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MINISTRY OF HEALTH

Indigenous Peoples Policy Framework

UGANDA REPRODUCTIVE, MATERNAL, NEONATAL AND CHILD HEALTH IMPROVEMENT PROJECT

Final Report

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Acronyms

BDR:	Births and Deaths Registration
CRVS:	Civil Registration and Vital Statistics
DHT:	District Health Teams
FGD:	Focus Group Discussion
GoU	Government of Uganda
HC:	Health Centre
HIV:	Human Immune deficiency Virus
IDA:	International Development Association
IP:	Indigenous People
IPP	Indigenous Peoples Plan
IPPF	Indigenous Peoples Policy Frame work
MoH:	Ministry of Health
NGO:	Non-Governmental Organization
PCU:	Project Coordination Unit
PHC	Primary Health Care
RMNCAH:	Uganda Reproductive Maternal Neonatal and Child Health Improvement Programme
TBA:	Traditional Birth Attendants
UBOS:	Uganda National Bureau of Statistics
USD:	United States Dollars
VHT:	Village Health Teams
WB	World Bank

1 PROJECT BACKGROUND

Government of Uganda (GoU) with financing support from the World Bank (The Bank) plans to improve reproductive, maternal, neonatal and child health from implementation of the *Uganda Reproductive, Maternal, Neonatal and Child Health Improvement Project* (RMNCAH Project). The project will be implemented for 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 targeted areas have indigenous peoples and hence require measures suitable to prevent and respond to the specific health requirement for the Batwa beneficiaries and a mechanism for grievance redress, as well as achieve project objectives and outcomes and therefore the Indigenous People's Policy Framework (IPPF). This Framework will review the general and health specific needs of the IPs as identified during the consultations legal and institutional framework applicable to IP and grievances mechanisms while assuring social and economic benefits from project implementation.

1.1 Project Development Objective

The project objectives are to improve utilization of essential health services with a focus on reproductive, maternal, new-born, child and adolescent health services in target districts; and scale up birth and death registration services.

1.2 Project Beneficiaries

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

[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.*

2 PROJECT DESCRIPTION

This chapter outlines project components of the proposed project and financing arrangements.

2.1 Project Components

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 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.

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[2] The government is considering adopting Community Health Extension Workers (CHEWs) Program. 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.

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.

2.2 Project Financing

The project cost is USD150 million contributed as flows:

- IDA (US$110 M) and
- Global Financing Facility Grant (US$40 M)

3 INDIGENOUS PEOPLES POLICY FRAMEWORK (IPPF)

The Indigenous Peoples Policy Framework (IPPF) has been prepared because it is not clear at this stage whether the project activities will be within the areas inhabited by the IPs or whether the arrangement of the projects may affect or not affect the IPs. The project is planned for the country as a whole and the actual impact can only be determined at arrangement of the proposed subprojects.

3.1 Purpose of the IPPF

This Indigenous Peoples Policy Framework (IPPF) has been prepared to promote project benefits for the Batwa through provision of culturally appropriate health services that also address the practical challenges/constraints faced in accessing health care. This will apply to all the RMNCAH subprojects. In addition, this IPPF highlights some of the key considerations for avoidance of negative project impacts on Indigenous.

3.2 Objectives of the IPPF

The principal objectives of the IPPF are to:

- Ensure the full participation of the IPs in the entire process of preparation, implementation, and monitoring of project activities;
- Ensure that the project benefits also accrue to IPs and mitigate any adverse impacts;
- Define the institutional arrangement for screening, planning and implementation of IP plans for subprojects; and
- Outline the monitoring and evaluation process as well as an implementation budget.

3.3 Applicable Policies and Potential Impacts

The RMNCAH project is to cover the whole country, including districts inhabited by the Indigenous Peoples of Uganda (the Batwa). The project activities are expected to involve and affect the IPs, thereby triggering the World Bank Safe guard Policy on Indigenous Peoples (OP/BP 4.10). Mothers, children, men and the youth will benefit from the improvement of the health facilities in the health centres.

Component 1: Aims to increase access and cost-effective RMNCAH services provided and this will be by the use of VHTs in their catchment areas to promote community based services including improved nutrition also provision of ambulance this will ease the mobility of the service providers in hard to reach areas.

Component 2: Aims to support the MoH to implement priority health systems and strengthen capacity to deliver RMNCAH services through availability of essential drugs and supplies, availability and functionality of medical equipment in the health facility and health infrastructure for PHC services. This will in return improve on the health service delivery.

Component 3 This component will strengthen the institutional capacity to scale up births and deaths and this will enable registration of birth and death rates in the IP community

Component 4: Through monitoring and evaluation by the consultants who will be identified by MoH, this component will help to assess how the project has benefited the IPs.

3.4 Key Principles

The following principles will guide the preparation and Implementation of activities, in relation to the IP

- Design training and related activities in a manner to ensure that the IP receive social and economic benefits that are culturally appropriate and gender sensitive.
- Affirmative Action in relation to the IPs should be used during selection of health centres to benefit from the RMNCAH projects.
- Engage in a process of free, prior and informed consultation with the affected IP.

3.4.1 Definition of IP

The definition of IP used in this framework in a generic sense refers to a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees:

i) Self-identification as members of a distinct indigenous cultural group and recognition of this identify by others
ii) Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories.
iii) Customary cultural, economic, social or political institutions that is separate from those of the leading society and cultures.
iv) An indigenous language, often different from the official language of the country or region in which they live.

For this framework, the World Bank criterion to identify indigenous peoples from the 65 ethnic groups in Uganda has been adapted. There are a number of groups in Uganda that have been identified as satisfying the Work Bank's policy for the identification of indigenous peoples. These include the Batwa, Benet, and (Ik) in Kaabong District. These people have historically suffered, and continue to suffer disempowerment and discrimination on economic, social and cultural grounds.

Their livelihood is threatened mainly by the decreasing access they have to land and natural resources on which they depend either as pastoralists or as hunt-gatherers. It will be demonstrated, however, that although the law in Uganda does not expressly recognize Indigenous Peoples, it makes provision for addressing some of the negative effects arising from ethnic vulnerability and imbalances. The Constitution, in the section on 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 everything necessary be done to promote a culture of co-operation, understanding, appreciation, tolerance and respect for each other's customs, traditions and beliefs.

The Constitution of Uganda even makes provision for the adoption of affirmative action in favour of marginalized groups in order to address historical imbalances. The National Objectives also make provision

for the fair representation of marginalized groups on all constitutional and other bodies. These provisions have direct relevance to Indigenous Peoples and could be used to compel government to undertake special measures to address the needs of these peoples.

To establish if IPs are in the project areas, Ministry of Health (MoH) has undertaken an Indigenous Peoples Policy Frame work in Kanungu District.

3.4.2 Key Elements of the IPPF

The key elements of the IPPF, which include activities that lead to the development of the Indigenous Peoples Plan (IPP), as well as follow on activities that include implementation and monitoring of the IPP, are listed below, followed by detailed discussion on each of these elements:

- In regard to the sub-section section 3.4.1 other IP groups could be identified in the proposed project districts under RMNCAH. Even if a social assessment has already identified Ik in Kaabong and the Batwa in Kanungu, the definition in Uganda refers to other tribes too like the Benet who live on the slope of Mt. Elgon and the entire Karimajong community given their vulnerability. During project implementation there is the possibility that IP communities from groups that are not identified in the assessment may be encountered in districts where the project is operating.

- The MoH will therefore undertake a supplemental social assessment to identify any other IP group appropriately and evaluate the project activities' potential impacts on them. The social assessment will also include the identification and evaluation, based on free, prior, and informed consultation with the affected IP communities, of measures necessary to ensure that the IP receive culturally appropriate benefits from the activities under the project.

- To carry out the social assessment, the MoH will engage the services of an IP/Social Development specialist, whose qualifications, experience, and terms of reference are acceptable to the MoH and approved by the Bank. The TOR of the IP/Social Development specialist will include, among others, identifying IP communities within the project Districts.

3.4.3 Consultation and Participation

- The Public Coordination Unit has to ensure that where the proposed project affects IP, it engages in free, prior, and informed consultation with them. To ensure such consultation, the MoH will:
- Use consultation methods appropriate to the social and cultural values of the affected IP 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 opportunities and benefits under MoH project.
- Provide the affected IP communities with all relevant information about the project, including the potential adverse impacts, if any, in a culturally appropriate manner at each stage of subproject preparation and implementation.
- Establish an appropriate framework that provides opportunities for consultation at each stage of training preparation and implementation among the MoH staff, the affected IP communities, the IP organizations if any, and other local NGOs identified by the affected IP communities.

3.4.4 Public Awareness

The project will support a public awareness and where appropriate include media campaign to ensure that stakeholders and beneficiaries are aware of their rights and responsibilities under the project, especially the targeted beneficiaries such as IPs, women and children, men and the youth.

The public awareness will be based on the social assessment which identifies the best media and message format to reach IP communities; the Public Awareness campaign will extend the mediums used for social marketing such as, radio and signage and introduce more targeted interventions by using an NGO known as Batwa Development Agency which helps the Batwa community access health care services from the Health centre owned by Kinkizi diocese. The terms of reference for the consultant designing and conducting the Public Awareness will be agreed with the Bank and will include in the scope of services the specific task of ensuring that the RMNCAH project message reaches IP.

3.4.5 Consultation with the Batwa community

Through the local district officials and the Batwa local leaders, advance information about the project and need to consult with the Batwa, preparations for the consultations were done to ensure Free, Prior, Informed Consultations. The IPs identified the convenient timing and location of the consultation meetings. Through their local leaders, the Batwa communicated appreciation of the opportunity to engage them in the early processes of the project design. They openly shared in advance the key health concerns that they would like to discuss and proposed discussions in their local language and setting. Consultations were thereafter held with a large part of the Batwa. Having attentively listened to the RMNCAH objectives and its various components including the proposed activities to be implemented, participants welcomed the proposed project in their communities and pledged their full support during its implementation.

The communities cited health services for their community as very important and therefore agreed that the development of their health centre to provide better health services for proposed RMNCAH activities was welcome. However, they mentioned in order to improve on the health services in their community the following should be considered in addition to the proposed activity:

i) They mentioned that there was lack of adequate maternal services and therefore they have to travel far a way to Bwindi hospital to seek maternal services and therefore requested for improvement in in existing services in order to reduce on the long distance to other facilities. In addition, they requested for reorganisation of inpatient services to include isolation rooms to avoid disease transmission once admitted in hospital. There was also mention of lack of an ambulance to assist in the transportation of very ill people to the referral hospital.
ii) Common use of harmful tools such as pliers to extract teeth was identified and this was attributed to absence of dental services at the health centre.
iii) The project should consider the provision of solar power in order to improve on the health services and also continuity of night shift service delivery.
iv) They requested for provision of medical supplies to enable them treat the common diseases like malaria, respiratory tract infections and others, equipment to carry out minor surgeries and laboratory services for HIV testing and malaria.
v) They also requested for sanitary wear for the young girls and women since they are they can’t afford.
vi) They also lack “mama kits” to help them in the delivery process and sometimes pregnant women commonly deliver along the road side as a result of lack of transport to the health facilities.

vii) They also mentioned they have a common disease locally known the "Bukamba" disease which is believed to have come from Bwindi Forest and therefore people who live around this forest are given vaccines every year to curb it.

3.5 DEVELOPMENT OF AN IPP

Apart from the IPPF, which would serve as a guideline for the development of an IPP, the Project coordination Unit (PCU) will prepare an IPP that is suitable for Uganda in general. In addition to that, the PCU will develop an IPP template to be used by the districts inhabited by Batwa to develop district precise IPPs. The PCUs IPP will have to be reviewed by the Bank for compliance with OP 4.10.

MoH will disseminate the IPPF and the IPP template to prospective participating Districts and engage a consultant to provide appropriate training on the IPPF and how to develop an IPP. Districts partaking in RMNCAH project will then develop specific IPPs, tailored to the IP groups in their particular area and based on the respective social assessment, referring to the IPPF as guidelines and using the IPP template. The MoH will guide Districts in developing the IPPs and review them before submitting them to the Bank. Upon the Bank's approval, the Districts will then need to integrate the IPP provisions into the training and other relevant elements of the project.

An IPP is prepared in a flexible and pragmatic manner, and its level of detail varies depending on the specific activities, the nature of effects to be addressed and the characteristics of specific IP groups. However, an IPP needs to include the following elements, as needed:

i) A summary of the social assessment;
ii) A summary of results of free, prior, and informed consultation with the affected Indigenous Peoples' communities that was carried out during training preparation and that led to broad community support for the training approach;
iii) A framework for ensuring free, prior, and informed consultation with the affected Indigenous Peoples' communities during project implementation;
iv) An action plan of measures to ensure that the Indigenous Peoples receive social and economic benefits that are culturally appropriate, including, if necessary, measures to enhance the capacity of the implementing agencies;
v) The cost estimates and financing plan for the IPP;
vi) Mechanisms and benchmarks appropriate to the project 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 IP communities.

Table below summarizes likely project interactions with IP groups under each component of RMNCAH and need to be taken into consideration when to developing the IPP.

Table 1: Likely project interactions with IP groups

Project components and sub-components	**Possible project interactions with IPs**
Component 1: Effective health care services	

Provision of ambulance at the RMNCAH referral services	The point of interaction will be the health centres where IP women and children will benefit from quality health care and ambulance services and also nutritional benefits for the children. They community will also benefit from the provision of the ambulance which will help in mobility of the service health providers as well as the Batwa community.
Component 2: Improved health system	
Through MoH the project aims to implement priority health systems and strengthen capacity to deliver RMNCAH services through availability of essential drugs, medical equipment and PHC services	The point of interaction with the IPs will be ability of the IPs to get access to drugs. Through Primary Health Care (PHC) programmes, they will be able to learn the benefits of accessing formal healthcare services.
Distribute essential health commodities such as mama kit, contraceptives to the communities	The point of interaction especially with the women who will be able to access mama kits for delivery purpose because this was one of the major concerns during consultations, ability to use birth control pills will also be useful for family planning.
Increased health work force	This will be a directive benefit to the IP community who will have more health workers recruited at their HC to improve on the health service delivery.
Improved health infrastructure	This will be a direct benefit to the IP especially the women who will benefit from the construction of maternity wards. During the meeting with the women this was one of cited.
Improved quality and care and supervision	This is a direct positive benefit to the Batwa because they will be able to access services even for those who are in far to reach areas. This will be done with the support of the properly trained, equipped, motivated and supervised VHTs
Component 3: Strengthen Institutional Capacity	
This component is to strengthen institutional capacity to scale up delivery of births and death registration	The point of interaction will be both at the Health facility and community level where the IPs will be registered at birth and also their deaths registered.
Component 4: Project management and technical assistance	
This component will provide M&E using consultants To evaluate the benefits of the project	This will be a positive impact because it helps to assess how the IPs have benefited from this project.

4 IMPLEMENTATION AND INSTITUTIONAL ARRANGEMENTS

4.1 Capacity building for safeguards officer at the Ministry 0f Health

Ministry of Health will build capacity and provide necessary training to a designated staff to handle safeguard issues particularly Indigenous People. It is recommended that this activity be assigned to the officer responsible for Gender issues in the Ministry whose capacity for social safeguards will be enhanced through training and hands on support by the World Bank Social Development team and a consultant to be hired by the MoH. These staff will then train the Local Government Social Services Committee Members staff comprising: District Health Officer, officers- in charge at the respective health centres and District Community Development Officers of the respective districts where IPs are found. These officials' capacity will be enhanced in undertaking social screening and will participate in the development of the District specific IPPs, including reporting. At the District Level, the District Community Development Officer will be tasked with the role of IPs Focal Point officer responsible for day to day implementation of the IPP and will be expected to submit progress reports to the designated officer at the MoH in charge of Safeguard aspects who will then report to the Department of Health Planning. The short-term consultant recruited to provide this technical assistance will be located at MoH with regular presence in the respective districts and will report directly to the Project Coordinator.

4.2 Additional resources for raising awareness about IPs

Kanungu district which is inhabited by Indigenous Peoples is found at the extreme most end of the country. This place is remote and difficult to reach especially penetrating the Bwindi Forest where the Batwa are found. Special consideration in terms of activities to promote quality health care through a rights-based approach, which ensures that all stakeholder are aware of their rights and responsibilities will be provided as appropriate. Deliberate efforts to meet the health needs of women, taking into account age and other socio economic differences will be prioritised. In addition, technical assistance will be provided during the development and implementation of the IPP and intensive monitoring to ensure compliance with World Bank policy OP 4.10. The project may consider providing full packages of the activities in the respective components in health centres involving IPs.

4.3 Recommendations to enhance participation of the IPs in project activities:

Consultations with the Batwa have resulted in the following recommended approaches for the project:

- Provide Primary Health Care programmes for the Batwa communities
- Provide a mortuary at the HC to enable them preserve the dead bodies.
- Train the health workers to be culturally sensitive to the IPs.
- They requested for provision of ambulance to ease on the transportation when they are referred to the hospital which is very far.

- Embark on intensive mobilization and sensitization of the Batwa, about the positive impacts of using health services so that they effectively participate and benefit from the RMNCAH project. This could be done through radio, church and the use of their community structures should be critical in the mobilization and sensitization efforts. In addition to that, the Batwa need to be provided with a good atmosphere free of stigma and discrimination, where there are health workers who can speak their local language. Such efforts can motivate them to access health services. The contractors should procure raw materials for renovations and related construction works from the

local community, as well as provide employment opportunities for the Batwa . The latter will enable the Batwa earn income but also promotes ownership of the developments in the facility.

4.4 Institutional roles and responsibilities

Table below outlines responsibilities of institutions that will be involved in implementation of the IPPF.

Table 2: Institutional roles and responsibilities

Institution	Responsibilities
The Ministry of Health through the department of Health planning which coordinates RMNCAH project in capacity as the Project Coordination Unit (PCU)	i) The MoH will have overall responsibility for implementation and accounting for the project funds and coordinating activities under all project components. ii) The Permanent Secretary under MOH will be supported by a full time project coordinator who will be responsible for overseeing day to day coordination of the project components. iii) MoH will develop the IPPF and integrate it in the Project Operations Manual (POM) to serve as guidelines. iv) Designate specialists such as safeguard specialist, Monitoring and Evaluation specialist at MOH to coordinate all safeguard aspects and provide key technical support during implementation, monitoring and evaluation. v) Re-assessment of Districts and healthcenters in the specific Regions to ensure inclusion of IP inhabited districts and health centres in the RMNCAH project area. vi) Hire a dedicated Social Development officer to be responsible for providing support to the designated staff (Gender Officer) on the overall social safeguards aspects of the project and implementation of the IPP. vii) Build capacity of the Local Government team in selected districts inhabited by IPs to enhance their monitoring skills of IP issues
The Local Government Health group	▪ Disseminate guidelines and templates developed by MoH/Department of Health Planning. ▪ Mobilization and facilitation of the involvement of community members and other stakeholders starting from identification through implantation and M&E of the project. ▪ Participate in the social screening to confirm the presence of IP communities in the district, and attendance of IP patients in health facilities ▪ Monitor and report on the implementation of the IPP. ▪ Ensure that the IPs are regularly updated on the project progress and their views sought on necessary improvements.
Development Partner (NGOs) and Civil Society as an advisory	i) Involvement of Development Partners and Civil Society in the project areas to deliver capacity building services is

Institution	Responsibilities
and coordinating group as per RMNCAH institutional arrangements	important to ensure participation of the IP groups. Capacity building at community level will involve helping IP communities to conduct participatory needs assessment to identify, prioritize and plan projects and to choose members (especially IP members) to represent them as part of community level project coordination. ii) Participate in the monitoring of mitigation measures intended to involve participation of the IP communities in health issues. iii) Engage to help mobilization of the IP communities and carry out consultations and information dissemination.
District Community Development Officers (DCDO) in their capacity as the implementers of the IPP at district level.	i) The DCDOs together with the Assistance Community Development Officers will be responsible for coordinating project activities at sub-county and community levels. ii) Participate in mobilization of the communities; work with sector specialists to provide technical support to communities. iii) Participate in the social screening exercise iv) Participate in the development and implementation of the IPP v) Create awareness through sensitization of the wider community on issues of IP. vi) Provide IP related reports to the Department of Health Planning.
The World Bank	▪ Review and approve the IPPF developed by MoH. ▪ Reviewing regular monitoring reports and officially disclosing the IPP on its website. ▪ Review and approve District specific' IPPs ▪ Monitor and supervise the implementation of IPPs

4.5 Monitoring and Evaluation

Monitoring and evaluation (M&E) are important mechanisms of projects involving affected entities. It should be participatory and include the monitoring of beneficial and adverse impacts on Indigenous peoples within project impact areas. M&E should be based on free, prior and informed consultation with the IP who should play an integral role in its implementation. All monitoring activities are ultimately the responsibility of the MoH. Implementing departments/districts/agencies will be responsible for compiling the data and auditing for completeness of the records, and they will be responsible for providing compiled information to the M&E Unit of MoH.

The overall goal of the M&E process for the Indigenous Peoples plan is to:

- Ensure effective communication and consultation takes place;
- Report any grievances that require resolution;
- Document the performance of RMNCAH program as regards the Indigenous Peoples; and

- Allow project implementing staff and participants to evaluate whether the Indigenous Peoples have maintained their rights, culture and dignity and that they are not worse off than they were before the project.

The monitoring and evaluation of the implementation of IPPF will be an integral part of the results framework of the RMNCAH project.

- There will be inventory from from the M&E Unit of MoH who will carry out observation and making unceremonious visits to the targeted health centres to evaluate the number of Batwa who are accessing the health services. This will help ascertain if the IP communities are benefiting from the MoH project.

- Through direct field monitoring reports by MoH and the districts during project implementation.

- The proposed impact evaluations of the IPPF implementation will be incorporated in periodic joint MoH and World Bank Supervisory and Implementation Mission. (mid-term and project completion evaluations)

4.6 Grievance Mechanism

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 IP 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.. Efforts will be made to ensure that existing structures among the Batwa are part of the GRM.

MoH will address any potential unresolved grievances by: 1). Involving community and Sub-county authorities to mediate with the group's interest in relation to project and communities' agreements recorded on official community books. 2). In case of disregard for the indigenous norms and values, traditional authorities in conjunction with suitable staff associates, will call and hold necessary meetings with indigenous community participants to peacefully resolve conflicts. 3). Record on official community books the grievances and resolution of grievances at hand. These types of meetings at the community level are the normative forms of conflict resolution in most communities in Uganda and the Batwa community will be no exception. More to that MoH through its local partners and an identified NGO will follow up on grievances to resolve them promptly and according to indigenous norms and processes. Project monitoring and evaluation procedures will also be designed to anticipate and avoid different sorts of project grievances on indigenous peoples. Since potential grievances will be handled promptly and accordingly, there is no anticipation of legal disputes or court trials.

4.7 Institutional Capacity Building for Safeguard Management

For any works to commence, MoH Department of Health Planning will engage the services of a social development consultant under terms of reference agreed by the Bank to help build capacity of a designated focal point officer within the MoH, Local Government Health Group of Districts with IPs, for safeguards management among other tasks. The specialist will be located in the Department of Health Planning to

provide technical assistance during the development health care services and strategic planning. The specialist will work closely with the Village Health Teams and designated safeguard focal person for better safeguards management and their combined duties will include, but not be limited to:

i) Identifying IP communities within the project areas.
ii) Ensuring that in all the selected districts with IPs, a Social Assessment is conducted as the basis for developing an appropriate IPP (Indigenous Peoples Plan), and that the IPP is agreed with the Bank in each instance where an indigenous community is encountered.
iii) Ensuring that the details of the plan in point (b) above are disseminated in the indigenous community, the surrounding local community and routinely updated centrally on the project website.
iv) Conducting and participating in training in matters related to the identification, communication and provision of services to indigenous peoples.
v) Ensure that IP communities are appropriately represented in discussions at an early stage in the project, (for example by local village council, and health management Committees).
vi) Ensure that appropriate media are used to communicate with IP communities.
vii) In ensuring the appropriate use of media will also include the translation of project materials, such as brochures and guidelines, into the local language or dialect of the indigenous group(s).
viii) Ensure that involvement of the indigenous community provides for the culturally appropriate inclusion of community members regardless of gender or age.

The MoH/Department of Health planning with support from the short-term Social Development Consultant would be in charge of developing and updating the project document to reflect the standard operating procedures for dealing with IP. This working arrangement will allow the staff at the Districts to build their capacity in developing approaches that would ensure the inclusion of IP groups in mainstream government programs (currently running and future projects), not just limited to RMNCAH.

The on-the-job training conducted by the social safeguards specialist for both the PCU and Local Government Team in matters related to the identification, communication and provision of services to indigenous peoples will serve as a sustainable approach for capacity building of these institutions, in managing social safeguards

4.8 DISCLOSURE

Before finalizing an IPP a draft should be disclosed together with the social assessment report (or its key findings) in a culturally appropriate manner to the Indigenous Peoples affected by the project. Language is critical and the IPP should be disseminated in the local language or in other forms easily understandable to affected communities – oral communication methods are often needed to communicate the proposed plans to affected communities.

After The World Bank has reviewed and approved the IPP as part of the overall proposed project for funding, the implementing agency (MoH) shares the final IPP again with affected communities. The final IPP is also disclosed at The World Bank Infoshop.

ANNEX 1: BACKGROUND INFORMATION ON BATWA INDIGENOUS PEOPLE IN UGANDA

The Constitution has no express protection for indigenous peoples but provides for affirmative action in favour of marginalized groups. There is no official definition of indigenous peoples, and neither are there criteria in place for their identification. The term 'indigenous' is used to describe the different ethnic groups that historically have resided within Uganda's borders. The Third Schedule of the Constitution, which names the 65 ethnic groups of Uganda, is titled 'Uganda's Indigenous Communities as of 1st February 1926'. This understanding differs markedly from the manner in which the term has been used by international and regional organizations and by experts in the area of indigenous peoples and indigenous issues. Uganda uses aboriginality, to the exclusion of other factors, as the only method of identifying indigenous people. There are a number of groups of persons in Uganda that have been identified as satisfying the international criteria for the identification of indigenous peoples. These include the Batwa, Benet and the Ik. These people have historically suffered, and continue to suffer disempowerment and discrimination on economic, social and cultural grounds.

The Constitution, in the section on 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 everything necessary be done to promote a culture of co-operation, understanding, appreciation, tolerance and respect for each other's customs, traditions and beliefs. The Constitution of Uganda even makes provision for the adoption of affirmative action in favour of marginalized groups in order to address historical imbalances. The National Objectives also make provision for the fair representation of marginalized groups on all constitutional and other bodies. These provisions have direct relevance to indigenous peoples and could be used to compel government to undertake special measures to address the needs of these peoples.

The Batwa are forest peoples spread all over the Great Lakes region and parts of Central Africa. In Uganda, the Batwa are estimated to be about 6200 (Uganda Bureau of Statistics 2015) people; they live in the South-western districts of Bundibugyo, Kisoro, Kanugu and Kabale. They have historically depended on the forest for hunting and fruit gathering; their methods of survival have been very rudimentary and based on nature as provided by the forest environment in which they live. They also maintain a special spiritual relationship with the forest, which they believe to be their God-given source of livelihood. In spite of this, the Batwa have witnessed changing life patterns, rearing livestock and engaging in some form of subsistence farming and such self-employment activities as making crafts to be sold in the informal market sector

ANNEX 2: SUMMARY RECORD OF CONSULTATIONS

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with Batwa community members	Total pages	1

Item	Consultation
1.	**Introduction**
	The team consulted Batwa community at Kitariro HC II premises, Kanungu District in a meeting organized with assistance of one Nibarema Godfrey. He introduced the consultant's team to the congregation and encouraged his kinship to freely air out their views about the project's possible impact and benefits.
2.	**Issues discussed**
2.1.	**Diseases the Batwa community noted as prevalent are:** Malaria, diarrhoea, cough, ulcers, allergy and HIV.
	Language used for communication at healthcenters: Language of communication at the nearest HC is Rukiga and Batwa people, who speak it fluently, said they were comfortable with it.
	Traditional practices that prevent Batwa from seeking health services Cut marks on children's chests to prevent and treat pneumonia.
	Challenges • Patients referred by VHTs and HCs for further management do not have transport to their destinations, they are usually carried on locally made stretchers for long distances; • Lack of In-Patient Department (IPD), especially maternity ward for women to deliver; • Lack of dental services, as a result some Batwa people use crude implements including pliers to extract teeth; • Lack of electricity and lighting in HCs.
3.	**Recommendations**
3.1.	• Provision of ambulances (vehicles or motorcycles); • Upgrade one of the nearby HC IIs to a level to offer IPD services, especially maternity ward; • Provide dental service equipment and personnel; and • Provide solar power equipment to the healthcenter

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with the In-charge of Kitariro HC II	Total pages	1

Item	Consultation
1.	**Introduction**
	The team met the officer at her office, Kitariro HC II in Kanungu District. Kitariro is one the health facilities accessed by the Batwa in Kanungu.
2.	**Issues discussed**
2.1.	**Common diseases among the Batwa people:** The officer mentioned malaria, gastro-intestinal disorders, ulcers and respiratory tract infections as the common diseases. Coccidiosis (Butamba) was named as a rare but dangerous disease, especially among population near Bwindi Forest. As result, people near the forest receive vaccines twice every year as a cautionary measure. In addition, scabies was reported as a seasonal disease especially during dry seasons.
	Common language healthcare staff use to communicate with Batwa people The widely used language is Rukiga. This is because the minority Batwa have learned to speak the language of the majority- Rukiga. Secondly, the Batwa are uneducated and therefore cannot get technical placement at the HC, which up to now has precluded opportunity for a native Batwa person being a staff at the healthcenter.
	Traditional practices that prevent Batwa from seeking health services The Batwa believe that traditional healers cure/prevent witchcraft, false teeth and pneumonia, therefore they consult them first and only visit a healthcenter when the healers fail to provide healing solutions.
	Healthcare waste management: Waste generated is sorted and disposed of by opening burning in pits. It was also noted that the HC does not have mortuary facilities.
	Land resource: Church of Uganda through Kinkiizi Dioceses brought land for the Batwa to settle on. The In-Charge of the healthcenter indicated that the HC has sufficient land for development and expansion.
	Challenges: Patients referred by VHTs and HQCS for further treatment or management always lack transport, resorting to usually being carried on locally made stretchers for as long as 30 km before they get a taxi to a hospital.
3.	**Recommendations**
3.1.	**Health services:** Provision of ambulances (vehicles or motorcycles) is essential for this community
	Waste management: For proper waste management, a suitable incinerator should be constructed

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with the VHTs	Total pages	1

Item	Consultation
1.	**Introduction**
	The team met VHT members at Kitariro HC II premises, Kanungu District.
2.	**Issues discussed**
2.1.	**Challenges cited** • Lack incentives hence motivation for their services; • Lack of adequate safety wear such as gumboots and umbrellas and tools (registers and first aid boxes) needed for duties. VHT members indicated receiving few medical supplies which also take long to get replenished once used up; • Members indicated lack of relevant information/ health care knowledge and required continual training. • Batwa community's mindset was also cited as challenge: Batwa people are used to free things and are reluctant to pay for any service however little the charge might be
3.	**Recommendations**
3.1.	**Health services** • Monetary allowances should be provided; • Government should increase quantity and frequency of replenishment of health supplies; • VHT should be provided with adequate safety gear and tools; and • Community should be sensitized to change their mindset of always expecting free services

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Focus Group Discussion with Batwa Women	Total pages	1

Item	Consultation
1.	**Introduction**
	The team met a group of Batwa women at the Kitariro HC II premises, Kanungu District.
2.	**Issues discussed**
2.1.	**Diseases among the Batwa community** The Batwa women mentioned some of the common diseases in their children and these included; Malaria, Diarrhoea, Pneumonia, Cough and flue
	Health services for women Family planning
	Challenges • Lack of maternal ward, therefore expecting mothers have to travel long distances to Bwindi Hospital to deliver; • Women cited lack of access to sanitary facilities; • Mothers and children lack transport to the HCs; • Batwa women who are financially disadvantaged wait in queues at the HCs for long periods which sometimes leads of loss of lives of mothers, babies or both.
3.	**Recommendations**
3.1.	• Upgrade a HC II in their community to offer IPD services, including maternal care; • Recruit professional midwives to help women to deliver; • Provide motorcycle ambulances to take pregnant women to the HCs;

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with the Secretary of Kinkizi Diocese	Total pages	1

Item	Consultation
1.	**Introduction**
	The team met the officer in his office at Kinkizi Diocese.
2.	**Issues discussed**
2.1.	**Contribution of Church to Batwa well-being** • The church of Uganda through Kinkiizi Diocese brought land and settled Batwa people. • The church established "*Batwa Development Program*" to give assistance to Batwa in education, knowledge for agriculture and health services. • It was also mentioned that Batwa people pay UgShs2000 per year quarter for treatment at health centers (many of whom consider it high and not affordable).

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with the Coordinator of Health Sector on IPPF for Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	1

Item	Consultation
1.	**Introduction**
	The team met the officer in his office, Kanungu District.
2.	**Issues discussed**
	Health Services The Batwa community have a number of health facilities they can visit to access health services, such as: ▪ BWINDI HOSPITAL ▪ KIHEMBE HEALTH CENTER II ▪ KITARIRO HEALTH CENTER II ▪ JUMBA SATELLITE CLINIC ▪ KANYASHOJE HEALTH CENTER II
	Diseases among the Batwa community The officer mentioned Malaria, Malnutrition, scabies, cough and diarrhoea as most common diseases amongst the Batwa. Coccidiosis (Butamba) was named as a rare but dangerous disease, especially among population near Bwindi Forest. As result, populations near the forest receive vaccines twice every year as a preventative measure.

Week		Meeting date	April 2016
		Recorded by	Richard
Meeting/subject	Meeting with the Coordinator of Health Sector on IPPF for Uganda Reproductive, Maternal, Neonatal, and Child Health Improvement Project	Total pages	1

Item	Consultation
	Challenges Batwa people commonly face • Inadequate maternal services • The shs.2000/= paid quarterly for treatment is still high for Batwa; • Batwa people are harsh and need sensitivity in handling. They have a negative attitude towards healthcare staff; • The Batwa always expect free services; • The Batwa travel long distances to Bwindi Hospital where they receive free treatment. Similar services are needed within their proximity to mitigate distance.
	. **Language of communication** The District Health Officer informed that the Batwa people use Rukiga Language for communication. Therefore there is good communication between the Batwa and other people they surround.
	Traditional practices that prevent Batwa from seeking health services He said that the Batwa people have some cultural practices that prevent them from seeking health medication. It was revealed for instance that Batwa people believe false teeth are important and they do not seek medical attention to remove them from babies.
	Recommendations • HCs need more clinical officers in the Batwa community; • The project interventions should include providing Infrastructure such as maternal wards and laboratories for better services for the Batwas;

UGANDA REPRODUCTIVE, MATERNAL and CHILD HEALTH IMPROVEMENT PROJECT (P155186) BY MINISTRY OF HEALTH WOMEN ONLY (FOCUS DISCUSSION FOR WOMEN)

Attendance List

Project District;……………………………………………Date………………………………

No	Name		Village	Designation	Signature	
15	Kemitumba	catherine	Kitariro	peasant	catherine	
16	~~Nat~~ sunday	Hope	kitariro	peasant	hope.	
17	Bakanyomera	Alice	Kitariro	peasant	Alice	
18	karandiro	Aren.	Kitariro	peasant	Aren.	
19	kazunga	Airett.	kitariro	peasant	Airett.	
20	katibiri	Aidah	Kitariro	peasant	Aidah.	
21	Ninsiima	gloria.	Kitariro	peasant	gloria.	
22	Ekibahigire	Abias	kitariro	peasant.	Abias.	0755782532

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

WOMEN ONLY (FOCUS DISCUSSION FOR WOMEN)

Attendance List

Project District;……………………………………………Date……………………………………

No	Name		Village	Designation	Signature
1	Kesando	Magret	Kitariro	Peasant	Magret
2	Kiconco	Medius	Kitariro	Peasant	Medius
3	Monday	Hope	Kitariro	Peasant	Hope
4	Mugasha	Peace	Kitariro	Peasant	Peace
5	Namiria	Phoeb	Kitariro	Peasant	Phoeb
6	Twaciima	Florence	Kitariro	Peasant	Florence
7	Kyomugisha	Evalyne	Kitariro	Peasant	Evalyne
8	Kato	Evalyne	Kitariro	Peasant	Evalyne
9	Twikirizi	Florah	Kitariro	Peasant	Florah
10	Kyomugisha	Allen	Kitariro	Peasant	Allen
11	Kabibi	Provia	Kitariro	Peasant	Provia
12	Nyanjura	Betrice	Kitariro	Peasant	Betrice
13	Betise	Loy	Kitariro	Peasant	Loy
14	Musiimenta	Jane	Kitariro	Peasant	Jane

0788331981

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

Attendance List

Project District;......Kanungu..................Date.....02/05/2016.........

No	Name	Village	Designation	Signature
01	Atuhaire Innocent	Kanungu	D/planner	[illegible]
02.	DR. SEBUDDE STEPHEN	Kihihi	DHO	[illegible] drsebuddese@doctor.com

ANNEX 3: PHOTOGRAPHIC RECORD OF CONSULTATIONS

	Consultation with District Health Officer Kanungu
	Consultation with the In-Charge of Kitariro Health Center II
	Consultation with Kinkizi Diocese Secretary

	Consultation with Batwa Community
	Focus group discussion with Batwa women
	Consultation with VHT staff

	Kitariro Health Centre II
	Healthcare waste kept in buckets.
	Open medical waste burning. No incinerator existed at the Health facility.