The Republic of Uganda

MINISTRY OF HEALTH

Indigenous People's Plan

(IPP)

UGANDA REPRODUCTIVE, MATERNAL, NEONATAL AND CHILD HEALTH IMPROVEMENT PROJECT

Final Report

May 2016

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Acronyms

BDR:	Births and Deaths Registration
CRVS:	Civil Registration and Vital Statistics
CRSO:	Civil Society Organisation
DHT:	District Health Teams
DLI:	Disbursement Linked Indicators
FGD:	Focus Group Discussion Government of Uganda
GoU	Government of Uganda
HC:	Health Center
HIV:	Human Immune deficiency Virus
HFQAP:	Health Facility Quality of Care Assessment Programme
IDA:	International Development Association
IP:	Indigenous People
IPO:	Indigenous Peoples Organisation
IPP	Indigenous Peoples Plan
LC:	Local Council
MoH:	Ministry of Health
NGO:	Non-Governmental Organization
OP:	Operational Policy
PDO:	Project Development Objective
PHC	Primary Health Care
RMNCH:	Reproductive Maternal Neonatal and Child Health Improvement Programme
TBA:	Traditional Birth Attendants
USD:	United States Dollars
UWA	Uganda Wildlife Authority
VHT:	Village Health Teams
WB	World Bank

INTRODUCTION

Government of Uganda (GoU) with financing support from the World Bank (The Bank) plans to improve reproductive, maternal, neonatal and child health outcomes through implementation of the *Uganda Reproductive, Maternal, Neonatal and Child Health Improvement Project* (RMNCAH Project). The project will be implemented through health centres IIIs and IVs all over the country. A Health Facility Quality of Care Assessment Program (HFQAP)[1] has been developed in response to the perceived poor quality of healthcare. Some of the project target areas have indigenous peoples and hence the requirement for the Indigenous People's Plan (IPP) that includes measures suitable to address the specific health needs of the Ik. This will include supporting a mechanism for grievance redress that takes into account unique constraints among the IK for channeling complaints and providing feedback on project implementation. This Plan reviews the general and health specific concerns, legal and institutional framework applicable to Indigenous Peoples in Uganda, describes the demographic, socio-cultural and political organization of project intervention components. The plan also provides a description of the approach used to attain the required "free, prior and informed consultation" in accordance to the World Bank policy on Indigenous People OP 4.10. The plan assesses the potential positive and negative effects arising from project implementation, and proposes measures for mitigating adverse effects and grievance handling while assuring RMNCAH service delivery benefits from project implementation that are culturally appropriate.

2.1 PROJECT DEVELOPMENT OBJECTIVE

The Project Development Objectives (PDOs) are to:

The Project Development Objectives (PDOs) are to: (a) improve utilization of essential health services with a focus on reproductive, maternal, newborn, child and adolescent health services in target districts; and (b) scale up birth and death registration services.

2.2 PROJECT BENEFICIARIES

The primary project beneficiaries are women of childbearing age, adolescents and children under 5, the objective for the IPP is to assess the health needs and mitigations for the indigenous people's community (the Ik) including new-borns and infants. The Ik community among others will benefit from a specific package of high impact quality and cost-effective RMNCAH interventions provided by health facilities.

PROJECT DESCRIPTION

i) Component 1: Results- Based Financing for Primary Health services

The RBF design for the project draws on the National RBF Framework, and aims at incentivizing the District Health Teams (DHTs) and HC III and IV to expand provision of quality and cost-effective RMNCAH services. Under this, the health centres will support the VHTs in their catchment areas to promote

[1] Ministry of Health, Health Facility Quality of Care Assessment Program Implementation Manual, January 2015; and the Health Facility Quality of Care Assessment Program Facility Assessment Tool, January 2015.

community based RMNCAH services, including nutrition.[2] The district selection was based on predefined criteria, which included: district poverty levels, access/coverage of RMNCAH services, disease burden, and presence/absence of other RBF schemes.[3] The selection of health facilities in the designated districts will be based on their readiness to provide RMNCAH services using a RBF readiness assessment tool adapted from the health facility quality of care program. To further strengthen the referral system, strategically located hospitals with capacity to provide ambulance and RMNCAH referral services will be selected based on criteria outlined in the Project Implementation Manual (PIM). As part of the RBF institutionalization, government will establish an RBF unit in the Health Planning Department to oversee RBF operations. The unit will also serve as the secretariat for the Interagency RBF Coordination Committee to promote coordination, alignment and harmonization of RBF programs. Implementing the various RBF programs together, within a common framework is expected to promote RBF sustainability

ii) Component 2: Strengthening Capacity to Deliver RMNCAH Services

The objective of this component is to strengthen institutional capacity to deliver RMNCAH services. The project will support the MoH to implement priority health systems strengthening actions to enhance capacity to deliver RMNCAH services. The selected priority actions from the RMNCAH Sharpened Plan address the most critical health systems bottlenecks to RMNCAH service delivery, and include improving: (a) availability of essential drugs and supplies; (b) availability and management of the health workforce; (c) availability and functionality of medical equipment in health facilities; (d) health infrastructure for PHC services; (e) quality of care and supervision. The actions will be included in the annual plans and budgets of the MoH.

iii) Component 3: Strengthen to scale –up Delivery of Births and Death registrations

The objective of the component is to strengthen institutional capacity for CRVS and scale-up BDR services. The project will support government efforts to strengthen capacity of the principle CRVS institutions at central and subnational levels to carry out their mandate to provide BDR services and to scale-up BDR services countrywide.

iv) Component 4: Enhance Institutional Capacity to Manage Project Supported Activities

This objective of the component is to enhance institutional capacity for management of project supported activities. This component will support costs related to overall project management, training, and project operations (safeguards, M&E, citizen engagement) in order to ensure the intended objectives are achieved in a sustainable manner. The project will address the skills gaps in project management and build institutional capacity of the relevant units for efficient and effective project implementation.

[2] The government is considering adopting CHEWs. The project will support the CHEWs when the change takes effect.

[3] Reproductive health voucher schemes are currently under implementation in 50 districts (26 under the Bank financed project (P144102) and 24 under the USAID-funded project. In addition, the BTC is implementing a supply-side RBF in 10 districts and CORDAID in the Busoga Region. These excludes small schemes by partners in the districts.

2.2.1 PROJECT FINANCING

The project cost is USD150 million contributed as flows:

- IDA (US$110 M) and
- Global Financing Facility Grant (US$30 M)

2.2.2 Social Assessment Methodology and Process

The project implemented covers Kamion Sub-county in Kaabong district where the indigenous people (the Ik) are located. OP 4.10 World Bank's Policy on Indigenous Peoples is triggered for this project. It contributes to the Bank's mission of poverty reduction and sustainable development by ensuring that the development process fully respects the dignity, human rights, economies, and cultural values of Indigenous Peoples. Additionally, for the World Bank the requirements are that the project:

a. Establishes an appropriate gender and inter-generationally inclusive procedure that provides opportunities for consultation at each stage of project preparation and implementation, among the borrower, the affected Indigenous Peoples' communities, the Indigenous Peoples Organizations (IPOs) if any, and other local civil society organizations (CSOs) identified by the affected Indigenous Peoples' communities.

b. Uses consultation methods appropriate to the social and cultural values of the selected Indigenous Peoples' communities and their local conditions and, in designing these methods, gives special attention to the concerns of Indigenous women, youth, and children and their access to development opportunities and benefits.

c. Provides affected Indigenous Peoples' communities with all relevant information about the project (including an assessment of potential benefits and adverse effects if any, of the project on the affected Indigenous Peoples' communities) in a culturally appropriate manner at each stage of project preparation and implementation.

During the Social Assessment, field introductory meetings were held with the respective stakeholders, including: the District Health Officer, the officer-in-charge of the Health Center II, the Local Council chairperson (LC1), the cultural leader as well as the coordinator of the IADI (Lomeri John Mark), Traditional Birth Attendants (TBAs), Village Health Teams (VHTs) and community members. The information regarding the project was presented by the Assistant District Health Officer (Kaabong), officer in charge of Kamion HCII and VHTs. The purpose of the information sessions was to explain to the communities the project objectives and the various aspects of the project, seek their views, and to understand directly from the community the challenges faced by the community in accessing health services. Face-to-face interviews with the help of a semi-structured interview guide were conducted along with health personnel who were well informed about maternal health, disease burden and challenges of healthcare access among the IK. Focus group discussions with women and youth were also conducted to help further probe for challenges

faced regarding health services. Such challenges include lack of means to transport for the patients from the health centre to referral hospital in Kaabong and, insufficient drugs at the health centre, direct observation was also used to draw on the challenges faced by the Ik people in the project area. These include: inadequate facilities at the health centre that cannot accommodate needs of the community, for example there is only one bed that serves all the patients, poor staffing of the health centre and therefore inability to handle all the patients.

During an interview with the officer in-charge, he mentioned that there is hardly any neo- natal or post-partum deaths recorded at the HC because most of the women prefer to deliver from the TBAs due cultural reasons. In addition to that, most the Ik community lack means of transport to the health centres and so for proximity reasons they prefer to go to the nearby TBAs for childbirth. This was seen as some of the limitations in capturing neo-natal and post-partum deaths in the project area,

It was reported by the Ik cultural leader (Lomeri John Mark) that before project implementation, the developers need to understand the "ways of the Ik" (cultural and traditional practices and values). One of the existing cultural practices mentioned was widow inheritance by the brother of the deceased. It is important to note that this poses a health risk to the community given the high possibility of transmission of communicable diseases including HIV. Other cultural practices by the Ik before birth include pregnant women having their bellies massaged by the elderly women in order to identify the position of the baby. They are also not allowed to the till in the gardens because they believe that this could stagnate the growth of the crops. The men with pregnant wives are not allowed to join the main stream of hunters because this is considered bad omen.

After birth, the woman stays indoors, because she is neither allowed to look at the roof nor clean the house until the umbilical cord for the baby drops off. Once the umbilical cord is off, the elderly women give a name to the baby and clean the house and this is done as an initiation ceremony for the baby and mother.

2.2.3 Free, Prior and Informed Consultations with the Ik in Kaabong

In consulting the IK community, the principle of Free, Prior and Informed Consultation was adhered to. This was an important process to ensure that meaningful engagement was attained. The first step was to share the project objectives with the health workers who routinely engage with the IK community. The health workers in turn shared the information with the IK leaders who relayed the information to the communities to prepare them for discussions with the assessment team. In addition, this initial step aimed at establishing trust between the IK community on one hand and the assessment team and services providers on the other. This was considered critical for the assessment and future project implementation with the ultimate goal of ensuring that specific health needs of the IK will be met under the project. The FPIC process established a basis for constructive dialogue for both parties to identify health challenges and specific needs of the IK community and collectively recommend appropriate solutions with unbiased participation.

The communities were informed of the consultation exercise through the officer- in –charge of Kamion HC II and consultations were carried out using participatory methods. Categories of targeted people who attended this meeting were mainly mothers, youth, local and cultural authorities. Due to the conservative

nature of the IK community, discussions remained focused on health concerns and related challenges. No information outside the topic of discussion was asked to avoid suspicion and the risk of refusal to engage by the Ik community. Focus Group Discussions were also conducted and these were only for the women, to enable space for free interaction and sharing. The consultations were conducted through translation from English to Ik in keeping with the preference of the IK community. The preference to use local language is not different from the majority tribal groups in the area who both prefer to be consulted in the local language. Participants were asked to share their concerns regarding health issues. The most common diseases and categories of people most affected by these diseases were identified. It was cited that the most common diseases include malaria, dysentery and pneumonia which were said to mainly affect children and the elderly. Communities were informed about the project objectives and future benefits. Local leaders were also informed and requested to share their knowledge and experiences about health related problems in the community. As an outcome of this process, broad community support for the project was attained from the IK community. Since community support is mainly influenced by the cultural leaders, the FPIC process enabled confirmation of support for the project. Photo 1 shows the FGD meeting that was carried out with the IK women while Photo 2 shows the discussion with the VHTs in Kamion HCII.

The indigenous health practice that was documented is the use of local herbs for tattooing their bodies in order to treat them themselves. The project will potentially improve the IK health seeking behaviour if implemented in a manner that is in favour of their norms and values. A key consideration for project success will be ensuring that only female midwives deliver mothers and that their placentas are given to mothers after birth. In the IK culture there are superstitions around the placenta thus the value attached to mothers retaining their placentas after birth.

BASELINE INFORMATION IN THE PROJECT AREA AND LEGAL FRAMEWORK

2.3 LEGAL AND INSTITUTIONAL FRAMEWORK APPLICABLE TO THE INDIGENOUS PEOPLE

- **Constitution of Uganda -** The Constitution offers no express protection for indigenous peoples but Article 32 places a mandatory duty on the state to take affirmative action in favour of groups who have been historically disadvantaged and discriminated against .The Constitution also mandates Parliament to enact appropriate laws, including laws for the establishment of an Equal Opportunities Commission (EOC), for the purpose of giving full effect to Article 32. Overall, the Constitution provisions fall short of international standards in regard with recognition of Indigenous People.
- **National Land Policy 2011** - The new land policy addresses contemporary land issues in Uganda and regarding land rights of ethnic minorities. The policy provides for Government shall in its use and management of natural resources, recognize and protect the right to ancestral lands of ethnic minority groups. In addition it also provides that Government shall pay prompt, adequate and fair compensation to ethnic minority groups that are displaced from their ancestral land by government action. Under the policy, Government will take measures among others to pay compensation to those ethnic minorities that have in the past been driven off their ancestral lands for preservation or conservation purposes.

- **Gap Analysis -** Uganda has no specific policy on indigenous peoples. However, the Constitution of the Republic of Uganda, 1995 under its National Objectives and Directive Principles of State Policy, provides that "every effort shall be made to integrate all peoples while at the same time recognizing the existence of, amongst others, their ethnic, religious and cultural diversity". In this regard, the Constitution requires that effort be done to promote a culture of co-operation, understanding, appreciation, tolerance and respect for each other's customs, traditions and beliefs. It however offers no express protection for indigenous peoples although Article 32 (of the Constitution) places a mandatory duty on the state to take affirmative action in favour of 13 groups who have been historically disadvantaged and discriminated against. Article 32 therefore, enjoins the state to take affirmative action in favour of groups marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom for purposes of redressing imbalances that exist against them. In this respect the Constitution mandates Parliament to enact relevant laws, including laws for establishment of an Equal Opportunities Commission (EOC), for the purpose of giving full effect to Article 32.

  Conversely, the World Bank's policy on Indigenous Peoples (OP 4.10) is specific in underscoring the need for borrowers and the Bank staff to identify indigenous peoples, consult with them, ensure that they participate in and benefit from Bank funded operations in a culturally appropriate way and ensuring that the adverse impacts are avoided, minimized or mitigated.

  Gap - It is known that Uganda has three indigenous peoples (Ik, Batwa and Benet) and it can only be presumed that these 3 indigenous groups are included in the 13 groups referred to in the Constitution. While the declaration in Article 32 of Uganda's Constitution was a positive step in recognition of the rights of marginalised people in Uganda, it fell short of specific requirements of the World Bank's policy on indigenous people. Given the more concrete and specific requirements in the World Bank Indigenous People Policy OP 4.10, the project is applying OP 4.10 to prepare an IPP.

2.3.1 Demography

The Ik are 13,939 (Uganda Bureau of Statistics in number and live on the edge of Karamoja – Turkana region along the Uganda – Kenya border. Despite the highest poverty levels among the Karamojong, deprivation among the Ik is even worse. Their remote location in the mountainous parishes of Lokwakalmoi, Kamion and Timu in Kaabong district, which are difficult to access due to poor roads, leaves them lacking basic services such as quality healthcare and education Figure 1 showing the location of Ik community.

2.3.2 Map showing the Locations of the IPs

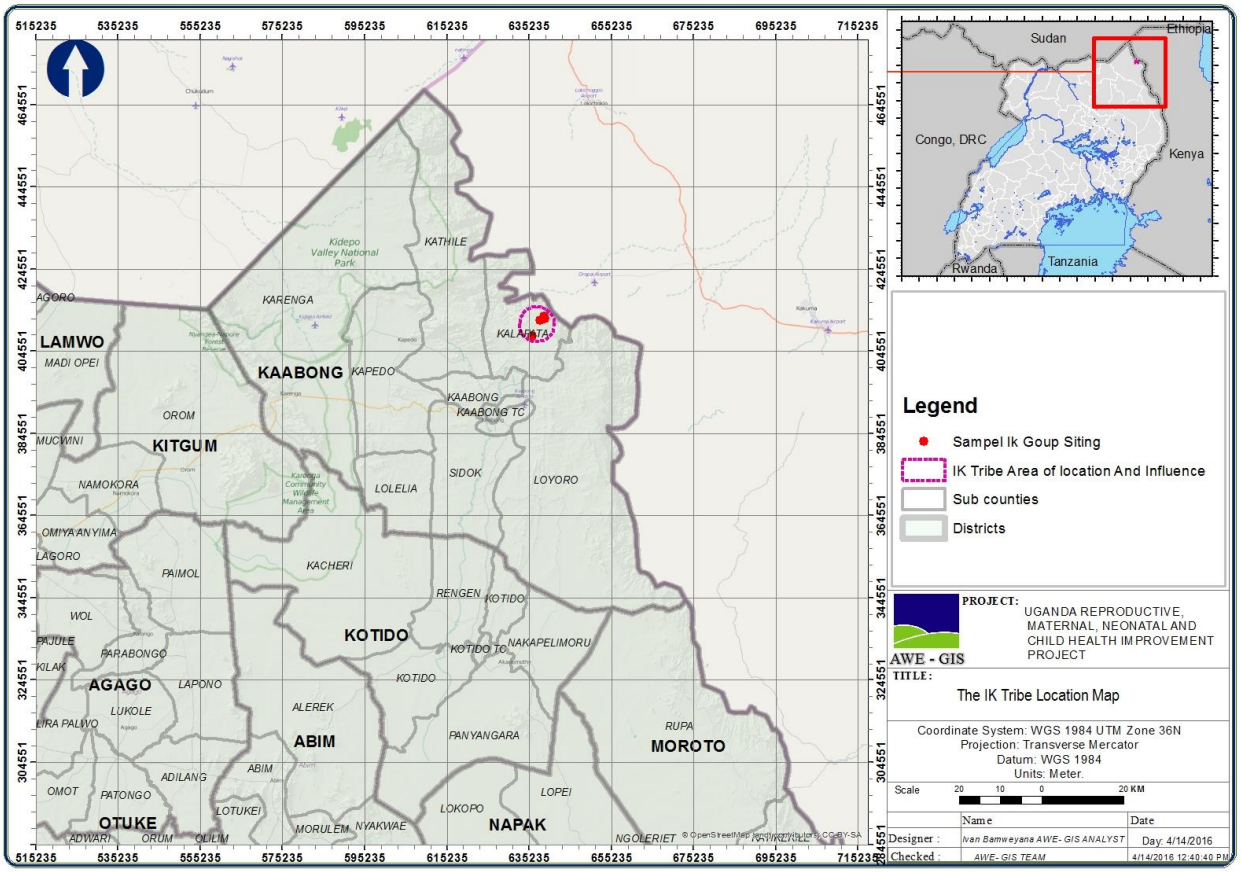

Figure 1: The map of the Ik community

2.3.3 Social – cultural and political organization of the Ik community

In most communities**,** social and political organization is formed by both the state and the local authorities within the community. This is not any different for the indigenous peoples' community where both of these authorities co-exist. Kaabong district council is the highest political authority in the district which has LCV chairman as its head, followed by the sub-county, parish and villages which are headed by the Sub-county chief, Parish chief and LC1 respectively. The technical team is headed by the Chief Administrative Officer. The district has one (1) sub-county, three (3) parishes and 9 villages. The community also has their cultural leader called Lomeri John Mark who is currently their LCV chairman and he is highly respected, the community normally gathers to pray to their gods in case of natural calamities like drought or famine. Photo 3 shows some of the cultural officials in the project area and the sacred place where they go to pray to their gods and Photo 5 shows the meeting held with the cultural leader Lomeri John Mark.

In the Ik community, power and gender relations between the men and the women favour men as superior to women. This was mentioned by the men during the meeting citing examples like harvesting for wild fruits and apiculture is done by the men whereas work done by the women such as fetching water and cooking is regarded as 'lazy work' by the men. The role of the youth isn't so pronounced.

There was mention of early child marriages by the Local Defence Units that are newly recruited by the government to ensure security in the community however; there is no law to protect these girls. During the social Assessment, it was mentioned that there are some cultural factors that relate to the project such as the habit of owning placentas back after birth and also ban from a male person to attend to a woman during birth, these were mentioned as some of the hindrances to seek medical help from the Health centres.

2.3.4 Land and natural resources

The community had significant cultural sites but following the gazetting of the Game Park in 1958, a large portion of their forest reserve (Timu) was taken by the government. This in turn has deprived them of natural resources on which they attach their cultural value, including sacred places of worship, historical sites, sacred rivers and streams for ritual cleansing and the medicinal herbs and honey. This gazetting has also affected the Ik people in a way that they can no longer fulfil their spiritual and nutritional needs. Nonetheless, herbal f medicine is still provided by the traditional herbalist to treat diseases such as malaria, diarrhoea among others.

2.3.5 Land Tenure and ownership in the Ik community

Land ownership among the Ik was largely affected by the gazetting of Kidepo National Park which meant the Ik losing a large portion of their land. Today the Ik occupy areas of Kamion sub-county in Kaabong district. Land is communally owned and any member of the Ik clan is free to cultivate anywhere within the Ik land.

2.3.6 Legal protection against illegal intruders onto their land

The Land Act of 1998, the UWA Act, and the National Environment Statute of 1995 protect customary interests in land and traditional uses of forests. However, these laws also authorize the government to exclude human activities in any forest area by declaring it a protected forest or National Park, within which activities are regulated, thus nullifying the full customary land rights of indigenous peoples

2.3.7 Relationship between the Ik and other neighbouring Communities

There is a tense relationship between the Ik and the neighbouring communities; the Ik community is despised by other surrounding tribes. They are also not regarded as part of the Karamojong. The Ik are deprived of natural resources, for example the existing pastoralist tribes intimidate them with their guns and ensure that their animals take water first before the Ik can access it for domestic use. This has in turn created a lot of friction. However, there is an effort to resolve this by disarmament of the Turkana and Karamojong who use guns to threaten this community. To avoid conflict with the neighbouring communities, the Ik have moved further upland for safety. This migration has further exacerbated the challenge of distance to health services located in the low lands. It is important to note that despite the existing friction between the IK and neighbouring tribes, the project will not exacerbate any conflict among the Ik and the neighbouring communities. The officer-in charge of the existing HC III expressed that presently the Ik have their own constituency and sub-county. Under these bodies, they have leaders such as the MP, Women Councillor, LCV (who happens to be the Ik cultural leader) and LCIII. These leaders are

able to defend the rights of the Ik which was not the case in the past when they were dominated by other tribes. The government has also recruited Local Defence Units (LDUs) among the Ik to guard their community. As a result of disarmament, the neighbouring community that includes the Karamojong and the Turkana are no longer able to attack the IK with ease.

2.4 INSTITUTIONS AND PROJECT STAKEHOLDERS

2.4.1 IPPs representative in the Ik community

The Ik community has come together to promote and protect their interests under the umbrella of Ik Agenda Development Initiative (IADI) which is a registered Community Based Organisation established in 2012 to respond to development issues. This body is managed by cultural activists and students of higher institutions of learning of Ik origin. It represents all Ik communities in all parishes of Kaabong district. The community appeared comfortable with the support provided by this NGO. There were no religious institutions identified to sensitize the Ik community about the benefits of accessing health care services but it is recommended that the capacity of this CBO be assessed further to act as an intermediary between the indigenous people and the government for the implementation of the IPP. During an interview with the cultural leader as well as the coordinator of IADI, he assured the assessment team that the community is very willing to collaborate with the CBO in order to achieve the objectives of the project.

2.4.2 Implementing Agencies in the IP projects areas

Uganda government does not have a definite institution that is assigned responsibility for implementation of the IPP; the project will be implemented through the MoH under the department of Health who has potential to partner with IADI, registered as an NGO in June 2012. The Ik community have trust in IADI because the coordinator is their cultural leader. The IK community will be engaged in identifying and establishing the most culturally appropriate and responsive grievance redress mechanism that ensures full participation and complaints channelling to respective entities. . Training of the District and sub county IK focal persons will be necessary to ensure that they have the capacity to ensure that the Ik are not excluded in project implementation and monitoring.

2.4.3 Relationship of the IK with Government and other stakeholders

Under the section on National Objectives and Directive Principles of State Policy, the constitution provides that every effort shall be made to integrate all peoples while at the same time recognizing the existence of, amongst others, their ethnic, religious and cultural diversity. In this regard, the IPP will provide necessary actions to promote a culture of co-operation, understanding, appreciation, tolerance and respect for each other's customs, traditions and beliefs.

KEY FINDINGS AND RESULTS FOR IPP PREPARATION

The project area will cover indigenous (the Ik) community. Overall it was noted that the community was positive about the project. This was evidenced through attendance and responses from the community members. However, some of the Ik are still conservative and withdrawn and therefore persuading them to participate was difficult, this is due to the fact that they regard themselves as inferior and therefore, are intimidated by any foreigner who goes to their community. During the FGD, it was mentioned that traditionally the women are not allowed to give birth with the help of a male so they seek maternal

health/care support from fellow women. Their traditional way of life and cultural values and norms do not allow a male health care provider to attend to women during delivery, and hence making them reluctant to seek medical services from the health centre. Despite the gazetting of the game park, it was mentioned during the meeting with the officer-in -charge HC III, that there is still substantial use of traditional herbs to cure malaria, respiratory tract infections and pneumonia which unfortunately has led to high mortality rates. The women also use the Traditional Birth Attendants (TBAs) to deliver babies and as in accordance to their cultural practice, keep their placentas after birth. (See **Photo 4**). This also prohibits them from seeking medical help from the health centre, but this does not imply that all deliveries are carried out from home, some women seek to deliver in the health facility under the care of a midwife, but are limited to only one mid-wife in Kamion Health Center.

2.5 ASSESSMENT OF DEVELOPMENT OPPORTUNITIES

2.5.1 Potential Positive Impacts

Some of the identified potential positive effects on Indigenous Peoples from project implementation are:

- Increased use of available health care services for infants/ children and mothers;
- Culturally appropriate services at the Health Center;
- Nutrition education support targeted to improving the health of mothers and infants ,;
- Increased awareness of preventable diseases;
- Outreach and mobile services to the community;
- Contribution to improved child survival rates by supporting a wide range of cost-effective high impact interventions to address the major causes of childhood mortality and morbidity in Uganda.
- Provision of employment opportunities related to tasks that require unskilled personnel during and after project implementation.

2.6 Assessment of adverse Impacts

2.6.1 Potential adverse impacts

Some of the adverse impacts can be seen in the context of the indigenous peoples' social –cultural beliefs and practices. The potential adverse effects could include:

- Disregarding cultural practices of the Ik

Recognizing and understanding the Ik cultural background is essential for effective implementation of the project. There should be awareness among the health service providers that men are not allowed to assist women in deliveries and this is for cultural reasons. If not highlighted from the start, could be disregarded during project implementation and may frustrate the community.

- Inadequate socio-cultural interaction and communication with beneficiaries and communities

Potential adverse effects in project implementation may arise from factors related to the improper and inadequate socio-cultural interaction and communication with beneficiaries and communities, such as:

i. Inadequate coordination and consultation with traditional leaders prior and during project implementation.

ii. Lack of use of local Ik language to communicate and interact with beneficiaries, local authorities and traditional leaders.

iii. Inadequate, improper and/or disrespectful behaviour from project staff not heeding or complying with local socio-cultural expectations, norms and value systems.

2.7 EVALUATION OF RISKS

The section below outlines potential risks to the project including capacity and financing aspects. It is clear that Government of Uganda is committed and capable of managing the risks foreseen to ensure successful delivery of the proposed project.

2.7.1 Borrower's capacity to implement the IPP

Kamion HC II lacks adequate healthcare staff, with only 3 health staff (including 1 midwife) at each health Center where the optimal national staffing level of doctor to patient and nurse to patient ratio is 1: 6 and 1:50 per day respectively. The health care centre also lacks capacity to provide the mandated services such as: HIV testing and counselling services and Family Planning services which are critical in advancing RMNCAH. The officer-in-charge of the HC III, attributed these limitations to marginalization of the Ik people by the government, capacity of the HC II often can't render services which are provided by HC III and IV.

Other noted challenges were,

- Lack of medicines both in quantity and of direct relevance to the common diseases among the IK.
- Lack of capacity and training for health care staff especially in new and emerging diseases like Hepatitis C.
- Insufficient budget to procure equipment for minor surgery services, laboratory services for HIV testing, malaria.
- Lack of transport and an ambulance at the HC constrains mobility of the staff and efficient service delivery
- Inability to communicate in Ik (though most of the IK speak and understand Karamojong).

2.7.2 Summary of the results of Free, Prior and Informed Consultation

Free, prior and informed consultations were carried out among the Ik community and below are the key findings:

- There is inadequate medical supply at Kamion HCII coupled with inadequate medical personnel to treat the common diseases. The HC team reported that there are only 3 medical staff and this constrained effective service delivery. The team believes that this project will go a long way in improving delivery of health services in the area.

- The burden of Transport in the event of referral to another health Centre (with the capacity to handle specific medical conditions) was identified as a challenge. Hence, making the prospect of establishing a better equipped health facility acceptable by the Ik.

- Service delivery gaps such as inadequate staffing of the health centre, insufficient drugs to treat the most common ailments and lack of a laboratory to enhance health care delivery were identified. The community hopes that these gaps will be addressed through the RMNCAH project. The IPP will be implemented by MoH through the district. It is recommended that the District partners with IADI; a local IK CBO that is present in the community, to act as an intermediary to mobilize the community and carry out monitoring and evaluation as well as submit monthly reports to the MoH. The NGO could also help in training and sensitizing the community about the positive impacts of good health practices, training VHTs who -are Ik to handle health related issues as well as conduct outreach visits to patients in hard to reach locations.

IMPLEMENTATION MEASURES AND ARRANGEMENTS

2.7.3 Consultation Values

The engagement with the Ik community was free prior and informed in that it was free from any form of coercion, corruption, interference, external pressures and other influences. Community members had the opportunity to participate regardless of gender, age, religion or socio-economic status. The community's response towards the project was positive. The community appreciated that they were engaged in identifying the challenges during the design phase and prior to the execution of the project to prepare an IPP responsive to the specific needs of the Ik community. The community was satisfied that the information was translated in IK language, traditional and customary leadership and decision-making processes were respected and effort to maximize community input into the process of preparing the IPP regardless of age and gender was respected. The information shared during consultation was timely, sufficient and accessible and covered the potential impacts of the project whether positive or adverse. In addition, the consultation process was carried in good faith and was meaningful.

2.8 INDIGENOUS PEOPLES ACTION PLAN FOR THE IK

The Project design and its implementation strategy try to ensure that IK concerns are sufficiently addressed. This approach is manifested in the following:

i) The Ik shall be encouraged and given first priority to partake in all stages of implementation and project monitoring.

ii) The design of facilities serving the Ik shall give great consideration to their sensitive cultural norms and beliefs, such as enrolling more female mid-wives, training more VHTs of Ik origin who fully appreciate the norms and values of their culture and providing delivery beds which are acceptable to the Ik.

iii) In a bid to solicit suggestions and views from the Ik, participatory discussions, workshops and FGDs shall be regularly carried out. Further still, separate sessions shall be held with them to provide a free discussion setting for their views and concerns about the project to be raised.

iv) Service delivery procedures associated with inquiry, diagnosis and treatment of the Ik shall be in line with traditional norms and values and form part of the training of health workers. More cultural practices and values will be identified during project implementation after additional trust is gained by the Ik. The involvement of the Ik community in implementation shall be actively sought and routinely reported on.

Table 1: Indigenous Peoples Plan

Issues	Actions
Insensitivity to the IK cultural practices and its influence on health services.	• Enhance the understanding among health workers of the Ik cultural practices and beliefs that influence health seeking behaviour. Provision of health care services to take into account identified cultural practices and related impact on service demand and uptake. Such measures that will be taken into account is provision of safe methods that will enable the Ik have their placentas back after birth. Prioritise health care provision efforts that do not undermine the current practices and beliefs in the participating communities. This should be done through training and recruiting mid wives from the Ik community and frequent sensitization among the health care providers about the Ik cultural practices • Create awareness on preventable diseases and illnesses. This should include health promotion activities that support reduction of preventable disease occurrence among the community. Given concerns raised by the IK improve access to clean water and better nutrition. Develop indicators and mechanism for social accountability. • Identification of community based monitoring indicators and promotion of participatory approaches led by the IK will be a helpful feedback mechanism on project implementation and performance.
Lack of appropriate services at HC II	• Provide additional mid- wives to help in provision of delivery services. • Increase beds, medical equipment, appropriate medicines • Increase budget for HC II to ensure sustained services

Issues	Actions
Difficulty in accessing health services due to poor terrain, distance and insecurity	• Introduce mobile health services/ camps to bridge service access gaps for IK caused by poor terrain and insecurity. Mobile health services will be adopted to enhance service access for the Ik. This will ensure that communities in hard to reach areas have access health services. • Increase the number of VHTs • Identify volunteers to contribute to health promotion among the Ik.
Existence of preventable diseases in the IK community	• Promote Primary Health Care among the Ik. • Improvement of access to clean water such as use of water treatment and encouraging the communities to boil drinking water, regular hand washing among others. • Promote use of mosquito nets by the community
Lack of employment opportunities for the IK	• The Ik community to be prioritised for unskilled employment. • Procure raw materials for construction from the local community.
Potential for Child Labour during health facility renovations	• Orientation of the contractors on all the labour laws including the child labour before start of works. This should include preparation of IEC materials that discourage child labour. • Ensure each labourer has a job contract with a clear code of conduct • Confirm age of potential labourers prior to hiring through National Identity card, birth certificate or confirming with LC and community elders.
Assessing Impact of services	• Develop indicators and mechanism for social accountability to monitor the provision of services identified in the IPP.

2.9 COST BUDGET FOR IPP

Table 2: shows the IPP management budget (USD)

Item	Frequency	Months	Cost per month (USD)	Total (USD)	Budget Notes
Awareness Trainings	5 years (Once every year)	5 months	500	2,500	Training of medical staff to attend to the Ik in a culturally appropriate manner.
Provision of more midwives.	5 years	-	-	-	Training of health workers including midwives is an ongoing government program. MoH/District to review staffing arrangements in the district to address this gap in Kaimo HC in the interim and to share plan for training of more midwives to serve in underserved areas including Kaimo HC.

Training of the Ik community in good health practices	5 years (twice every year)	10 months	500	5,000	Training of the Ik members to learn about positive impacts of good health practice
Provision of outreach health services	5 years (Every quarter of the year)	15 months	500	7,500	Provision of mobile health services in hard to reach areas
Provision of medical equipment	5 years (once every year	5 months	5,000	25,000	Improvement of appropriate services in the health centre.
Total				**40,000**	

2.10 PROCEDURES TO ADDRESS GRIEVANCES ARISING FROM PROJECT IMPLEMENTATION

Grievance Redress mechanism refers to a complaint instrument through which project affected persons and communities may raise their concerns to the project developer and find ways through which these grievances could be handled. Grievance Redress Management (GRM) will aim to provide a two-way channel for the project to receive and respond to grievances from IK or other interested parties. Grievances will be managed by a committee based at sub-county level in local government areas of jurisdiction along the project area as is the practise. In case of health related grievances, complaints will be filed at the sub-county level, and handed over to the Health management Unit to be solved whereas the cultural related grievances will be handed over to the cultural leader and his committee to handle complaints for the Ik in a peaceful way to mitigate resistance. Any other grievance which might not be health or cultural related will be lodged at the Sub-county level and there will be a committee set up to solve such complaints.

In supporting the establishment of Grievance Redress Committees among the IK, it will be important to understand the existing traditional GRMs, including the role of the local leaders and how these can in addition be utilised to report, address and channel grievances related to the project to the sub county for redress. Where such traditional committees/leaders can function as GRC members for the project, necessary linkage will be established to ensure that complains logged at the community level are advanced for redress through the existing mechanisms. Under the awareness trainings planned above, the IK will be sensitized on the functioning and benefits of the GRM/C and encouraged to openly participate and present their complaints through the agreed channels. Those identified as members of GRC will be trained in their roles and responsibilities.

.. The MoH and the respective district/sub county through identified local partner/s such as IADI; will follow up on grievances to ensure they are promptly resolved taking into account indigenous norms and procedures. Project monitoring and evaluation processes will also pre-empt grievances during implementation.

2.11 MONITORING AND EVALUATION

The following indicator to assess the progress of IPP will be included in the Project Results Framework: "Increase in the utilization of health services by Ik community". Monitoring and evaluation will be done by MoH (The developer) as well as an independent CBO (like IADI) to ensure a complete and objective process. This will also be done together with the help of the identified stakeholders in Kaabong district. The objective of monitoring is to identify implementation problems and successes as early as possible and also determine the extent to which activities are being implemented effectively and help to identify areas that need improvement. Monitoring will be done with the assistance of IADI, the DHO, Officer in Charge of the HC, VHTs and an Ik representative. Monthly reports will be prepared by the IADI for DHO and reviewed by MoH, to recommend corrective actions at HC before the next monitoring report.

Major monitoring tasks are:

- Follow up on the health indicators for the IK community in the Results framework.
- Involvement of the IK in the monitoring process (participatory monitoring)
- Ensuring that the indicators are achieved and the IK are better off than before the project implementation
- Evaluation of how the project has impacted on the IK community.

2.12 IMPLEMENTATION ARRANGEMENTS

MoH, will put in place a dedicated staff headed by one of its managers to implement this IPP. The dedicated staff working closely with the identified district and sub county level focal point, will be responsible for ensuring that IK community have understood and embraced the project.

The groups that will be involved in the implementation of the IPP are:

- MoH (Project proponent)
- Kaabong District Administration
- Local council leaders as well as the cultural leaders of the project affected area.
- IK community
- HC staff
- IADI CBO

A senior MoH management committee will generally oversee the implementation process, to guide and assist where necessary, day to day activities will be undertaken by the main implementation staff. They will ensure that measures identified in the IPP are acceptable to stakeholders, and ensure that implementation of the IPP is undertaken in an efficient manner. Before project implementation, the dedicated staff will be oriented to their roles and responsibilities. They will be responsible for planning specific activities identified in the IPP, communicating with the Ik people and dealing with the day-to-day activities associated with grievances. After the IPP, the staff along with partners such as IADI will be responsible for on-going

monitoring and grievance process, and ensuring that the IPs are assisted in logging and following up their complaint.

Annex 1: Photos taken during the project disclosure

Photo 1: FGD that was carried out with the Ik women in Kamion sub-county

Photo 2: Consultations with the VHTs

Photo 3: Some of the cultural representatives in the project area

Photo 4: Some of the TBA's in the project area

Photo 5: Consultation with the Ik cultural leader

Annex 2: Summary Record of Consultations

Week		Meeting date	31 March 2016
		Recorded by	Richard
Meeting/subject	Meeting with Kaabong District Health Officials and Kamion HC II Officials on, IPP For Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
1.	**Introduction**
	The team leader started by introducing himself, the project and purpose of the meeting which was primarily to learn more about health related issues among the Ik in Kaabong district. Kamion Health Centre II is one of the health centre located in the Ik community. The DHO welcomed the team and he expressed gratitude to consult the Ik people who for long have been marginalized and seen as minority among the people of the district.
2.	**Issues discussed**
2.1.	**Do you have Village Health Team (VHT) in Kaabong District?** We have them in all the sub-counties and villages.
	Are they active in their work? Yes they are active.
	What common diseases are there among the IK? There are many diseases but the most common ones are, Malaria, Respiratory Tract Infections (RTIs), Diarrhoea, Gastro-interties, eye infections and skin diseases.
	Which is the most prevalent but most dangerous? Malaria, Chicken pox, dysentery
	Are there staff who speak Ik language in health center(s) visited by Ik people? Unfortunately no and Ik people are compelled to use Karamojong language since they are the minority.
	Do the IK people practice any traditional health practice? Yes for example consulting traditional healers, medicine men/women and foretellers.
	Do Ik people have culture practices that may be harmful to their health? They copy the practice of the Karamojong for example body tattooing.
	Are the services provided to the IK very specific or general even to the other communities? No special services are provided to the Ik people. However, services such as safe delivery education are often offered, and they (Ik) are also taken as priority at any time, for example they are always attended to 24 hours 7 days a week.
	Is there any cultural practice that prevents them from seeking medical help? Not many apart from the practice of mothers demanding to keep placentas after birth.
	What is the staffing of health centre II? It is supposed to be 9 staff; however for our case we have only 3.
	Do you offer services of Health Centre II or Health Centre III? This is Health Center II which is meant to offer only out-patient department (OPD). However being the only health centre in the area we offer also other services for health centre III for example, antenatal care (ANC), family planning and deliveries and in-patient (Admission) but with only one bed.
	Does the community get epidemics and when? We get epidemics especially during wet season when there are many mosquitoes.
	How does Kamion HC II manage medical waste? Through segregation into different categories since there are different types of waste for example pharmaceutical waste, human excretes, and other waste.
	Do you have proper waste disposal facilities? No, due to the fact that there is no functional incinerator.
	How does the HC dispose of unclaimed dead bodies? They are always taken to the hospital cemetery

Week		Meeting date	31 March 2016
		Recorded by	Richard
Meeting/subject	Meeting with Kaabong District Health Officials and Kamion HC II Officials on, IPP For Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
	Does the HC own a cemetery? No.
	What do you suggest about the above? I suggest that the local health centre administration should purchase a parcel of land for that purpose.
	Who owns the land where the health centre located? It was donated by the local community.
	Is there some encroachment on the health centre land? Yes.
	How do you manage the land encroachment problem? Through meetings with the health unit management committee and the encroaching people so that we reach a mutual agreement.
	Generally, what are the challenges faced here? • No communication network available which creates communication gap between the health centre and the main hospital. • There is lack of transport to facilitate health workers movement during outreach programs and implementation of health programs. • Health programmes on radio, posters and brochures are only in Karamojong language creating an information gap for Ik people.
3.	**Recommendations**
	What do you think needs to be done to improve health sector facilities / services here? • Number of staff to be increased from 3 to 9. • Staff housing to be constructed so as to motivate them to offer quality services. • General structure of the health centre to be improved.
3.1.	**What are your recommendations on health?** • Health equipment supply to be increased due to wide catchment area. • Power to be installed for instance solar or standby generator for the purpose of proper storage of medicine and lighting as well. • Ambulance and bicycles to be given to VHTs. • Hiring Ik staff in the health department to make them help each other well.

Week		Meeting date	31 March 2016
		Recorded by	Faith
Meeting/subject	Meeting with Indigenous Peoples on Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
1	**Introduction**

Week		Meeting date	31 March 2016
		Recorded by	Faith
Meeting/subject	Meeting with Indigenous Peoples on Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
	The Social Development Specialist started by introducing herself, the project and purpose of the meeting which was primarily to inquire about health related issues concerning the Ik people in Kaabong district. Kamion Health Centre II is one of the health centre located in the Ik community. The officer in charge of Kamion Health Centre II welcomed the ik community and explained to them about the intentions of our visit there after he introduced the social team to the community who then explained about the project and its intended objectives.
2	**Issues discussed**
	There were challenges to seek medical help because the HC has insufficient drugs so they resort to the use of local herbs to treat the common diseases namely malaria, RTIs, Gastro- intestinal infections, eye infections and skin diseases and some of the local herbs are administered with the use of razor blades to cut their bodies, this poses a risk of infection for other diseases which are spread use of in sterilized instruments.
	They also made mention on the use TBAs and the major reason was that they have only one mid wife at the HC and in addition to that, men are not allowed to attend to men during birth There was also mention of a cultural attachment to their placenta after birth.
	Do Ik people have culture practices that may be harmful to their health? They copy the practice of the Karamojong for example body tattooing. In case of death by the husband to the wife there is a tendency of the brother to the deceased to take over the wife, this poses a risk contracting STDs.
	They also mentioned an increase in malaria especially during wet season.

Week		Meeting date	18th May, 2016
		Recorded by	Faith
Meeting/subject	Meeting with Cultural Leader on Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
1	**Introduction**
	The Social Development Specialist started by introducing herself, the project and purpose of the meeting which was primarily to inquire about health related issues concerning the Ik people in Kaabong district. Kamion Health Centre II is one of the health centre located in the Ik community. The Cultural leader welcomed the project and he was happy that the project will improve on the health challenges among the Ik
2	**Issues discussed**

Week		Meeting date	18th May, 2016
		Recorded by	Faith
Meeting/subject	Meeting with Cultural Leader on Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	2

Item	Update
	The cultural leader stated that the Ik community has been marginalized for so long but was pleased that Improved health facilities have been brought to the Ik land this will improve on the health care provisions for the Ik community. More midwives should be recruited at the HC in order to respect the cultural values for the Ik who do not accept the men to attend to them during delivery. Most of the pregnant women move long distances to go and seek ante-natal care so with the improvement of the health facility, it will greatly help the Ik to access health service deliveries. Before implementation of the project, the project developer should consult with the community and seek advice from the Ik on how the project should be handled without necessarily impacting negatively on their cultural values. He also requested that the Kamion HC II should be upgraded to the HC IV so that it can perform minor surgeries and also widen on the service delivery like other HCIV elsewhere in Uganda

UGANDA REPRODUCTIVE, MATERNAL and CHILD HEALTH IMPROVEMENT PROJECT (P155186) BY MINISTRY OF HEALTH.

LOKIYOTO VILLAGE

Attendance List

Project District: KAABONG – IK COMMUNITY. Date: 31/03/2016

No	Name	Village	Designation	Signature
01-	LOUPE REX TIMOTHY	DHO's office KAABONG	ADHO (MCH/FP)	
02	NGOYA PETER	LCI CHAIRPERSON	KAMION S/C	
03	KWAM LARGO MOT	LOKIYOTO S/S	KAMION S/C	
04	KUNUME ALICE	LOKIYOTO FARMER	KAMION S/C	
05	LOKIYANG SIMON	LOKIYOTO FARMER	KAMION S/C	
06	NATANG MACHILINA	FARMER LOKITOTO	KAMION S/C	
07	LEMEI ANNA	FARMER LOKITOTO	KAMION S/S	
08	NAKONG ALICE	FARMER LOKITOTO	KAMION S/C	
09	CHILLA ANDREW	FARMER NAWADOW	KAMION S/C	
10	LOTUKEI CHATINA	FARMER LOKIYOTO	KAMION S/C	
11	KALOYANG LUCIA	PPS LOKIYOTO	KAMION S/C	
12	NAKONG JESCA	FARMER LOKITOTO	KAMION S/S	
13	ADUPA ROSE	FARMER LOKIYOTO	KAMION S/C	
14	NYELECHA EMUYO	FARMER LOKITOTO	KAMION S/C	
15	NALEM CHRISTINE	FARMER LOKITOTO	KAMION S/C	
16	NAROT BETTY	PPS LOKIYOTO	KAMION S/C	
17	LODUKUI ROBERT	KAMION HEALTH CENTRE	KAMION S/C	

UGANDA REPRODUCTIVE, MATERNAL and CHILD HEALTH IMPROVEMENT PROJECT (P155186) BY MINISTRY OF HEALTH.

Attendance List

Project District: KAABONG Date: 31st/03/2016

No	Name	Village	Designation	Signature
01	ADUNGO RAJA	MORU-ATAP	V.H.T.	
02	NGOYA paulino	MORU-ATAP	V.H.T.	
03	SILO1 paulino	MORU ARENGAN	V.H.T.	
OK	LOJORE PASQUALE	NACHAKUNGET	V H T	
	ACUM MARK	LOUSUNA	V H T	
	COCHAM HELLEN	KOKOSOWA	V H T	
	KICHA ROSE	MORU-ARENGAN	V H T	
	ITAO MARCHLINA	NAWADOU	V H T	
	NAKOT MARIA	LOCHETO	V H T	
	MACHU CHICILIA	MORU-ATAP	V H T	
	GOKUDA DAVID	NAWADOU	V H T	
	NGOYA JAMES	NARUKIENY	V H T	
	NAKOR ALICE	LOKIYOTO	V H T	
	LOKIENY JAMES	LOCHETO	V H T	
	RIWOKE J. BOSCO	KOKOSOWA	V H T	
	ADUPA SARAH	LOUSUNA	V H T	

UGANDA REPRODUCTIVE, MATERNAL and CHILD HEALTH IMPROVEMENT PROJECT (P155186) BY MINISTRY OF HEALTH.

Attendance List

Project District: KAABONG Date: 31st/03/2016

No	Name	Village	Designation	Signature
0756760217	OCHU JOSEPH	LOKITOTO	V H T	
	ARICO ALFRENSA	NARUKIENY	V H T	
	NACHECHA REGINA	NACHAKUNGET	V H T	
	LOKIEN			

Stakeholder consultation record:

Name of agency/stakeholder/community:	Cultural leader (IK community)				
Purpose of consultation (*tick appropriate box*):	**Scoping**			**ESIA**	
	Sensitisation	✓		**RAP**	
	Environmental Audit			**Other (specify)**	IPP
Date: 18/05/16					
Project name: Reproductive Maternal Neonatal Child Health Improvement Project					
Proponent: Ministry of Health					
Name of person/ official met:	**Designation**		**Contact (Tel/email)**		**Sign/ initial**
LOMERI JOHN MARK	COORDINATOR (IADI) CULTURAL LEADER		0782911102/0755911102		