strategies for health financing as well improve social accountability in the delivery of health services among the VMPs in Kenya.

<table>
<thead>
<tr>
<th>THEMATIC ISSUE</th>
<th>IDENTIFIED PROBLEM/BARRIERS</th>
<th>STRATEGIC OBJECTIVE</th>
<th>ACTIVITIES</th>
<th>EXPECTED INPUTS</th>
<th>RESPONSIBLE PARTIES/ACTORS</th>
<th>OUTPUT INDICATORS</th>
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</thead>
<tbody>
<tr>
<td>Access to Health Services</td>
<td>Lack of effective health promotion activities, outreach programs and community health activities</td>
<td>To introduce and strengthen health promotion activities among the VMGs; To establish and strengthen community health; To enhance the provision of efficient and effective integrated outreach services to VMG communities</td>
<td>Establish functional community units for VMGs; Facilitate VMG participation in diseases and nutritional surveillance, conduct community dialogues, awareness creation, health talks to sensitize mothers attending MCH clinics and capacity building for VMG populations and health workers on development of culturally relevant IEC materials,</td>
<td>Mobilization costs, Venue hire, travel, facilitation allowances, stationery, secretariats, meals, Communication costs, accommodation, costs for production of IEC materials, purchase of drugs and reagents for outreach programs</td>
<td>KHSSP project to provide funds and implementation guidelines; County/DMOH to oversee/supervise the implementation of activities. Health Facility management Committees to implement activities within their VMG catchment areas.</td>
<td>No of community units established; No of CHWs reporting on a monthly basis; Number of dialogue days held / year; Number of integrated outreach sessions conducted per quarter; Number and nature of IEC materials developed for health promotion among</td>
</tr>
<tr>
<td>THEMATIC ISSUE</td>
<td>IDENTIFIED PROBLEM/BARRIERS</td>
<td>STRATEGIC OBJECTIVE</td>
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<tr>
<td>Utilization of health services by the VMG communities</td>
<td>Poverty, frequent shortage of essential drugs (EMMS) and cultural beliefs and practices are the main barriers to utilization of health services</td>
<td>To create mechanisms for the pro-poor strategies that can enhance utilization of basic health services by the VMG communities. To ensure adequate stock levels are maintained for Essential Medicines and Medical supplies through full implementation of pull system. To address cultural beliefs and practices that</td>
<td>Strengthen integrated outreach services</td>
<td>Purchase of drugs and reagents for outreach programs, mobilization costs, travel Facilitation fee, Purchase of Essential Medicines and Medical Supplies (EMMS), meals and accommodation, travel, communication costs Additional funds for waiver facilities, Mobilization and facilitation costs, venue hire, stationery, accommodation, meals, communication</td>
<td>KHSSP project to provide funds and implementation guidelines EAPHLN project to provide funds to purchase laboratory reagents. County/DMOH to oversee/supervise the implementation of activities. Health Facility management Committees to implement activities within their VMG catchment areas.</td>
<td>VMGs</td>
</tr>
<tr>
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<td></td>
<td></td>
<td>Number of HFMCs sensitized on pull system and management of medical supplies Reduced stock outs of EMMS at Health facilities No of H/F with increased HSSF allocation No of Health workers sensitized on waiver policy No of H/Fs implementing health service charter Number of needy VMG patients benefiting from health services</td>
</tr>
<tr>
<td>THEMATIC ISSUE</td>
<td>IDENTIFIED PROBLEM/BARRIERS</td>
<td>STRATEGIC OBJECTIVE</td>
<td>ACTIVITIES</td>
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<td>RESPONSIBLE PARTIES/ACTORS</td>
<td>OUTPUT/INDICATORS</td>
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</tbody>
</table>
| Social Accountability in the provision of health services | Lack of mechanisms to strengthen governance, representation and oversight as well as knowledge about where VMGs can complain has negatively affected effective healthcare | To strengthen governance, representation and oversight strategies among the VMG populations | medicines  
Sharing information on available essential medicine among all the stakeholders.  
Strategies to involve TBAs in hospital deliveries by redefining their roles and training them.  
Conduct sensitization meetings to educate VMG on the health implications of some cultural practices and beliefs | costs | KHSSP project to provide funds and implementation guidelines  
County/DMOH to oversee/supervise the implementation of | Number of the VMG elected representatives trained in social accountability among the VMG communities.  
No of Inventory of complaints registered |
<table>
<thead>
<tr>
<th>THEMATIC ISSUE</th>
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<th>OUTPUT INDICATORS</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>provision.</td>
<td></td>
<td>Sensitize the health workers on the implementation of complaints resolution mechanisms.</td>
<td>communication costs</td>
<td>Health Facility management Committees to implement activities within their VMG catchment areas.</td>
<td>and addressed by the grievance resolution committees.</td>
</tr>
</tbody>
</table>
REPUBLIC OF KENYA

NATIONAL AIDS CONTROL COUNCIL (NACC)

FINAL VULNERABLE AND MARGINALIZED PEOPLES PLANS (VMPPs) FOR TOTAL WAR AGAINST AIDS PROJECT (TOWA)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>KHSSP</td>
<td>Kenya Health sector support project</td>
</tr>
<tr>
<td>VMGs</td>
<td>Vulnerable and marginalized groups</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>People Living with AIDS</td>
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<td>MGCSD</td>
<td>Ministry of Gender, Children and Social Development</td>
</tr>
<tr>
<td>GRM</td>
<td>Grievance Resolution Mechanism</td>
</tr>
<tr>
<td>COBPAR</td>
<td>Community-Based Programme Activity Reporting (COBPAR) System</td>
</tr>
</tbody>
</table>
The Vulnerable and Marginalized Peoples Plans for the Total War Against AIDS (TOWA) are derived from field visits and free prior and informed consultations held with the Vulnerable and Marginalized Populations (VMPs) in Kenya between August and September 2012. The plans aim at creating enabling conditions for the VMPs to benefit from activities that are implemented to fight and control the spread of HIV/AIDS among the vulnerable populations in Kenya. The plans specifically aim at addressing issues such as identified limited capacity among the VMG communities to participate in HIV/AIDS control and prevention, gaps in HIV/AIDS service provision, inadequacy in social accountability in management of HIV/AIDS services and inadequate monitoring and evaluation mechanisms of HIV/AIDS activities.

<table>
<thead>
<tr>
<th>THEMATIC ISSUE</th>
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<th>ACTIVITIES</th>
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<th>TIME FRAME</th>
<th>OUTCOME INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited capacity among VMG communities to participate in HIV/AIDS control and prevention.</td>
<td>Inadequate capacity of VMGs to participate in HIV/AIDS control and prevention.</td>
<td>Increase the knowledge and awareness of HIV&amp;AIDS by VMGs</td>
<td>Identify and sensitize VMG opinion leaders on HIV&amp;AIDS</td>
<td>Mobilization costs; Travel, meals &amp; accommodation costs, Consultancy / Facilitation fees; Communication costs (stationery, internet and telephone etc), Stakeholder workshops (14); Anti-retroviral and TB drugs and nutritional</td>
<td>National AIDS Control Council (NACC) /TOWA project The World Bank(WB) Community Based Organization (CBOs)</td>
<td>By June 2013</td>
<td>Number of VMG community members sensitized on HIV&amp;AIDS control and prevention; Number of stakeholder forums held in VMG communities; Number of VMG opinion leaders sensitized on HIV&amp;AIDS. Number of post –test clubs formed. Number of peer educators trained among the VMGs</td>
</tr>
<tr>
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</tr>
<tr>
<td>Gap in HIV&amp;AIDS service provision for VMG communities</td>
<td>Limited HIV&amp;AIDS services to most VMG communities.</td>
<td>1. To promote condom access, use and disposal</td>
<td>Train VMG communities on appropriate use and disposal of condoms; Distribute condoms to VMG communities.</td>
<td>Facilitators; Mobilization costs Communication (stationery etc), Consultancy / Facilitation fees</td>
<td>TOWA /KHSSP The World Bank CBOs</td>
<td>By June 2013</td>
<td>Number of female and male VMGs sensitized on appropriate use and disposal of condoms. Number of condoms distributed (male and female).</td>
</tr>
<tr>
<td></td>
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<td>2. To promote understanding of and access to HIV Counseling and Testing (HCT) services</td>
<td>Mobilize VMG communities for HIV Counseling and Testing (HCT) services. Carry out HCT among the</td>
<td>Mobilization costs Communication (stationery etc), Consultancy / Facilitation fees Transport ,</td>
<td></td>
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members
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<th>TIME FRAME</th>
<th>OUTCOME INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequacy in social accountability in management of HIV&amp;AIDS services</td>
<td>Inadequate information on TOWA project amongst the VMGs.</td>
<td>VMGs.</td>
<td>Initiate formation of support groups for People Living with HIV &amp; AIDS (PLWHA) among the VMGs.</td>
<td>Meals</td>
<td>NACC /TOWA project/KHSSP; WB</td>
<td>Immediate action</td>
<td>Number of female and male VMGs counseled and tested;</td>
</tr>
<tr>
<td></td>
<td>Inadequate participation in TOWA by</td>
<td></td>
<td>Strengthen referral systems for PLWHA</td>
<td></td>
<td>Ministry of Gender, Children and Social Development (MGCSD) CBOs in VMG communities</td>
<td>Number of VMG support groups formed.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Involve VMG Action To be Taken By: -</td>
<td>Number of clients referred.</td>
<td></td>
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<td></td>
<td></td>
<td>1. Enhance access to information on TOWA project amongst the VMGs.</td>
<td>Develop Information Education and Communication (IEC) materials in vernacular languages Disseminate information on HIV and AIDS and in community forums.</td>
<td>Facilitators; Mobilization costs Communication (stationery etc), Consultancy / Facilitation fees Facilitators Consultancy fee Transport, Meals and Accommodation</td>
<td>NACC /TOWA project/KHSSP; WB</td>
<td>Number of IEC materials distributed / disseminated to the VMGs.</td>
<td></td>
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<td></td>
<td></td>
<td>2. Increased participation of VMGs in TOWA</td>
<td>Involve VMG</td>
<td></td>
<td>Ministry of Gender, Children and Social Development (MGCSD) CBOs in VMG communities</td>
<td>Number of meetings</td>
<td></td>
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<tr>
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<tr>
<td>Inadequate monitoring and evaluation mechanisms of HIV&amp;AIDS Activities</td>
<td>VMGs</td>
<td>activities</td>
<td>communities in TOWA activities</td>
<td>costs; Venue hire</td>
<td>TOWA/KHSSP</td>
<td></td>
<td>Number of VMG community members utilizing Grievance Resolution Mechanisms.</td>
</tr>
<tr>
<td></td>
<td>Inadequate knowledge on M&amp;E reporting tools among the VMGs</td>
<td>3. Increase awareness and utilization of Grievance Resolution Mechanisms (GRM)</td>
<td>Sensitize the VMGs on Grievance Resolution Mechanism (GRM)</td>
<td></td>
<td></td>
<td></td>
<td>Number of VMG community members sensitized on GRM.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enhance monitoring and evaluation mechanisms among the VMGs.</td>
<td>Diversify Grievance Resolution Mechanisms channels</td>
<td></td>
<td></td>
<td></td>
<td>Number of additional Grievance Resolution channels.</td>
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<td>Enhance feedback on Grievance Resolution Mechanisms</td>
<td></td>
<td></td>
<td></td>
<td>Number of complaints addressed and documented.</td>
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<td></td>
<td>Train VMGs on COBPAR.</td>
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<td></td>
<td>Number of VMGs trained and reporting on COBPAR.</td>
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REPUBLIC OF KENYA

MINISTRY OF PUBLIC HEALTH AND SANITATION

FINAL VULNERABLE AND MARGINALIZED PEOPLES PLANS (VMPPs) FOR EAST AFRICAN PUBLIC HEALTH LABORATORY PROJECT (EAPHLN)

PRESENTED BY:

MULTIFACE RESEARCH AND DEVELOPMENT CENTRE
P.O. BOX 54-40100, KISUMU

MARCH 2013
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EAPHLN</td>
<td>East African Public Health Laboratory Network</td>
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<tr>
<td>KHSSP</td>
<td>Kenya Health Sector Support Project</td>
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<tr>
<td>VMGs</td>
<td>Vulnerable and Marginalized Groups</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>MPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<td>NGOs</td>
<td>Non Governmental Organizations</td>
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<tr>
<td>DMOH</td>
<td>District Medical Officer of Health</td>
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<td>DHMB</td>
<td>District Health Management Board</td>
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<td>LHFMC</td>
<td>Local Health Facility Management Committee</td>
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<td>IDS</td>
<td>Integrated Disease Surveillance</td>
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</table>
The Vulnerable and Marginalized Peoples Plans for the East African Public Health Laboratory Network (EAPHLN) are derived from field visits and free prior and informed consultations held with the Vulnerable and Marginalized Populations (VMPs) in Kenya between August and September 2012. The plans aim at enhancing access to and utilization of Laboratory testing and diagnostic services for the Vulnerable and Marginalized Populations (VMPs) within the framework of East African Public Health Laboratory Network (EAPHLN) which has five cross-border laboratories as centres of excellence in Wajir, Kitale, Busia, Malindi and Machakos. The plans will specifically address issues related to gaps in health promotion/outreach activities for laboratory services, gaps in interventions addressing access, equity and utilization of laboratory services and capacity building of laboratory staff and VMPs in Kenya.

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<tbody>
<tr>
<td>Gaps in health promotion/outreach activities for laboratory services among the VMG communities</td>
<td>Most VMG communities do not have access to laboratory services/disease surveillance and health promotion activity</td>
<td>To enhance health promotion through outreach services among the VMG communities; To integrate laboratory services in outreach among the VMGs; To form and operationalize community units</td>
<td>Create awareness on priority diseases and EAPHLN project objectives to VMGs; Create and functionalize community units in VMG-dominated areas; Improve laboratory data management for disease surveillance.</td>
<td>Facilitators; Mobilization costs; Public Address System, multi-media and publications; Transport, meals accommodation costs; Stakeholder workshops (14); Facilitation fees; Communication costs (internet, telephone and stationery etc).</td>
<td>Project Leader, KHSSP; EAPHLN World Bank; Action To be Taken By: EAPHLN and KHSSP Project leader.</td>
<td>June 2013</td>
<td>Number of awareness sessions conducted; Number of VMGs reached; Number of VMGs utilizing laboratory services; Number of community units formed and functional; Reports received; Number of VMGs referred to the lab; Number of IEC materials distributed; List of information and publicity</td>
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<td>Gaps in interventions addressing access, equity and utilization of Laboratory services by VMG members</td>
<td>Inadequate laboratory services provided by the satellite laboratories to VMGs</td>
<td>To enhance the capacity of the laboratory service delivery to VMGs.</td>
<td>Procure mobile laboratory facility (vehicle with in-built utilities and equipments; Communication (stationery); Transport, meals &amp; accommodation and reagents</td>
<td></td>
<td>Project Leader EAPHLN, MPHS; DHMB, Local Health Facility Management Committees (LHFMC) within the VMG communities</td>
<td>Action To be Taken: EAPHLN Project Leader</td>
<td>September 2013</td>
</tr>
<tr>
<td>Capacity Building of Laboratory staff and the VMG</td>
<td>Inadequate knowledge and skills on disease surveillance among lab staff</td>
<td>To enhance the capacity of laboratory staff on use of laboratory services disease</td>
<td>Train more laboratory staff in all components of integrated disease</td>
<td>Workshops (4); Venue hire; Communication (stationery and</td>
<td>Project Leader; EAPHLN, MPHS, DHMBs, and LHFMCs in VMG</td>
<td>December 2013</td>
<td>Number of laboratory specimen transportation equipments procured Number of outreaches conducted Number of VMGs benefiting from outreach services Number of mobile laboratories in place</td>
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<td>communities.</td>
<td>to provide quality services to the VMG populations.</td>
<td>surveillance and diagnosis</td>
<td>surveillance (IDS), Conduction training courses on basic descriptive epidemiology, Train laboratory staff on data collection, analysis and use; records storage and management, Train laboratory staff on basic computer skills; data entry and analysis and inter-linkages Strengthen structures for cross border fora, disease surveillance and outbreak investigations and data sharing; Recruit trained laboratory staff</td>
<td>internet ) Travel, meals &amp; accommodation Wages and salaries</td>
<td>communities Action To be Taken By: EAPHLN Project Leader</td>
<td></td>
<td>practices; Number of laboratory staff trained on bio-hazardous waste management Changes in management of laboratory generated waste; Number of laboratory staff trained on basic computer skills, data entry and analysis.</td>
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