Republic of Kenya

Ministry of Public Health and Sanitation

VULNERABLE/MARGINALISED PEOPLES PLANNING FRAMEWORK

Prepared for the KENYA Health SWAP and the Regional Health Systems and TB Support Project - KENYA

January 2010
Background and Project Description

Health Sector Reforms and the SWAP

Country Background

1. **Recent economic performance.** Kenya is a low-income country with GNI per capita at US$680 (in 2007) and a population of about 38 million. Kenya’s economy grew strongly between 2003 and 2007, peaking at 6.9 percent in 2007. In 2008, however, growth contracted to 1.7 percent and remained feeble in the first half of 2009, due particularly to: (i) post-election violence in 2008, (ii) the international financial crisis; and (iii) drought.

2. **Kenya faces many corruption and governance challenges.** Kenya used to be the most prosperous country in East Africa, but its economic performance and institutions worsened significantly in the 1990’s due to corruption, inefficient use of public resources, loss of economic competitiveness, a deteriorating security condition, reductions in donor funding and the HIV/AIDS epidemic. In recent years, some positive steps have been taken to address corruption, but there is much unfinished business in the fight to strengthen governance and improve services for the people.

3. **Kenya is on track to achieve some MDGs, but greater efforts are needed to achieve them all, especially those related to health.** On the basis of recent trends, it appears that Kenya is likely to achieve: (i) MDG 2 (achieve universal primary education); and (ii) one target of MDG 3 (promote gender equality); and (iii) MDG6 (combat HIV/AIDS, with a fall in HIV prevalence rates from 10 percent in the late 1990s to 7.1 percent in 2008, partly attributable to successful awareness raising efforts. However, Kenya is not likely to achieve MDG 1 (eradicate extreme poverty and hunger). Despite some good progress in under-five mortality during the period 2003-07, Kenya may not achieve MDG 4 for child health; while MDG 5 (maternal health) also remains a major challenge, due to weak health systems and service delivery.

Health Status

4. **Health indicators in Kenya were stagnant or deteriorated for nearly 15 years until 2003, but made some notable progress in the period from 2003-2007.** Between 1993 and 2003, infant and under-five mortality rates actually increased from 60 to 78, and from 100 to 114, per 1,000 live births respectively. During this period, life expectancy dropped by about five years. However, in the period 2003 to 2007, some notable progress was made. According to the 2008 Kenya Demographic and Health Survey (KDHS), there were remarkable declines in under-five and infant mortality rates after 2003 (from 115 to 74, and from 77 to 52, respectively). These gains were probably largely due to: (i) increases in immunization rates (the proportion of children under one year of age fully immunized rose from 58 percent in 2004/05 to 80 percent in 2006/07); (ii) the increased use of mosquito nets (13.5 million bed nets were distributed, with the percentage of children sleeping under them rising rapidly to 52 percent in 2006, from 5 percent in 2003); and (iii) the positive rate of per capita economic growth in that period (averaging about 3-5 percent annually). The leading causes of morbidity and mortality include malaria, acute
respiratory infection, malnutrition, diarrheal disease, HIV/AIDS and TB. Overall, most health outcomes in Kenya compare quite favorably with its East African neighbors.

5. **The foundations have already been put in place for a Sector-Wide Approach (SWAP), with the Kenya National Health Sector Strategic Plan (NHSSP II) 2005-2010 setting out the approach.** Its goals are to reduce health inequalities and to reverse the downward trend in the health of the Kenyan people. The NHSSP II policy objectives are to: (i) increase equitable access to health services; (ii) improve service quality and responsiveness; (iii) improve the efficiency and effectiveness of service delivery; (iv) enhance the regulatory capacity of the MOH; (v) foster partnerships in improving health and delivering services; and (vi) improve the financing of the health sector. While the NHSSP II is ambitious in scope and its targets, and requires prioritization and clarity on some important sub-sector policies, it is rooted in the Medium Term Expenditure Framework (MTEF) and does provide a viable overall planning framework (with specific policies and strategies to be developed and adopted as part of the Annual Operational Plans).

6. **The NHSSP II is complemented by other key planning documents and processes.** These include the following: (i) the Joint Program of Work and Funding (JPWF), which translates the sector priorities into activities to guide investment decisions; (ii) a Roadmap of Agreed Priorities for the Health Sector, which is based on a review of the JPWF carried out in 2008; (iii) Annual Operational Plans (AOPs), which have been written and used annually since 2006; (iv) a Comprehensive Code of Conduct, which has been agreed and signed by all principal stakeholders in the health sector; and (v) a Kenya Essential Package for Health (KEHP), which defines services at the community level for a population of 5,000 people, with the assistance of volunteer workers who are identified by the community and trained within the community.

7. **The regional Health Systems and TB Support Project: Sub-Saharan Africa has the highest rates of tuberculosis and the worst treatment outcomes, with the continent contributing significantly to the global rise in TB.** Africa represents about 10 percent of the global population yet carries over 30 percent of the global burden of TB cases and related deaths. The average incidence rate on the continent is about 350 cases per 100,000 in contrast to 62 per 100,000 in Brazil, 102 per 100,000 in China and 4 per 100,000 in the United States. TB is a disease of poverty which affects the most vulnerable groups (e.g. refugees, migrants, rural populations, and pregnant women). Tuberculosis programs in Africa find only 50 percent of TB cases and successfully treat 70 percent of those, in comparison to the global case detection and treatment targets of 70 and 85 percent. Kenya is one of the 22 high burden countries worldwide, nine of which are in Africa.

8. Countries in the East Africa region also reports frequent outbreaks of communicable diseases such as meningitis, measles, cholera which tend to spread across the countries in the absence of strong regional mechanism for information sharing. This requires high quality public health laboratories linked to a strong disease surveillance system especially focusing on the border areas. Such need has become a higher priority with the threat of global pandemics like H1N1 and Avian Flu.
Project Objectives:

9. The main objective is to enhance national and regional health systems capacities for diagnosis and surveillance of Tuberculosis and other communicable Diseases to address:

- Increasing concerns of TB Diagnosis among HIV+ individuals
- Rapidly increasing cases of MDR and XDR TB
- Urgent need for increasing access to specialized TB diagnostic services to rural and migrant populations
- Concerns about outbreaks of communicable diseases like meningitis, Cholera, measles, Viral Hemorrhagic fevers.
- Emerging Challenges of pandemics like H1N1 due to increase in global trade and travel
- Very weak PH lab capacities at the intermediate level
- Poor linkages between surveillance program and laboratory network
- Limitations in confirmation of causative organisms due to weak public health lab capacities and consequently inadequate and inappropriate response
- Poor sharing of information between the countries regarding outbreak prone diseases and lack of harmonization in surveillance

Rationale for an IPPF

10. The Regional Health Systems Strengthening and TB Support Project (RHSS and TBSP) is a national initiative. It involves beneficiaries from all population groups in the country. It will have focused activities in 5 rural districts strategically located at the entry points for the migrant and refugee populations for the Regional Health Systems Strengthening and TB project but will have national coverage for the Kenya Health SWAP. Since initial screening indicates 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, a framework for developing an Indigenous Peoples Plan is needed. However, due to the broad scope of the project, their presence or collective attachment cannot be determined until the programs or subprojects are identified. Thus, the Indigenous Peoples Planning Framework provides for the screening and review of these programs or subprojects in a manner consistent with the World Bank’s Indigenous Peoples Policy (OP 4.10)1.

11. Kenya National Archives contain reference materials on ‘Ethnic Minority Groups’ comprising about 30 distinct groups, some of which may have partially or fully assimilated. These include such groups as the Abasuba, Asagidze, BajunI, Bok, Bongomek, Boni,

---

1 The purpose of the Indigenous Peoples Policy is to ensure that the development process fully respects the dignity, human rights, economies, and culture of indigenous peoples, and that the project is able to gain the broad community support of affected indigenous populations through free, prior and informed consultations. It aims to avert any potentially adverse effects on the indigenous peoples’ communities; or if avoidance proves not to be feasible, minimize, mitigate or compensate for such negative impacts. An additional goal of is to ensure that the indigenous peoples receive social and economic benefits that are culturally appropriate, and inclusive in both gender and intergeneration terms.
Chifundi, Digiri, El molo, Endorois, IL Chamus, Gabra, IL Ngwesi, Kony, Kuchchi, Lanat, Makonde, Malakote, Mumonoyot, Ngikeebotok, Nubian, Nyal, Nyang’ori, Ogiek, Ribe, Sebei, Sengwer, Shiranzi, Soboiga, Waata, and Yiaku.

12. Since the projects have broad coverage, including areas with some degree of marginalization due to remote locations, ethnicity, etc a framework is developed in case more detailed IPPs are required. Consistent with the World Bank’s operational policy on indigenous peoples (OP4.10), and following best practice, the Government of Kenya (GoK) will apply Planning Framework (IPPF) to ensure that the development process fully respects the dignity, human rights, economies, and culture of indigenous peoples, and that the project and its IPPF has broad community support from indigenous peoples who are likely to benefit from the projects interventions. To achieve this, this IPPF develops measures to: (a) avoid potentially adverse effects on the indigenous peoples’ communities; or (b) when avoidance is not feasible, to minimize, mitigate, or compensate for such effects; and (c) ensure that the indigenous peoples receive social and economic benefits that are culturally appropriate, and gender as well as inter-generationally inclusive.

13. Subprojects to be financed under the RHSS and TBSP and the Kenya Health SWAP will be screened and if some vulnerable indigenous peoples are identified as part of a subproject, a subproject specific IPP will be prepared. These subprojects will be implemented with the associated IPP in agreement with the affected Indigenous People’s communities, cleared and disclosed.

Social Management Requirements

The World Bank Operational Policy 4.10 (Indigenous Peoples) provides guidelines to ensure full respect of Indigenous People’s dignity, human rights, economies, and cultures by countries that seek the Bank’s financing of projects that may affect Indigenous People. Paragraph 5 of the Bank’s Policy provides for the use of country’s system to address environmental and social safeguards issues in a Bank-financed project that affect Indigenous People. Through this policy, the Bank recognizes that certain groups, such as those dependent on hunting and gathering, have identities and cultures that are inextricably linked to the lands on which they live, and the natural resources they are dependent on. These distinct characteristics and circumstances make indigenous peoples vulnerable to different types of risks and levels of impacts from development projects. Such risks include loss of identity, culture and customary livelihoods as well as exposure to negative health impacts. Recognizing this fact, this IPPF for the Kenya Health SWAP and RHSS and TBSP project has been developed to ensure that vulnerability of communities such as IPs is recognized and this project strive to provide services as well as all other marginalized groups that may be found in the project areas.

Regional Aspects of Hunter-Gatherers

14. In 2003, the African Commission on Human and Peoples’ Rights (ACHPR), a sub-body of the African Union adopted the document “Report of the African Commission’s Working Group of Experts on Indigenous Populations/Communities”. The report emphasizes that the overall characteristics of groups identifying themselves as indigenous peoples as follows:
• Their cultures and ways of life differ considerably from the dominant society
• Their cultures are under threat, in some cases to the point of extinction
• The survival of their particular way of life depends on access and rights to their lands and the natural resources thereon
• They suffer from discrimination as they are regarded as less developed and less advanced than other more dominant sectors of society
• They often live in inaccessible regions, often geographically isolated
• They suffer from various forms of marginalization, both politically and socially.

15. The African Commission report concludes that this discrimination and marginalization threatens the continuation of indigenous peoples’ cultures and ways of life and prevents them from being able to genuinely participate in decisions regarding their own future and forms of development.

16. Following the publication of its report on indigenous populations, the African Commission has produced an Advisory Opinion on the UN Declaration on the Rights of Indigenous Peoples which concludes that the UN Declaration is in line with the African Charter on Human and Peoples’ Rights and with the conceptualization and work of the African Commission on indigenous peoples. The African Commission further engaged in a series of country visits and seminars aimed at examining the situation of indigenous peoples and establishing dialogue with African governments and other stakeholders. The African Commission has published a series of reports from its visits, and it is regularly raising indigenous rights issues in its examinations of government reports submitted to the African Commission.

17. It is, therefore, clear that the African Commission on Human and Peoples’ Rights (the major regional African human rights institution) recognizes the discourse of indigenous peoples based on the fundamental UN principles and spearheads the discussion in an African context and the World Bank should, therefore, work with African governments to address issues relating to indigenous peoples in the African continent.

Vulnerable Indigenous Groups in Kenya

18. The African Commission’s Working Group on Indigenous Populations & Communities affirms that “…almost all African states host a rich variety of different ethnic groups (…). All of these groups are indigenous to Africa. However, some are in a structurally subordinate position to the dominating groups and the state, leading to marginalization and discrimination. It is this situation that the indigenous concept, in its modern analytical form, and the international legal framework attached to it, addresses”. According to the ACHPR, there are several vulnerable/marginalized ethnic groups in Kenya that identify as indigenous peoples. Some of them are hunter-gatherers, including the Ogiek, Watta, Sengwer, Yiaku (ACHPR, 2006). Other similar groups such as the Boni and Watta would also benefit as hunter-gatherers. During project implementation such groups would be targeted so that project benefits reach them.

The Legal and Policy Framework Regarding Indigenous Peoples in Kenya
19. According to ACHPR (2006), there is no specific legislation regarding indigenous peoples of Kenya. However, there are public policies that address issues to do with land and education among others.

20. For example, the GoK has made clear its intention that “land issues requiring special intervention, such as historical injustices, land rights of minority communities (such as hunter-gatherers, forest-dwellers and pastoralists) and vulnerable groups will be addressed. The rights of these groups will be recognized and protected” (Draft Land Policy: p.6).

21. Very relevant to this project is the Health Sector Policy. The health Sector Policy of 1994 (now under revision and update) governs health policy in the country. Other relevant documents are the Health Sector Strategic Plan of 2005-2010 and more recently the MOPHS Strategic Plan of 2008-2012. Overall, GoK’s health policy articulates that the benefits of good health care must benefit all citizens of Kenya equally. Where pockets of poverty and geographically disadvantaged areas are concerned, Ministry of Public Health and Sanitation (MOPHS) has targeted pro-poor investments which should be strengthened through the recently proposed Health Sector Services Fund (HSSF), also being funded by the Kenya Health SWAP. Beneficiaries of such programs include most vulnerable children and orphans, girls, children from the arid and semi-arid lands (ASALs), urban slums, and populations in pockets of poverty. The proposed HSSF recognizes the expanded role of facilities and facility committees. Further the recently introduced Community Strategy enhances the role of community in the provision of health services, with a view to increasing equity and access for all. This IPPF will further complement the intentions of the Kenya Government.

IMPACTS

22. This IPPF is expected to provide the framework in which negative impacts to the vulnerable and marginalized groups and indigenous people are mitigated and positive impacts are enhanced based on the free, prior and informed consultations with the affected beneficiaries. Although no negative impacts are foreseen, positive impacts for the IPs are many. As such a Social Assessment will be to inform development of an action plan together with the IP communities. Such a plan will provide the project team with practical ways in which the vulnerable can be taken care of. The potential adverse impacts and problems and proposed mitigation measures are summarized in the table below.

<table>
<thead>
<tr>
<th>Potential Adverse Impact</th>
<th>Description of the problem/Potential Impacts</th>
<th>Proposed mitigation measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displacement</td>
<td>Proposed rehabilitation of the laboratories may displace the indigenous populations from their habitations.</td>
<td>No land acquisition is envisaged under the project for building laboratories and all constructions will be undertaken in hospitals located in land owned by the Government. Hence, there will be no displacement of the Indigenous populations.</td>
</tr>
<tr>
<td>Adverse health impact</td>
<td>The indigenous populations residing in the neighborhood of the</td>
<td>The projects will support development and implementation of an Environmental</td>
</tr>
</tbody>
</table>

KENYA HEALTH SWAP, Potential Adverse Impacts and Benefits of the Kenya Health SWAP and Regional Health Systems Strengthening and TB support Project on Indigenous Populations
laboratories supported under the project may get exposed to infectious agents due to poor implementation of infection control and health care waste disposal practices.

Management Plan meeting the national and international norms for infection control and health care waste management. The plan will be disclosed and will be shared with the indigenous populations residing close to the laboratories supported under the project. The implementation updates will be made available at the facilities.

<table>
<thead>
<tr>
<th>Potential Benefits</th>
<th>Description of the problem/Potential Impacts</th>
<th>Proposed mitigation measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non involvement of Indigenous population in design.</td>
<td>Specific needs of the indigenous populations may not be addressed by the project.</td>
<td>There will be adequate consultation and participation of indigenous peoples during the design and implementation to ensure that the project adequately deals with the needs, priorities, and preferences of indigenous peoples.</td>
</tr>
<tr>
<td>The benefits envisaged under the project may not reach Indigenous Populations.</td>
<td>The plans may not have specific focus on improving services for the Indigenous populations.</td>
<td>Annual program work plans from the MoPHS, will clearly describe the activities proposed to be included in the projects to improve services for the Indigenous Populations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The projects will also support capacity development of district officials, and facilities committee to sensitize them to their responsibilities for consultation, screening and monitoring &amp; evaluation.</td>
</tr>
</tbody>
</table>
Participatory Social Assessment

23. The project plans to undertake social assessment which will use a participatory/consultative approach and give voice to the vulnerable groups and indigenous people. This social assessment will be undertaken in two stages – (1) initial screening, followed by a; (2) detailed assessment. The objective of the initial screening is to identify all existing Hunters and Gatherers in the project operational area (If another World Bank Funded Project would have done this screening in the project area, then this stage will be skipped and available information utilized.).

24. The objective of the detailed social assessment is to help the project support the aspirations and the needs of the vulnerable groups and indigenous people. As such, in addition to providing the social, economic and other relevant information, the project will come up with an action plan that will be developed in consultation with the beneficiaries on how the project will extend the benefits of the project to these groups and also mitigate any negative impacts. This action plan will be adopted by all the stakeholders and will pave the way for a standardized approach in all project areas where vulnerable and indigenous people live.

25. This action plan will include arrangements for the free, prior, and informed consultations with the affected indigenous peoples’ communities, as well as arrangements for a participatory impact monitoring (PIM) at the project implementation level. The IPP will be prepared in a flexible and pragmatic manner, and its level of detail varies depending on the specific sub-projects, and the nature of effects to be addressed. The IPP will include the following elements:

a) A summary of the social assessment.
b) A summary of results of the free, prior, and informed consultation with the affected vulnerable/marginalized communities that was carried out during subprogram preparation and that led to broad community support for the subprogram.
c) A framework for free, prior, and informed consultation with the affected vulnerable/marginalized communities during subprogram implementation.
d) An action plan of measures to ensure that the vulnerable/marginalized groups receive social and economic benefits that are culturally appropriate, including, if necessary, measures to enhance the capacity of the subprogram implementing agencies.
e) When potential adverse effects on vulnerable/marginalized groups including hunter-gatherers are identified, an appropriate action plan which includes measures to avoid, minimize, mitigate, or compensate for these adverse affects.
f) The cost estimates and financing plan for the IPP.
g) Accessible procedures appropriate to the subprogram to address sector grievances by the affected vulnerable/marginalized communities arising from subprogram implementation. When designing the grievance procedures, the borrower takes into account the availability of judicial recourse and customary dispute settlement mechanisms among the affected groups.
h) Mechanisms and benchmarks appropriate to the subprogram for monitoring, evaluating, and reporting on the implementation of the IPP. The monitoring and evaluation
mechanisms should include arrangements for the free, prior, and informed consultation with the affected communities.

**Institutional Arrangements**

26. The planned Social Assessment will provide and outline the existing and relevant institutions and how these can be strengthened.

27. A short-term consultant, functioning as development specialist, will be contracted during projects supervision to assist the KHSWAP and RHSS and TBSP Secretariat *inter alia* to facilitate the development and implementation of the IMPPF activities, and eventually the relevant project IPPs. KHSWAP and RHSS and TBSP programs staff would receive capacity development in dealing with social issues and skills necessary for screening project supported activities, evaluating their effects on indigenous peoples, preparing IPPs, and addressing any grievances. The social assessment, rolling annual consultations, and the preparation of the relevant IPPs would be undertaken by one consulting firm or individual, according to terms of reference approved by the World Bank. If necessary, a local NGO with expertise in the indigenous peoples’ cultures and issues would be subcontracted to implement the IPP.

**Monitoring and Evaluation**

28. Project Secretariat in the ministries of health, and more specifically MoPHS will establish the monitoring system to monitor the implementation of the indigenous peoples plan (IPP) against monitoring indicators set out in the Project Results Framework annually Monitoring and Evaluation would be undertaken to assess the impact of the project on indigenous peoples and other vulnerable groups. Several supplementary measures, which will be included in the project design to ensure that the IPPs are properly implemented. The measures include:

a) Annual program work plans from the MoPHS, describing the activities proposed to be included in the project, together with any safeguard plans (including relating to indigenous peoples) for relevant programs as required by the safeguards framework, for prior Bank review and approval.

b) An annual supervision report to assess the extent to which indigenous peoples are reached and are benefiting from the national program. The distribution of benefits to indigenous peoples will be assessed; and if there are any obstacles to them accessing project benefits, the obstacles will be addressed through the project.

c) Capacity development for district officials to sensitize them to their responsibilities for consultation, screening and monitoring & evaluation.

d) Review of results of the monitoring & evaluation through supervision and annual joint review processes with WB and other stakeholders.

e) Assignment of institutional responsibilities for monitoring, training district officials, and following-up to ensure that indigenous peoples benefit from the project.
f) Consultation and participation of indigenous peoples in the relevant programs to ensure that they adequately deal with the needs, priorities, and preferences of indigenous peoples.

29. The final draft of this IMPPF will be submitted by the ministries of health to the World Bank for review and clearance. Once cleared, it will be disclosed in country, in the appropriate form, manner and language. Later on, the information from the documents specified, particularly the relevant activities in the programs will be made available to beneficiary populations in the appropriate local language. The MoPHS will post the relevant documents on its website, and in the World Bank’s InfoShop. During implementation, MoPHS will prepare social accountability reports (showing available services, complaints received and response measures from MoPHS) and make them available to indigenous peoples, post them on its website, and submit these to the Bank for review along with the remaining annual supervision reports.

30. Budget. All costs required to implement the IPPs will be incorporated into the relevant subprogram budgets, which are normally included in the annual work plans. KHSWAP and KHSWAP.

References


Kenya Health Sector Policy Ministry of Public Health and Sanitation Strategic Policy