minority rights group international

FINAL EVALUATION REPORT

OGIEK PEOPLES' DEVELOPMENT PROGRAM

"ETHNIC MINORITY DEFENDERS: AMPLIFYING THE VOICES OF INDIGENOUS HUMAN RIGHTS DEFENDERS TO ADVOCATE FOR THE RIGHTS TO HEALTH & EDUCATION"

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Acronyms

ANC	Ante-natal Clinic
CBC	Competence-Based Curriculum
CBO	Community Based Organisation
CHP	Community Health Promoter
CHV	Community Health Volunteer
CWD	Children Living with Disabilities
DAC	Development Assistance Committee
ECDE	Early Childhood Development Education
EM	Ethnic Minority
EMHRD	Ethnic Minority Human Rights Defender
EUDK	European Union Delegation to Kenya
FGM	Female Genital Mutilation
GBV	Gender Based Violence
KWS	Kenya Wildlife Service
MCA	Member of County Assembly
MoH	Ministry of Health
MRGI	Minority Rights Group International
OPDP	Ogiek Peoples Development Programme
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
ToC	Theory of Change
WASH	Water Sanitation and Hygiene

Executive Summary

Introduction

Ethnic Minority communities (EM) in Kenyan experience marginalization and unequal recognition unlike the dominant ethnic communities. The EM often face evictions from their ancestral /forest lands following they are gazetted as protected forest reserves without EM consent. Article 56 of the Kenyan Constitution (2010) affirms the existence of the country's minority and indigenous communities. The Kenya's Ministry of Health (2013) indicates that the majority of ethnic minorities in the country lack sufficient access to health services. A Fact-Finding Mission Report (2020) organised by MRGI and OPDP established that gaps in Health and Education Access among the EM in Kenya are broad and immense. Other previous studies on EM by other stakeholders established that access to Education and Health are indeed a challenge despite the Government of Kenya's strides to achieving universal coverage in service access across the country as outlined in the Kenya Vision 2030 Strategic Action Plan. Kenya is a signatory to the UN Sustainable Development Goals (2015), and yet the realization of SDG 3 and SDG 4 among the EMs is shrouded in marginalisation and silent neglect.

Project Background and Evaluation Purpose

MRGI and the Ogiek Peoples Development Programme (OPDP) implemented a 3-year project (2021-2023) called "*Ethnic Minority Defenders: Amplifying the voices of indigenous human rights defenders to advocate for the rights to health & education"* to improve access to quality health care and education for ethnic minority communities in Kenya, reinforcing social and economic rights, and strengthening of capacity of EM communities and rights defenders to monitor and advocate for their education and health rights. The project involved 4 sub-grantee community-based organisations operating in 6 counties of Lamu, Nakuru, Narok, Bungoma, Elgeyo Marakwet, and Baringo where the Awer, Ogiek Mau, Ogie Mt. Elgon, Sengwer, and Endorois EMs live. The project aimed to systematically tackle the root causes of community marginalization, striving to create an environment conducive to the effective realization of SDGs. Following the completion of the project in August 2023, an external evaluation was conducted to assess the achievement of project objectives and document the project's Relevance, Effectiveness, Efficiency, Impact and Sustainability in order to learn from the implementation and identify recommendations to partners for future programming. The project was financed by the European Union (EU) Delegation to Kenya, with an investment worth €463,868.76.

Evaluation Methodology

A qualitative participatory evaluation approach was adopted, combining conventional Development Assistance Committee (DAC) evaluation criteria for assessment of achievements and lessons. Outcome Harvesting was employed to understand the exact outcomes attributed to the advocacy and awareness initiatives implemented by the project through ethnic minority rights defenders, as well as the factors that influenced these outcomes. Data was collected from community Focus Groups Discussions, In-depth Interviews with EM defenders, Community Health Volunteers (CHV) and Key Informant Interviews with key stakeholders (ward administrators, public health officers and other health practitioners, community chiefs, implementing partners' project staff, project staff of sub-grantees). Project documents were also reviewed to cross-check baseline and progress review findings in order to make meaningful deductions on achievements.

Evaluation Findings

<u>Relevance</u>

The project Fact-Finding Report highlighted the deplorable state of healthcare and education services among the communities targeted by the project, and the expert knowledge and experiences of MRGI and OPDP about these communities formed the basis of the project design and formulation of its objectives. The recruitment of 50 ethnic human rights defenders (EMHRD) and 25 CHVs, and 4 local CBOs; and the coordination role of MRGI and OPDP in the implementation were relevant. The trainings of rights defenders, health volunteers and sub-grantees by implementing partners led to improved empowerment for effective advocacy, community mobilization and participation in public budget processes. The health awareness campaigns and messages were appropriate to community needs and conveyed by community members. The participation networking strategies for EMHRDs, CHVs and sub-grantees locally, nationally, regionally and internationally were relevant and equipped them to present their issues.

The project design and theory were relevant; however, improvements were needed in terms of enhanced stakeholder integration at both county and national level government administrations for adequate implementation of agendas that were tabled. The monitoring and evaluation design was less appropriate, and its implementation needed some adjustments in indicator alignment with SDG indicators for relevant data collection and reporting. Learning events were largely unconducted and unplanned in the project design. The budget priorities for critical activities were not matched with sub-grantee needs, and planning was less participatory and transparent to sub-grantees at design stage of the project. Cross-cutting issues such as climate change, insecurity, evictions, female genital mutilation, gender-based violence among others were not catered for adequately in project design and budget. Gender was not well designed although the project in fact met women, children and children living with disabilities at times without planning. Women's practical need for health was met, but girls' educational needs such as sanitary towels to remain in school were not factored in. Emerging needs along the project implementation such as need for bursaries grew. The project did not remain fully relevant in such cross-cutting issues that are complementary with health and education.

Effectiveness

The project overall goal and strategic objectives were fairly well achieved. Communities were empowered and participated in budgetary processes in the counties. Petitions were signed and sent to county and national level administrations on their rights to health and education. Communities were sensitized and made aware of their rights and importance of healthcare access and education for all including girls. Health awareness messages were spread in project villages and EMs improved in overall community primary health. Latrine coverage improved in project locations. School access improved and scholastic materials were received following advocacy to key stakeholders, including receiving bursaries for their children. Antenatal and postnatal care access improved in project locations. Poor health seeking behavior and negative beliefs towards healthcare access generally improved for the better.

Despite these improvements, there was still many to tackle in regard to quality of access to healthcare and education. Among some communities like Awer, a petition made to the Cabinet Secretary, Health in July 2022 for operationalisation of health care facilities which included establishing a maternity wing, presence of deployed staff in designated health facilities, supply of drugs in the facilities had not been responded to. The health care facilities, Kiyange and Mengai that served the Awer community remained closed due to lack of medical personnel and supplies. Other unforeseen issues also cropped up such as evictions in Sengwer and Ogiek Mau which hampered activities and displaced communities from their original dwellings who lost access to education for children as a result. Other cross-cutting events such as the COVID 19, insecurity in the Boni Forest and inter-community conflicts in Sengwer caused disruptions in activities. FGM and SGBV which is part and partial of women's issues in health continued to afflict the communities, further compromising the gains in health in these communities. The project did not address all corners of the community with equal needs especially in Baringo. The geographical coverage was adequate although in Baringo a larger part of the community went unserved, especially occasioned by insecurities in the area as well as fewer CHVs.

Efficiency

The project strategic collaborations/ partnerships and involvement of local community actors through their EMHRDs and CHVs on voluntary basis ensured project activities were implemented at low cost, but wide coverage although some sections of these communities with equal needs were not served probably occasioned by fewer number of volunteers per community. Other than the COVID 19 delays that led to extension at no cost, the project planned activities were generally completed on time. CHVs reported covering wider community sections, leading to some overloads and not serving the communities adequately.

Impact

Access to health and education improved in the project communities. Distance covered by communities to access healthcare reduced because of getting additional healthcare facilities or making operational those that had been abandoned for lack of healthcare personnel and lack of supplies as well as maintenance of these facilities. Medical supplies were provided to some facilities that had not received such from the Kenya Medical Supplies Authority. In the Sengwer community, a non-operational dispensary built in 2011 was renovated and operationalised after the community petitioned the county government. More than 80 patients are seeking /receiving health care services at the facility daily. Additional nurses were posted to the community health dispensaries for basic healthcare services. Women are now reporting better access to antenatal and postnatal care compared to the pre-project phase. Deliveries in the hands of

medical nurses, midwives and doctors have increased compared to pre-project period. Generally, healthcare seeking behaviour has improved among the EMs. Key stakeholders are starting to perceive the project EMHRDs positively and this is creating opportunities for the communities to tap into county budget allocations and bursaries.
In terms of education, community awareness messages have led to equal chance for girl child education, and part of the EM communities such as Awer, Sengwer and Ogiek Mau received scholarships or bursaries for education in higher institutions of learning. Advocacy effort to the county administrations led to disbursement of resources such as learning materials and school supplies in EM communities, for example ECD books and CBC textbooks were distributed to schools. Besides the project partners and the government administration as the key stakeholder, a few more partnerships were also created by OPDP during the project implementation for the support of girls' education in Ogiek Mau.

Coherence

The project was implemented in line with the constitutional provisions, policies, laws and statutes of the Kenyan government. Its interventions were perceived to be contributing to the achievements of ministry priority objectives in the Vision 2030 and its Medium-term goals. Besides, the SDG 3 and 4 were targeted by the intervention and implemented for their achievement in the country. The project was also viewed as non-confrontational and therefore ensured Do No Harm to the communities who already had vulnerabilities.

Sustainability

The project has high sustainability potential because of its participatory action-oriented approach with the community. EMHRDs and CHVs were project community members themselves, and given the capacity the project built in them, it is highly likely that the volunteers will continue to support their communities moving forward, both vertically and horizontally. County administrations have begun to embrace the gains made in these communities through advocacy for equality and rights to health and education by the EMHRDs. In spite of these, EMHRDs activities focussed less on tackling negatively impacting cross-cutting issues, for example those that are culturally masterminded such as FGM and SGBV among others, in order to maximise on the gains from the project and the positive collaborations with the local government administrations as far as right to health and education. Given the geographically diverse communities, coverage by CHVs and EMHRDs was limited in come counties, for example Baringo, and therefore without basic facilitation of EMHRDs and CHVs in mainstreaming advocacy and awareness might hamper sustainability. However, there are prospects across most of the sub-grantees to continue with such initiatives beyond the project period. County government administrations have also assimilated majority of CHVs into their community health policy programs except in Baringo where the plans are still underway.

Evaluative learning

- There were multiple positive learnings from the completed intervention, especially its community-led and community-owned implementation approach with heavy reliance on activists (EMHRDs and CHVs). The Scaling up potential is very high, and more external collaborations are still needed in order to increase access to health and education services.
- The project identification phase was consultative and issue-based. However, the design phase was less participatory, with key stakeholders of county administrations stating that there was little involvement or none. Wider stakeholder consultations were needed throughout the project cycle but there were also financial limitations for stakeholder interactions, especially that the project outcomes depended more on the willingness of county leadership and equitable county resources sharing.
- The project intervention logic was well crafted, but theory-of-change gaps did exist and needed early identification for improvement. There were opportunities for purposive learning around the Theory of Change and engagement with stakeholders through Learning Events which were not explored.
- Involvement of the EMHRDs in project implementation was more targeted for advocacy to duty bearers and decision-makers, and less structured around how they would implement awareness raising and sensitization, unlike the CHVs. There were multiple sociocultural barriers to health and education, with consequences on the project desired results but were not well contextualised for confrontation in order to maximise gains through accessing of these services.
- The project adaptive mechanism to COVID – 19 restrictions made the project implementation possible. However, the implementation was also confronted by other factors such as the abrupt evictions of the EM

communities (Ogiek Mau, Sengwer) and insecurities in the Awer community in Lamu. Some of these required budgetary resources to ensure the communities have continuous access to shelter, food, health and education in the emergencies. Unfortunately, the project scope was limited and could not be scaled to these responses. It was learned that OPDP reached out to external partners (e.g., the Kenya Red Cross, Kenya Human Rights Commission (KHRC) and other relevant stakeholders to intervene during the Mau evictions. Future project designs could usefully establish emergency response partners beforehand, and secure formal partnership agreements and institute internal budgets to secure immediate access to critical services needs by these vulnerable communities.

- Some county administrations were less responsive, especially Baringo and Narok. Extra stakeholder engagements were needed in these circumstances as a whole in order to bring decision-makers and duty-bearers closer to the communities and respond affirmatively to their demands.
- Legislators were not responsive to the project call for action on the fate of the EMs. The project needed a review of strategy to make the activity possible owing to the importance of policy direction, statutory declaration and budget prioritization for EM communities.
- Overall, the project registered significant achievements in health outputs & outcomes as well as in education. The lesson learned is that the CHV activities were more structured and integrated into county health programs, unlike advocacy on rights by EMHRDs on education. EMHRDs were also not budgeted for transport incentives for outreach activities.
- The project monitoring and evaluation staff role was essential in the project, but the evaluation learned that the post was removed from the project at the design stage at the request of EUDK.

Conclusion

The project's overall objective to improve access to health care and education for ethnic minority communities in Kenya was fairly well met, more over within a short period (3-year project). Communities have begun participation in public budget processes and holding duty bearers to account. Healthcare and education services delivery systems are starting to improve. Community primary healthcare and sanitation practices are starting to transform among others. The project advocacy and networking initiatives were mostly successful and its activity outputs were of high quality as evidenced by the knowledge on rights to health and education by the community and the EMHRDs /CHVs. The project was relevant to communities needs and was appropriate in terms of design and intervention logic even though with limitations that needed slight improvements based on emerged learnings. The project use of EMHRDs and CHVs for advancing project implementation was appropriate and efficient as it maximized outreach to the communities and leaders. However, the coverage was limited in some communities therefore some community sections felt left out. The project outcomes improved the general perception of the communities. The project's low cost locally-owned and locally-led initiatives strengthened the communities and thereby increasing chances of project sustainability. The project general and specific objectives were fairly well realised and were complementary with the Kenyan government constitutional provisions, laws and statutes. The communities are actively exploiting these provisions in the articles of the constitution, regional and international laws in regard to the EMs. The project contribution to Vision 2030 is well recognized by County Governments and National Government key stakeholders. The general impression about the project in the communities and government leadership is largely positive, and MRGI, OPDP and the EU have played a significant role in the realisation of the emerging health and education access outcomes.

In spite of these strides, it must be recognised that decades of marginalisation could not be addressed entirely in a three-year project and that the communities' access to health and education services still exists with plenty of limitations, occasioned by multiple factors especially emerging from decades of marginalization and poor representation. The prevalence rates of poverty, illiteracy, HIV/AIDS, SGBV and FGM are still very high, thereby meaning that despite the achievements in health and educational outcomes, a great deal more work remains to be done.

Recommendations

- The project intervention logic and theory of change were relevant to the achievement of project goal and project strategic objectives. However, it should have been reviewed against common practice and cross-checked regularly during implementation so that adjustments are made in time to allow for more efficient and impactful outcomes.

- MRGI and OPDP planning processes needs to be more inclusive and participatory of strategic stakeholders, specifically the Government of Kenya and County Administrations since the project success heavily depended on county allocation of essential resources and willingness to advance the cause of the EMs.
- Participatory approach in project implementation, monitoring reviews, learning visits and learning events and stakeholder feedback need to be maximised, which the project did not fully exploit.
- Project human resource capacity in the area of monitoring and evaluation was needed to ensure indicator alignment, data collection, data analysis and reporting on project progress. Learning practice needs to be purposed in project implementation for timely improvements.
- The monitoring and evaluation indicators needed to be adjusted and aligned with the SDG 3 and SDG 4, as well as the Medium-Term Plans of the National Development Agenda (Vision 2030) indicators. It would have been advantageous if the project contributions towards these goals could be easily established from the project chosen indicators (whilst retaining local ownership which should be given priority).
- Reprogramming and incentivizing EMHRDs to advocate against glaring cross-cutting issues that impact health and education access in these communities is recommended. These include campaigns against FGM, GBV, Sanitation access by CWDs, negative perception on reproductive health among others that the project was confronted with.
- Exploring opportunities and lobbying, beyond Advocacy and Awareness raising, with the government for physical infrastructural development projects would be vital in order to increase access to health and education services as the needs are still lingering in most of these communities. For example, communities are aware of their rights of access, but adequate physical medical infrastructure (admission wards) and adequate quality learning /educational infrastructure (classrooms) are visibly inadequate in most of the EM communities.
- Future interventions could explore access quality and stability besides increasing physical infrastructure in order to address the remaining gaps the completed project could not sufficiently address, as the SDGs emphasise quality of service access.

1. Introduction

1.1 Background

The Ethnic Minority communities (EM) in Kenya have a long complex history of political injustices arising from unwilful gazettement of their ancestral lands to become protected forest reserves by the colonial administration. Later administrations continued to uphold and even continue these demarcations. Marginalization, forced evictions, denial of public services, and other geopolitical and economic disadvantages continue to afflict these indigenous forest dwelling communities. Access to basic services and resources by government administrations remain limited. Recent years have seen many of these communities forcibly evicted due to environmental conservation programs. Access to healthcare and education are universal human rights, but EMs are nowhere close to these due to multiple vulnerabilities.

Kenya is a signatory to the UN Sustainable Development Goals (SDGs) and access to quality education and healthcare are among the government's key priorities, enacted through the constitution and the Vision 2030 development frameworks.

SDG3: *Ensure healthy lives and promote well-being for all at all ages (Especially targets 3.1, 3.2, 3.3, 3.4, 3.7, 3.8*).

SDG 4: *Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all* (especially target 4.5: *By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities,* ***indigenous peoples*** *and children in vulnerable situations*")

The Kenyan constitution enshrines the right to the highest achievable standard of health, including geographical access for all. Key priorities in the Health Policy include improving access to essential primary health care and ensuring that high-quality health services are available to the population. Following Kenya's switch to devolved governance in 2013, county governments have been mandated with the ownership and management of county healthcare facilities (county hospitals, health centers and dispensaries) and healthcare service delivery. In contrast, the central government, through the Ministry of Health (MoH) manages national referral hospitals, health policy and regulatory functions. The devolved governance has hardly impacted the EMs as they continue to grapple with poor health service access.

Indigenous Peoples (IPs) often rely on their traditional knowledge and herbs for treating common illnesses. With the increasing occurrence of new diseases due to global warming, EMs remain at risk given their limited healthcare access. A health assessment study by Kenya's Ministry of Health (MoH) in 2013, under the Kenya Health Sector Support Program (KHSSP) established that the majority of ethnic minorities in Kenya lack sufficient access to health services. A Fact-Finding Report (2021) by MRGI and OPDP funded within this project identified the continuing gaps in health access among the hunter gatherer EM&IP communities which are very wide, and similar findings have been documented in previous MRGI reports and publications of other partners. Further, KHSSP also argued that EMs neither participate in local health care decision-making nor in the activities of health programmes, mainly attributed to lack of capacity rather than poor policy design. The findings indicate that poverty, discrimination, low levels of education as well as lack of information significantly contributed to their poor accessibility and utilization of health services. Similarly, prevailing harmful socio-cultural practices further complicate the situation.

On the other hand, Kenya's education sector has improved rapidly. The Kenyan government has embarked on ambitious reforms that seek to improve the quality of education. For example, the Competency-Based Curriculum (CBC), Reforming Professional Teacher Development, Textbook Policy, and Management Practices emphasize the educational reforms. However, education experts observe that there is poor implementation of CBC in Kenya. Some of the reasons cited include limited infrastructure and inadequate staffing for Junior Secondary Schools[4]. As government continues to implement CBC in all counties, the EM educational facilities remain poor, distantly located, poorly resourced and with documented high teacher - pupil ratios.

The United Nations Sustainable Development Goal 4 (SDG 4) states that providing "quality education for all is fundamental to creating a peaceful and prosperous world, as education gives people the knowledge and skills that they need to stay healthy, get jobs and foster tolerance". The UN Human Rights Council Expert Mechanism on Indigenous

Peoples (EMRIP) observed that **deprivation of access to quality education** is a major contributing factor to social marginalization, poverty and dispossession of indigenous peoples.[1] EMs children do not access pre-school and early education. Child-centred pedagogical methods including developmental play, socialization and nutrition, would provide a better basis for learning, but only exist in a few private centres more likely to be found in urban areas.[2] The 2012/13 Service Delivery Indicator (SDI) study found that in Kenya, low content knowledge, teacher absenteeism, and low time on task impact learning outcomes.

Therefore, the realization of SDGs 3 and SDG 4, as well as Vision 2030 Health and Education Goals are a challenge among the EMs given the above contexts unless deliberate interventions are instituted to address these gaps in service.

1.2 Purpose and Objectives of the project

Minority Rights Group International (MRGI) and the Ogiek Peoples Development Programme (OPDP) implemented a 3-year project (2021-2023) named "*Ethnic Minority Defenders: Amplifying the voices of indigenous human rights defenders to advocate for the rights to health & education"* to improve access to quality health care and education for ethnic minority communities in Kenya, reinforcing social and economic rights and strengthening of capacity of EM communities and rights defenders to monitor and advocate for their education and health rights.

Project Specific Objective: To strengthen ethnic minority human rights defenders (EMHRDs) from Ogiek Mau, Ogiek Elgon, Sengwer, Endorois and Awer to effectively advocate and secure equal access to quality health care and education for EM in Kenya.

The project involved 4 sub-grantee community-based organisations operating in 6 counties of Lamu, Nakuru, Narok, Bungoma, Elgeyo Marakwet, and Baringo where the Awer, Ogiek Mau, Ogie Mt. Elgon, Sengwer, and Endorois EMs live. The project aimed to systematically tackle the root causes of community marginalization, striving to create an environment conducive to the effective realization of SDGs. Its main objective was to improve access to quality health care and education for ethnic minority (EM) communities in Kenya.

Strategic interventions earmarked to achieve these objectives included:

- Increase knowledge, awareness and capacities of EMHRDs and members of targeted EM to understand regional, national and international laws/policies relevant to the implementation of their right to equal access to health and education.
- Increase participation of targeted EM in annual county, national and regional budget development processes on health and education.
- Increase psycho-social support to address stigma and improve access to health for community members of targeted EM.
- Increase networking within EMHRD grassroots movement and with national, regional and international activists on policy formulation & EM rights advocacy.

The project was funded by European Union Delegation to Kenya (EUDK) with a total budget of **€463,868.76**.

1.3 Purpose and Objectives of the End-term Evaluation

Following the completion of the project in August 2023, an external evaluation was instituted to assess the achievement of project objectives and document learning from the implementation and suggest recommendations to partners for future programming.

1.3.1 Specific Objectives of the Evaluation

The following specific objectives guided the Final Evaluation:

1 https://www.ohchr.org/EN/NewsEvents/Pages/QualityEducationForIndigenousPeoples.aspx

2 Ministry of Public Health and Sanitation, 2013, Final Report for Development of Vulnerable and Marginalized Peoples plans, Government of Kenya, page 39

a) Assess the relevance, efficiency, effectiveness, sustainability and impact of the project in relation to the objectives and supporting outputs set out in the proposal documentation;
b) Provide MRG with an opportunity for 'structured evaluative learning', with the aim of learning from the design and implementation process.
c) Make recommendations to any other stakeholders as appropriate.

2. Evaluation Approach and Methodology

2.1 Approach

The evaluation adopted a qualitative mixed methods approach for data collection. The evaluation combined DAC (Development Assistance Committee) evaluation criteria and Outcome Harvesting approaches for fulfilment of the evaluation objectives. DAC criteria was instrumental in assessing the Relevance, Effectiveness, Efficiency, Impact and Sustainability of the project. Outcome harvesting was essential in understanding the outcomes and what exactly led to these outcomes from the advocacy and awareness initiatives. Various qualitative methods of field data collection were employed i.e., Focus Groups Discussions with communities, In-depth Interviews with EMHRDs and CHVs, and Key Informant Interviews with key stakeholders (ward administrators, public health officers and other health practitioners, community chiefs, implementing partners' project staff, project staff of sub-grantees). Secondary data especially from project documents were also reviewed to cross-check evaluation findings with baseline and progress review report findings.

2.2 Study locations, participants, data collection methods and tools

Table 1: Sampling Frame – Qualitative Primary Data Collection

Target Group	Location of Sampled Interviews	Sample Size	Sampling Technique	Data Collection Method
1. Project Communities				
▪ Endorois	Kamar in Baringo	13 (40%m, 60%f, 30% youth, 10% PWD)	Purposive & quota sampling	FGD
▪ Ogiek Mau	Nessuit, Njoro in Nakuru	10 (20%m, 80%f, 20% youth, 0% PWD)	Purposive & quota sampling	FGD
▪ Sengwer	Tangul, Kapyego Ward in Elgeyo Marakwet	15 (45%m, 55%f, 40% youth, 5% PWD)	Purposive & quota sampling	FGD
NOT SAMPLED (Ogiek Chepkitale (Mt Elgon) and Awer)		40% of Total Communities		
2. EMHRD /CHVs				
▪ Endorois	Kamar, Baringo	3 (30%m, 70%f) (2-HRD, 1 CHV)	Purposive	In depth interview
▪ Ogiek Mau	Nessuit, Nakuru	6 (33%m, 67%f) (3-CHV, 3-HRD)	Purposive	In depth interview
	Narok North in Narok (Telephone)	1 (100%m, 0%f) (1-HRD)	Purposive	In depth interview
▪ Sengwer	Tangul, Kapyego, Elgeyo Marakwet	8 (30%m, 70%f) (4-CHV, 4-HRD)	Purposive	In depth interview
▪ Ogiek Mt. Elgon	Bungoma (Telephone)	1 (100%m, 0%f) (1-HRD)	Purposive	In depth interview
▪ Awer	Lamu (Telephone)	2 (50%m, 50%f) (1-HRD, 1-CHV)	Purposive	In depth interview
NOT SAMPLED	NONE	0% of Total Locations		
3. Key stakeholders	Baringo	-Sub-county education director	Purposive	Key informant interview

		-Ward Administrator -Chief Kamar -Assistant Chief Kamar - 2 Medical practitioners (Kamar Dispensary)		
	Nakuru	-Public Health Officer, Njoro Subcounty -Ward Admin, Nessuit Ward	Purposive	Key informant interview
	Elgeyo Marakwet	- PHO - 2 Nurses - 2 Teachers - Ward Admin Rep	Purposive	Key informant interview
NOT SAMPLED (Ogiek Chepkitale (Mt Elgon) and Awer)		40% of Total Communities		
4. Sub-Grantee Staff				
Endorois Welfare Council (EWC)		3 (CEO, 1-Project Officer (PO), 1-Project Admin)	Purposive	Key informant interview
Tirap Youth Trust (TYT)		1 (CEO)	Purposive	Key informant interview
Sengwer of Embobut Community Based Organization (SEECBO)		2 (CEO, PO)	Purposive	Key informant interview
Awer Community Conservancy (ACC)		2 (CEO)	Purposive	Key informant interview
NOT SAMPLED		0% of Total Sub-grantees		
5. Implementing Partner Staff				
OPDP		3 (CEO, Coordinator, Administrator)	Purposive	Key informant interview
6. Main Applicant Staff				
MRG – Africa Region		3 (Regional Manager, Project Manager, Project Assistant)	Purposive	Key informant interview
7. Development Partner /Donor				
EU Delegation to the Republic of Kenya		2 Staff		

Besides primary data, multiple sources of secondary data were explored, mostly project documents and/or progress review reports, including but not limited to the final project proposal document (description of the action), Log frame, Fact Finding Report, ROM Report, Annual Reports (narrative), line ministry reports to mention but a few.

2.3 Data analysis technique

Data was analysed based on content from across the different primary sources and complemented with secondary information where it was necessary. Identifying important themes and patterns relating to education and health outcomes of the indigenous communities was employed and discussed. Outcomes reported from different sources were cross-checked and verified before including into the report as required of OH approach. The findings were organised based on the DAC Evaluation Criteria of Relevance, Effectiveness, Efficiency, Impact and Sustainability.

Context analysis was employed in analysing factors that contributed to observed outcomes such as social, cultural, economic, environmental and political factors that influenced education and health outputs /outcomes of the project and their overall effect on desired impacts.

2.4 Evaluation Delimitations

The community-based field data collection locations were remote and in hard-to-reach areas by road. Even though the consultants desired to interview a sufficient number of community members in double FGDs per county and at least all EMHRDs, it was logistically impossible given the distance to reach these communities. The sub-grantee organisations mobilised the communities, EMHRDs, CHVs and key informants into a common location where the interviews, FGDs and KIIs were contacted in parallel by the Consultants and Research Assistants. Communities that were not sampled were represented through their EMHRDs and telephone interviews were adopted for such discussions. To overcome the challenge of traversing long distances, the respondents were mobilised to central grounds such a local administration centre (Endorois met at Kamar Chief's camp), Ogiek of Mau (met at one of the homes of the community members), Sengwer (met at Tangul School ground). Among those interviewed on phone, the evaluation team were flexible during interviews, they took longer and also extended beyond the stipulated field schedule to ensure those scheduled for interviews were reached.

Despite some of these shortcomings, the evaluators remained adaptive and flexible, and with the continuous coordination by sub-grantees and OPDP, the data collection process was successful.

3. Evaluation Findings

This section presents the evaluation findings on Relevance, Efficiency, Effectiveness, Impact, Cross-Cutting Issues, Coherence, and Sustainability.

3.1 Relevance

Project Initiatives vs Community Needs

The project strategic actions were geared towards an empowered community capable of demanding their rights to education and health services and holding duty-bearers and decision makers to account. These were aimed at addressing the pertinent educational and health service needs gaps among target beneficiaries following their decades of geopolitical and economic marginalization. The evaluation assessed that there were shared challenges across the project communities. For example:

A community member in Sengwer expressed:

> *'Recently there was recruitment at county level for nurses, KWS rangers and Junior secondary school teachers. We only had one youth taken as an intern Junior secondary school teacher. The rest were left even though they are qualified. Even with all the efforts we have made in lobbying for equality in education and health, we still feel vulnerable and marginalized.'* Community member in Sengwer.

An Ogiek Mau community member expressed:

> *'Even when we attend the public participation meeting and air our issues, they are never implemented. One time we requested for a road and instead of bringing the road to our community after it was included in the county government allocation plan, we later heard the road was constructed in another community where the majority Kipsigis are'.*

Another Ogiek member added:

'We now know how to advocate for our issues, but to be sincere, who will listen to us, the Member of County Assembly (MCA) is not from our community, neither is the area Member of Parliament, look around even the power lines just go past our village, nobody has made the effort to ensure that the power comes to our village'?

An EMHRD from the Endorois community stated:

'Even when they invite us to share our issues in national events, we feel it's just superficial, and sometimes we are not even given an audience, their aim is to report that we were in the event'.

Interviews and focus groups in project counties established that before the project, primary healthcare services were largely lacking or insufficient, food and waterborne diseases were common among the populations. Healthcare centres were either far away from communities' reach, understaffed, understocked with supplies and equipment, dispensaries were limited in capacity, or dysfunctional. Traditional herbs served the majority of treatment needs, and healthcare seeking behavior was low, thereby leading to prevalence of preventable & treatable diseases such as Tuberculosis (TB) and HIV/AIDS among others.

A community CHV in Awer expressed:

"Outsiders are like 'white rhino', they are never seen, but apparently, they are on government payroll and appear in the records as medical staff posted in Awer community. They are very active on paper, but not on the ground.'

One EMHRD expressed:

'We did a very good job assessing our situation, highlighting the issues around health and education and presented them to the county government, but they did nothing! It's very frustrating! We still do not have equipped health centers, the women cannot deliver safely and with dignity, maybe in future we shall have the community members themselves, and not EWC, to present these issues and see if we get a better response as it is easier for the community to hold their area MP accountable compared to EWC.'

Cultural beliefs of what men can do or cannot do influenced their attitude towards medical care access. In some communities such as the Endorois, it was perceived to be a sign of weakness for a man to go to the hospital as it is something meant for children and women. Women delivered mostly in the hands of traditional birth attendants, while negative cultural ego prevented access to healthcare for some who believed they cannot be attended by uncircumcised midwifes or in the hands of male nurses /midwives as is a taboo. For example, in the Endorois community, it was learned that some women could not visit the nearby dispensary for delivery as the only two (2) nurses at the facility were male. Communities were unresponsive and mostly unaware about the importance of reproductive healthcare.

Community discussions underscored that in educational access, children were walking for long distances to access available Early Childhood Development Education (ECDE) and primary schools, some estimating as far as 5km or more to reach school, making it impossible for the young ones (4-6-year-olds). Teacher pupil ratios were very poor as classes were crowded, with poor infrastructure and lacking essential learning materials. Girls were not prioritized in furthering their education as they were believed to be sources of dowry for parents, and early /forced marriages characterized these communities.

The evaluation confirms that the objective to strengthen ethnic minority human rights defenders (EMHRDs) (and CHVs) from these communities to effectively advocate and secure equal access to quality health care and education for the EMs was relevant to needs or gaps, irrespective of whether these were felt or unfelt, responded to or not.

A government Key Informant in Endorois Community expressed:

"Communities where EWC had a presence, their presentation in the public participation forums came organized and with their issues clearly articulated. They were more confident when presenting their issues

compared to other communities, where they could openly differ over issues that they were presenting and were disorganized. The project was indeed the right one for the community".

Interviews with community HRDs and CHVs revealed that increasing their knowledge, awareness and understanding on the regional, national and international laws on right of access to health and education was very useful. It assisted them in mobilizing the communities for joint action in seeking for these rights without any fear of contradiction despite some negative attitudes by government officers because of what they perceive (communities seeking land rights). Some attested that the trainings they received from the project on budget processes and public participation were eye opening as it enabled them to press for a share of revenue allocations for their community. Trainings received by CHVs also empowered them for community outreach and counselling, as it enhanced their confidence in articulating healthcare concerns and education to their people. The participation of EMHRDs in national, regional and international conventions on human and environmental rights, as well as rights of ethnic minority communities broadened their understanding to articulate their challenges national, regional and international conventions on human rights and EM groups. In the words of some HRDs, the evaluation cites:

EMHRD in Sengwer expressed:

'We now have knowledge on our rights to Education and Health as enshrined in the constitution'. We were ignorant and we didn't know our rights. In the last ten years or so since the devolution was ushered, I have never participated on issues of government budgetary planning until the project came. We went for public participation in December during county government education budget planning. You cannot go for such public participation unless you are aware of your education rights'

A EMHRD stated:

'After understanding that we were entitled to quality education and healthcare I became very zealous knowing that we had been deliberately neglected, oppressed and marginalized for too long! That is why whenever an opportunity arises, I attend the forum where I can highlight the plight of the people of Endorois community'.

A CHV in Awer community expressed*:*

'Before the trainings I did not have the courage to stand in this community and speak. I did not even have anything to talk about. But after the training, I can now address 100+ people and talk to them on issues pertaining to health, sanitation, managing TB and HIV stigma among others.'

The project success pivotally depended on the roles played by these EMHRDs and CHVs who served as community activists and catalysts for change in health and education access for EM communities. The evaluation learned that their various advocacy activities, such as petitioning of duty bearers on education and health rights was embraced by the communities who gave willing support. CHVs' activities on essential psychosocial counselling services, awareness raising on health and rights, as well as information dissemination were well met by the communities they represent. Above all the messages were conveyed by their own daughters and sons from within the community, thereby making it more relevant. The same was attested to by key stakeholders met during the evaluation.

The final beneficiaries and local leaders backed the project initiatives by playing significant roles through supporting its implementation, for example permitting EMHRDs /CHVs to address the community over these rights issues and health education in funerals, religious gatherings, chief's Barazas and other community forums. They also influenced through direct action /investment, for example, community fundraising for school construction and land donations for educational purposes in the Ogiek Mau; community financial support of a volunteer nurse and 3 ECDE teachers in Tangul dispensary and Tangul ECD school; volunteering of community youth group in Endorois in digging pit latrines for homesteads that cannot afford among others, therefore implying that there was local ownership by the beneficiary communities across the five (5) project communities important for sustainability.

Project Theory of Change

The intervention logic strategically aligned with the needs and priorities of the target beneficiaries. These needs were also within the priorities of MRGI, OPDP, subgrantees, as well as within government health and education sector priorities, not forgetting its alignment with European Union's priorities with the Kenyan Government. The theory of action was pertinent and capable of influencing access to health and education services by the ethnic minorities. Its endeavours to reinforce community empowerment and public participation, especially in county planning and budgeting processes, coupled with its focus on rights-based advocacy were all credible in preparing communities for their own action against historical injustices and denial of rights to access to health and education.

The three pillars of the project initiative in the community were: 1) Awareness Raising on national, regional and international laws regarding right of access to education and health; 2) Capacity Building to demand for their rights and social action for change; and 3) Community Participation in Public Budget Processes, whose combined net effect was positive reinforcement of project ownership, inclusion, empowerment and sustainable action towards overall project goals. The project awakened the knowledge of stakeholders on the state of health and education services through them.

The project's Fact-Finding Report (2021) was widely disseminated with stakeholders, from grassroots communities to decision-makers /duty bearers, whose objective was to sensitise or act as an eye-opener for community needs realization and to engage duty bearers and decision makers constructively for action on the fate of the EMs. This was largely achieved, and it paved way for the EMHRDs to engage duty bearers /decision makers based on this evidence and which was widely perceived by key stakeholders as non-confrontational, sincere and articulate. This enabled some of the EMHRDs to successfully lobby and attract development interventions to their respective areas.

a) Awareness raising and Capacity building:

MRGI and OPDP leveraged on their knowledge and extensive experience in serving these communities from previous projects, and therefore chose cautious interventions, guided sub-grantees professionally to deliver on behalf of their communities. This was vital given the lean project budget for diverse communities, implemented through semi-autonomous community-based organisations (sub-grantees). MRGI and OPDP had implemented projects in these communities on land rights through EMHRDs, and thereby relied on the competencies of these change actors, built more capacity in them and CHVs to get them involved in capacity building and awareness raising in the communities on Health and Education rights; as well as mobilising the communities in advocacy and participation in demanding for their constitutional rights. Relying on the already existing structures and experience of the sub-grantee EMHRDs was strategic and appropriate in the project design and implementation. Additionally, this being EU's second intervention funded through the same IPs among the ethnic minorities in Kenya, and the transition from land rights advocacy to advocacy on health and education was a well interlinked integration. The five (5) CBOs also had shared objective anchored on strategic missions of respective sub-grantees prior to this project. The institutional, human and financial capacities and experiences of MRGI, OPDP and sub-grantees summed the success of coordination and capacity building of sub-grantees. Overall, the knowledge and capacity of the EMHRDs and CHVs was well attested in the project and resulted into successful implementation of project planned activities.

Despite the capacity building efforts of sub-grantee CBOs, it was learned that Awer Community Conservancy (ACC) had limited capacity especially in financial reporting which led to general delay at times on the side of MRG who was to share interim reports with European Union Delegation Kenya (EUDK). The ACC staff needed a more intense and structured training for their staff, including taking professional courses to achieve optimal performance and efficiency in the partnership with MRGI and OPDP.

b) Stakeholder participation:

The project initial stages were consultative and needs gaps were obtained from the communities themselves. Interaction with stakeholders revealed that there were perceived gaps in project design and implementation. Even though the project was crafted on expert knowledge of MRGI and OPDP on the plight of the EMs, it was not completely consultative and participatory in designing and deciding implementation budget. Despite this gap, sub-grantee partners embraced what was designed and implemented as per the guidelines in the agreements. OPDP, the local implementing partner had lesser role in supervising budget implementation and decision-collaboration if there were any challenges. Key stakeholders of county governments stated that they were not consulted in the design despite appreciating the

initiatives. Given that the project was targeting decision-makers and duty bearers with advocacy, it was necessary to contribute complementary ideas in design and suggest technical inputs if there were any. For example, an interview with a government health practitioner revealed that the duration of CHV Training Courses he helped to facilitate were rather short (3-days) and the standard practice to cover a training content for CHV trainings is spans 2-weeks for adequate knowledge transmission. Therefore, some sessions were rushed and not commensurate with the government standards for training Community Health Promoters (CHP) in Kenya. Government key stakeholders were hardly felt in project progress reviews and decision-making during the implementation. Therefore, the project design and implementation were less participatory as far as key (government) stakeholders on whom the project success partly depended.

Activities designed targeting policy makers at the national level were not feasible, although their intended purposes were pretty important as far as legislation and budget allocation for the EMs. Complexities arose and the legislators were non-responsive to the project team's calls for meetings. In an interview with the CEO OPDP, it was highlighted that emails sent to the parliamentarians were mostly not replied to. The project needed to rethink alternative ways of reaching Members of County Assembly (MCA), County Senators, and Members of Parliament (MP) after submission of petitions.

The project budgeted for CHV community counselling activities but lacked the same for EMHRDs for community education on rights, community mobilization for public participation in budgetary processes, and other community-based education themes such as girls' and boys' education and prevention of early marriages, forced marriages, early pregnancies, and FGM practices among others. The advocacy budget for HRD activities was vertical looking, targeting advocacy to key stakeholders at national and international level thereby leaving to chance the vulnerable girls and young mothers to the vagaries of negative culture and practice, which are suppressive to educational outcomes such as retention, completion and transition of vulnerable school children and young youths. It was never clear among EMHRDs how their community-based activities were structured around the project objectives as they mostly articulated advocacy efforts to duty bearers and decision makers, less on community initiatives.

The Project Design Frame:

As far as the project design frame, the interlinkages between results and activities look plausible. However, it requires significant improvements in areas where it did not maximise, including but not limited to: right alignment of preconditions to results, results-based budgets (than activity-based) and reviewing of performance indicators against targets from baseline, performance monitoring plan (with sufficient budget), right level of M&E staffing & skilling, regular monitoring reports and learning events organized for stakeholder feedback, fair and sufficient budgets for learning events, periodically reviewed ToC, EMHRDs to have advocacy and awareness milestones that are budgeted. While the narratives in the baseline column in the results frame look useful, it would have been easier to limit the wording and maintain the value of the proposed indicator for the respective result at baseline. Without this, the follow-up on the horizontal relationship between a result, its indicator(s), baseline, target and actual becomes complex as they were not well-aligned. The column for achievements were left unpopulated in the results frame until the end of the project, thereby making summary reporting on performance difficult as the narrative report formats are large and hard to sum up on specific achievements in the project, overall, without going into the details. Most of the indicators were quantitative and had targets to be achieved by the project. The monitoring and reporting practice and overall structure needed an improvement, and easy dashboards for stakeholders to interact where need be, with monitoring reports per visiting period without pre-emptying technical details which are mostly a requirement in annual monitoring review reports. Besides, the indicators selected to track goal level results were vague and impractical to track SGD 3 & 4 results, and indicators selected for outcome level results were equally unsuitable. They were mostly suited for tracking output level results as opposed to impact and outcome level results that the project chose to pursue. The project design needed to make reference to the SDG standard indicators or the Medium-Term Plans Kenya Vision 2030 indicators and modify according to project needs as would be practical. All interventions at grassroots levels feed into the same national, regional and international development goals and there must be a way of how this particular project aligned with the measurement of the indicators of the development goals as their achievement is registered at the grassroots first, then national, regional and internationally.

Project Implementation Structure

The five communities were primarily served by their respective CBOs who benefited from the sub-granting, with the overall coordination roles played by MRG and OPDP. Implementation was similarly structured and with equal budgets across the five sub-grantees. Therefore, the implementation model was similar and activities the same.

The project encountered a challenge in recruiting a sub-grantee applicant from the Ogiek of Chepkitale, but resorted to working directly with HRDs and CHVs under the supervision of OPDP. The HRDs and CHVs from Ogiek of Chepkitale were involved in all capacity building, networking, advocacy at the National and African Commission level activities but no sub-grantee was selected from the community because they never applied. Their budgets were therefore directly coordinated from Nakuru at the OPDP office, unlike other sub-grantees who had sub-contracts with MRGI and were receiving their project funds directly. The project also recruited a replacement sub-grantee in Ogiek Mau since Prohome CBO that was the applicant was incapable of sticking to the contractual obligations and financial rules /regulations. Tirap Youth Trust (TYT) was therefore entrusted with the implementation responsibilities. Although relatively newly established, TYT continued with project activities in Nakuru and Narok, while OPDP closely coordinated their activities from within their Nakuru office.

Similarly, there was no suitable sub-grantee CBO in Awer, and the project opted to onboard Awer Community Conservancy (ACC) known for conservancy initiatives in the Boni forest. Insecurities in Awer were largely an obstacle, and most of project actions were implemented under difficult conditions. Coupled with capacity gaps, the project persisted to implement activities with minimal physical interaction with the community from the IPs but still achieved desired results.

The rest of the sites were similar in implementation although common limitations faced operations, such as forced evictions during the project implementation; For example, the Ogiek Mau and Sengwer Community in Embobut. Operating in these contexts compromised project implementation, quality and effectiveness in results as communities were displaced from their original places, further constraining access to health and education services. In these contexts, it was rather difficult to continue with normal project activities than to attend to emerging needs of the project primary beneficiaries such as needs for food, shelter, water, and other essentials such as education and healthcare access services in the emergency context. The project could not scale into these areas adequately due to scope limitation and budget constraints. Therefore, such interruptions compromised program success and watered-down contribution to strategic results from the advocacy and awareness activities.

3.2 Efficiency

Institutional coordination

The project implementation and coordination structures were generally appropriate and empowering especially to the sub-grantees as everyone had a share of responsibility for their community's change. On the other hand, MRGI signed contracts with sub-grantees while OPDP as the local IP did not have any direct supervisory role with the sub-grantees regarding budget requisition, approval and monitoring of budget implementation. Whereas this approach was generally-acceptable given they had no direct role on budget implementation, it did not inspire transparency in OPDP as a partner having a joint role of coordinating sub-grantee activities, sharing of lessons and successes which would otherwise be empowering to them. The communication structure agreed upon between MRGI and the partners was that the grantee was to facilitate all communication about the project with EUDK. This limited close interaction between EUDK and OPDP as the local IP and the local sub-grantees in bargaining for extension of services that had not been well expressed during drafting of initial proposals owing to their capacity to handle such a grant.

Activity-based budgeting and periodic approvals for signed activities by sub-grantees did not enable flexibility in scaling up activities where opportunities were ripe for maximizing on results depending on emerging contexts.

OPDP stated:

'Funding for scheduled project activities was based on reporting of milestones, and whenever funds delayed, most likely due to bureaucracies, it became difficult to report on time for the next funding period'.

Sub-grantees expressed that this approach was restrictive and did not permit them to be flexible on activities they had not selected for the signed period. It was reported that at times funds release by MRGI was delayed as was also noted in the ROM report, possibly due to obvious admin approval processes, but such affected the timely delivery of planned activities by sub-grantees.

Learning and Adaptation

In-depth Interviews with EMHRDs and IPs reveals that the Bootcamp (2021) held with 50 EMHRDs in Naivasha helped in opening opportunities for exploring new ways of implementing their already planned activities and how these would be mainstreamed for project strategic results. EMHRDs and sub-grantee staff highlight that such interactions enabled them to realise the potential to hold duty bearers to account and demand for their rights, and hence better services access by their communities.

One EMHRD in Endorois Community stated:

"The bootcamp held in Naivasha gave us an opportunity to exchange ideas and share challenges faced by each of our communities. We realized what we are facing is not unique to us, and other vulnerable EM communities elsewhere are also experiencing these things. We resolved to keep in the network as long as our struggles still continue and support each other whenever we can".

Sub-grantee organizations praised the training conducted for EMHRDs and CHVs on relevant topics that enhanced their advocacy service delivery and counselling. However, inefficiencies were registered in reporting from some select sub-grantees, which was attributed to capacity gaps especially with ACC. It was reported that they at times delayed completion of their annual reports for MRG to finish in time since their narrative and financial reports needed an extra touch especially where good achievements could not be properly reported on. Such delays led to inefficiencies in report submission to the EU. Extra skills preparation /training was going to assist ACC staff beyond what the project accomplished.

Some activities did not take place at all due to getting hold of the parliamentarians. The office of the Clerk at the National Assembly made matters worse by not responding to emails to effectively and organizing advocacy meetings with relevant committees. Some activities were also delayed in year 1 and year 2, especially by COVID 19. Sub-grantees also highlighted that the budget allocation on priority activities were generally very low compared to the complex operational context in their communities. More would have been achieved in the project if the budget priority activities were revised and reallocated. The budgeting was more of activity-looking than results-based and with less participation of sub-grantees since they were recruited post project proposal acceptance. Interview with OPDP also established that the call from the EU needed to be responded to and accepted before raising expectations from sub-grantees as the call was competitive. Similarly overheads were reportedly higher than were budgeted, exacerbated by the global inflation firstly due to the COVID 19 and the Russia – Ukraine War.

Partners' Experience and Competencies

The collaborative strength and partnership with local CBOs in the five (5) communities was anchored on the shared objectives and strategic mission alignment of sub-grantee organizations [e.g., 1, 2, 3] with whom they have had previous working relations, especially on advocacy for land rights. The institutional, human and financial capacities and experiences of MRGI, OPDP and sub-grantees summed to the successful implementation and coordination. IPs' capacity building of sub-grantees, EMHRDs and CHVs led to efficiencies, as was reported that most of the partners implemented activities on time and completed reports for sharing in time, except for ACC that had unique challenges.

MRGI has many years of operational, human and financial management experience in delivering on similar interventions. OPDP on the other hand has had multiple years of EM program management experience and have led the hunter-

gatherers in coordinating other programs in the network before, and they demonstrated their competence in the just completed project. The joint institutional strengths and competencies led to the success of the project.

Sub-grantee Organizations also demonstrated that they had the capacity to deliver on the project, and this was proven by the multiple community-based activities, advocacy on their rights to key stakeholders, and coordination of all contractually agreed tasks and responsibilities with MRGI. It was learned that those without these capabilities were either suspended/dropped as was the case with Prohome CBO, or their capacity built, like ACC whose primary mandate is conservation in the Boni Forest, but were empowered to oversee the implementation of the health and education project among the Awer community.

The training and capacity building offered to 50 EMHRDs and 25 CHVs imparted knowledge and skills in these volunteers, who then championed the implementation of strategic activities including health awareness raising, counselling, advocacy on education and health rights, mobilization of communities to demand for these rights, and delivering of advocacy messages to stakeholders for equitable share of county resources as well as articulating their issues to national and international actors.

Timeliness of Activities

The COVID 19 outbreak-imposed delays on the project scheduled activities in Year 1, causing delays of up to 3 months, and the restrictions in movement and public gathering posed a challenge that required MRGI and OPDP to adjust methodologically to some extent. Coordination was channelled through Social Media WhatsApp groups, Zoom/TEAMs meetings, emails, telephones and radios which led to relative efficiency despite the lockdown and restrictions in public gatherings.

Unforeseen budget constraints during implementation

The evaluation found that community needs kept evolving and yet there was no budget to tackle some of these needs. CHVs EMHRDs wanted the project to scale to areas where it had not earmarked activities, but budget restrictions rendered the plan nonreceptive. Communities had land right as their main priority need, but the project was not able to address the land rights as a cross-cutting issue and support displaced peoples, given the budget was limited already and underbudgeted for the project determined activities. Scholarship needs grew exponentially during the project but there was no allocation for such to be incorporated as another cross-cutting theme.

Key activities such as regular monitoring visits by OPDP/MRG occurred but occasionally. Follow-up visits with stakeholders nor organizing of learning events for stakeholder learning and feedback were not accomplished as there was no budget.

Reimbursements to CHVs would at times delay up to 3 weeks, according to in-depth interviews with some of them, and this was demotivating although they maintained their momentum to complete scheduled community outreaches. EMHRDs were not budgeted for community activities' stipends, as they were overshadowed by the assumption that they were already on another project on Land Rights funded by the same EU which came to an end much before the completed intervention on education and health rights. Even though EMHRDs did appreciate the commitments in supporting them for advocacy works, it was not heard of how the structured horizontal awareness raising and advocacy was happening without being offered stipends.

Resources Maximization (human, financial, other)

The project maximised the use of financial resources despite sub-grantees stating that budgets were low for prioritized activities. This was attested by the completion of advocacy and awareness raising campaigns of the project and the realization of desired results even though there were limitations in budget for critical activities.

EMHRDs despite lacking stipends endured to deliver on project activities and this was plausible. Interviews with them revealed that the knowledge and skills they have received from this project is a motivator for them and they remained resolute in delivering for the sake of their community. Meaning that even though the stipend was required, they made dedicated sacrifices in order to deliver on the project despite this not being in the budget plan.

Alternatives for resources maximization
EMHRDs needed to be allocated stipends especially for community awareness, mobilization and follow-up on rights to education and health along sides the CHVs. Through this allocation, the project would have probably seen more educational outcomes, especially for the most vulnerable (girls and Children living with Disabilities) and improved enrolment, retention, completion and transition.

3.3 Effectiveness

Achievement of overall and strategic objectives
The project overall objective was to improve access to quality health care and education for ethnic minority (EM) communities in Kenya. Different data sources indicate that the project made strides towards the realisation of the overall objective though with some limitations.

In all project communities it was affirmative that the project enhanced access to education and health but quality-wise was not adequate due to multiple salient gaps. It was generally reported that the communities had embraced prenatal and postnatal care visits; more women are delivering at a medical facility than in the hands of traditional birth attendants; healthcare service seeking behaviour has generally improved and communities are making rapid shift from traditional herbs to modern medicine; women are embracing reproductive health practices and child spacing; HIV /AIDS treatment and antiretroviral access exists for those who need it: some dysfunctional medical facilities were upgraded and made functional, for example, the Tangul dispensary in Kapyego ward in Sengwer community was reopened after petitioning; Medicine supplies by KEMSA (Kenya Medical Services Authority) and restocking of health facilities among others took place.

For example, in the Awer Community a CHV reported:

> *'Women are now more empowered to take care of their children and seek ANC and family planning services, as they have men supporting them. Initially men were against family planning, but we continued talking to them, and we have seen positive responses. This was after reaching out to the men through family meetings'*

Educational access is starting to transform, and equal opportunity is accorded for both girls and boys, as well as for children living with disabilities (CWD); community girls received scholarships from the county education departments and other alternative sources; some educational infrastructure facilities were established during the project period and more is being sought by the EMHRDs to mention but a few.

However, challenges still persist. For example, in the Endorois community, it was learned that the only Kamar dispensary offered basic treatment services but lacked an admission ward and maternity wing. There were limited medical supplies, and there was no refrigeration facility for keeping certain drugs /medicines which lose potency if kept unrefrigerated, e.g., venom gel for treating snakebites (the area is reportedly highly infested) and snake bites are common. Some of the community members still travelled for long distances to access medical care at the facility. The only health centre with admission and maternity services was Mogotio Hospital which is 50km away from the community. There is no ambulance at the Kamar dispensary to rush patients in critical condition unless it is called from the Mogotio hospital. Worst still, most of the road network to the dispensary was very poor and about 40km of the stretch from the dispensary is in bad state. Kamar ward where the Endorois project community resides has poor mobile network connectivity, this compromised handling of health-related emergency cases. A nurse stationed at Kamar dispensary reported that they often experienced crises when they encountered complicated labours since they cannot handle such cases at their facility. The health facility also lacked a maternity wing which discouraged women from visiting for assisted delivery.

In the Awer Community, the insecurity situation led to displacement of medical staff at the local facility, thereby rendering it dysfunctional. Medical services are sought from the Kenya Forest Service facility where it is critical. The

communities still experience the challenge of poor road infrastructure, poor telecommunication network and insecurity, thereby rendering access to quality healthcare an almost impossible task.

A CHV expressed:

> *'One time we called for help for a woman who had been in labor for 3 days, a chopper was sent to get her, but it was too late, the fetus did not make it. The gains on health are yet to be seen especially where it requires intervention from the county and national government.'*

In educational access, it was reported that the number of ECDE centres are limited, have fewer teachers, and long distances are travelled by children, which again leads to poor retention and completion. The drop-out rates are high, especially attributed to pre-primary age due to distance, and by the time the child joins school when he/she is capable of covering the distance it is too late to concentrate in school and complete all levels. Therefore, they are easily distracted from schooling to income generating ventures, and girls get married off early. The forceful evictions were also affecting communities' children educational access, rendering displaced families helpless e.g., the recent Ogiek Mau evictions and property destruction including the community funded primary school.

In spite of these, the evaluation found that the overall and specific objectives of the project were generally met. It was found that a couple of petitions were made to the county responsible departments of which some were successful. For example:

In Sengwer community, they successfully petitioned and were granted allocations to health and education worth about €39,000 for additional classrooms in Tangul Primary, and construction of staff quarter for accommodation of medical staff at the dispensary. School suppliers were also received in many ECDE schools from across the communities after petitioning.

Ogiek of Mau advocacy activities led to improvement of road infrastructure in the locality with the road from Njoro to Mariashoni being tarmacked. Among the Endorois community, the community lobbied for relocation and rebuilding of a dispensary that had been submerged during flooding in Baringo East and this was achieved.

Among the Awer, community, they petitioned the government and secured bursaries for 150 girls, who received Kes 27,000 each. A boarding primary school, Mukowe R.C also received 6,000 shillings per pupil, the school receives pupils form Mukowe primary which is a day school for class 1 to 5, and then from class 6 they move to the boarding school. Additionally, 60 students were also supported to study handicraft courses in polytechnics. The Awer community petitioned to have a handicraft technical college in the community, but this request has not been honoured.

The Endorois people petitioned the county government to provide assistance to the People with Disability by facilitating them to generate a livelihood. The county government addressed the issue by providing assortment of items in support of people with disability. The county provided sewing machines, livestock, welding tools and wheelchairs to 14 people from the area where the petition originated.

The evaluation noted there are still challenges in documenting and accessing accurate and verifiable statistical data on access to healthcare by EMs, otherwise more health outcomes would be presented in this report but not possible at the moment.

Quality of Project Outputs

Generally, the expected project outputs from the activities implemented by EMHRD and CHVs were of high quality. A few highlights on the achievement and quality of project outputs are summarized below:

Op 1: Increased knowledge, awareness and capacities of EMHRDs and members of targeted EM to understand regional, national and international laws/policies relevant to the implementation of their right to equal access to health and education.

Interview with the EMHRDs highlight that they were knowledgeable about the SDGs (3 & 4), the constitutional articles relating to right of access to health and education and its declarations for EMs, the statutes relating to these laws /policies among others. Besides, they managed to submit petitions using this knowledge to the respective authorities and followed up with duty bearers, some of which yielded results.

A community member in Sengwer after receiving the training, followed up with their MCA to account for money allocated to the community. In Ngareta ward, Narok north subcounty, the ward administrator reported that the community is now keener in being informed when there is a public participation process, and they make sure they attend.

Op 2: Increased participation of targeted EM in annual county, national and regional budget development processes on health and education.

EMHRDs and communities they represent took part in annual, national and county budget development processes on health and education. This was confirmed through project reports and in community focus groups in the 3 counties visited. All the HRDs interviewed confirmed to this fact, although in some community focus group discussions members felt they were not fully aware of what their leaders (Sub-Grantee staff) were presenting, suggesting that there were less community consultations prior to these public participations but were simply mobilised to represent by physical body.

Op 3: Increased psycho-social support to address stigma and improve access to health for community members of targeted EM.

CHVs exuded confidence in their wealth of knowledge on Psychosocial Counselling, stating that many community members have come to appreciate and embrace healthcare after suffering stigma. It was reported by a CHV in the Endorois community that children with disabilities were viewed as a curse and would not be treated kindly like the rest of the other children and were sometimes denied medical and education access. Through these counselling visits, she narrated that the CWDs have now been assisted psychologically and their family members have changed their negative perceptions. All CHVs reported that that personal hygiene and use of latrines was part of training package delivered to communities. This promoted the uptake of hygiene practices including digging of pit latrines which was not a norm among some communities before they were reached out to.

Interview with a CHV from Awer indicated:

> *"In this community, the issue of pit latrines was not taken seriously, but after the trainings and with the support of other organizations such as Concern Worldwide, a few of the villagers now have a pit latrine"….. "Cases of early pregnancy are still there, but we have been talking to girls and parents and we can say more girls are going back to school to pursue education even if they get pregnant' These figures could not be quantified".*

Op 4: Increased networking within EMHRD grassroots movement and with national, regional, and international activists on policy formulation & EM rights advocacy.

The project embraced networking among EMHRDs, and this was confirmed by their participation in national, regional, and international forums for activism. For example, the Bootcamp of 2021 in Naivasha that brought together all the EMHRDs from the 5 communities to share knowledge and experiences. The Hunter and Gatherer's Forum Kenya (HUGAFO-K) network that was organised by OPDP in Nakuru among others. The regional summits in Arusha Tanzania and Banjul in the Gambia were attended and proudly well-articulated by the EMHRDs who participated and where they

made presentations. Capacity building of the HRDs enabled them to participate in international events where they could voice concerns over other development issues.

For example, a presentation of a EMHRD from Endorois community in 2023 was featured in the Voices of Change series developed in partnership with ClimBeR and the Centre for Minority Rights Development (CEMIRIDE) to explore how climate change affects different Indigenous groups of men and women, and the homegrown solutions that they use to combat climate shocks. He also participated in ClimBeR's side events at #COP28 to share his experiences and highlight how to better integrate and include indigenous voices in climate negotiations and decision-making.

Major obstacles met during the project

A summary of the major obstacles included, the COVID-19 delays and restrictions leading to later adoption of social media, zoom /teams' conference, email, phone calls for coordination of activities. Sub-grantees experienced budget shortfalls that could not warrant maximizing on desired results. OPDP reported high overhead costs which exceeded those in the budget. The forceful evictions of communities halted /disrupted smooth progression of education and general project activities in target areas like in the Ogiek Mau and Sengwer. The insecurity challenges in the Boni forest in Lamu hindered MRG /OPDP direct monitoring visits and coordination. The floods and insecurities that affected the Endorois in Baringo leading to relocation of the medical facility to Kamar from Loboi. This also disrupted education in some schools in the project area.

Despite these challenges, the project adapted to the conditions where it was feasible as has been presented above while some remained unresolved, especially the evictions and the displaced families but through the efforts of OPDP and other agencies, the families were supported with basic supplies at the temporary IDP holding area, although the children remained with no access to education during these circumstances. For the Sengwer, IDPs occupied makeshift potato houses in their neighbourhood, and citing challenges of access to latrine and lack of privacy as the parents had to share the room with teen children. This also limited access to education for the children.

Geographical coverage

The project endeavoured to reach to the 5 hunter gatherer communities evenly. However, there were challenges especially intra-community, where coverage to all members of the same community with equal needs was not possible in the project. For example, in the Endorois community, it was noted that of the 17 locations where the Endorois live, only 5 were served and the other 12 were unserved. In Narok North, the number of CHVs could not sufficiently address the needs of the population, and a EMHRD cites that the latrine coverage remains below 20% and awareness messages are still required at large in these communities.

Unintended effects

Whereas the project was generally perceived as useful and appropriate to community needs, and generated positive outcomes, the evaluation learned that family planning was met with some resistance by some sections of the community. Men want more children from their wives and do not support it. It was interesting to note that a man in the Endorois community threatened to cut open his wife's arm where the Nexplanon was implanted. But after some counselling he abandoned the plan. The nurses' lives were also at risk as they were viewed to be the agents for implanting these kits while the husbands did not consent. There is slow adoption by males as far as reproductive health, thereby causing frictions in families generally. Equally, older women believe it is a wrong practice. The community also thinks they need to grow their population continuously in order to solve their minority disadvantages. To some extent the good intentions of the project were therefore met with some resistance.

3.4 Impact

Project impacts (SDG 3 & 4) - access to healthcare and education

Access to education and healthcare has been impacted in the communities generally, although not exhaustively. The strides made in acquiring either additional healthcare facilities, operationalizing the never functional ones, supply of medicines and treatment drugs by KEMSA to facilities, the improvement of staffing in health facilities among others that were registered through the advocacy efforts are a manifestation that the project indeed contributed to these achievements which in turn increased communities' access to healthcare. The sensitization and awareness campaigns on health made gains, as negative perceptions on modern medicine, obstructive traditional beliefs on access by males, knowledge on reproductive health, and shortened distances to healthcare centers among others also contributed to this increased access although substantiating the change was not possible due to poor medical statistics on the EMs (which was beyond the scope of the project). These gains, even though complicated in some locations such as Lamu and Baringo, it can be said that the project made a difference on the fate of the EMs. Water, Sanitation and Hygiene (WASH) conditions have reportedly improved although statistical data to again ascertain these claims especially on zero open defecation rates and adoption of use of latrines by the households was not possible given the poor data on EMs made available by Kenya's national statistical bureau.

Similarly, the communities have progressed in education alongside healthcare access. It was widely observed that education departments from across the 5 communities embraced the advocacy messages and some took actions following this outreach by the EMHRDs. Bursaries were lobbied for and youths from these communities were able to access education from such schemes lobbied by Sub-grantees and OPDP. However, these were not reported in Baringo and Chepkitale Bungoma. In spite of this, the number of bursaries is still not commensurate with the level of need. The communities are still low on educational transition to higher education due to poverty. School infrastructures were either added or improved in among the Ogiek Mau, Sengwer and Endorois. In Awer the insecurity has scared away teachers who are not from within the community although substantial support was also secured for the local schools through advocacy works.

Policy action of decision-makers

Generally, there was positive reception by decision-makers and duty-bearers based at the county level. It is reported that the Fact-Finding Report was an eye opener for the Ministry of Education when it reached them. After reading the report, the Minister by then sent a delegation from the Ministry to visit the school (detailed in the report) where ICT equipment meant for learners was kept in the store by the head teacher for fear of being spoilt and held accountable if these laptops got broken or stolen.

Lamu and Elgeyo Marakwet county leaderships were a lot more responsive compared to the other 3. In Baringo for example, it was noted that some of the petitions raised were not given proper attention by the county administration, and this is causing some level of discouragement to some of the EMHRDs, suggesting that maybe the community should be mobilized to dialogue with the leaders directly than through the EMHRDs as they are not listened to and acted upon their submissions.

Despite submitting petitions to the parliament, no specific policy brief or statute has been issued, debated or materialized into a policy frame for adoption by the state at the national level, despite the constitutional pronunciations about EMs and equal rights.

Other Partners Attracted

External collaboration was established by OPDP and a volunteer funder, Professor Craig that benefited Ogiek of Mau which yielded scholarship for support of girls in secondary schools and the support to extend for four consecutive years until the girls complete high school. The OPDP Executive Director narrates that this was only possible after expressing the plight of the girls and the vulnerability of the families especially after the brutal evictions. The project has been eye-opening and an effort to look for collaborations externally like OPDP did where the opportunity exists would be beneficial and needs maximizing where government has limitations.

3.5 Cross-cutting Issues

The project design did not target addressing of any of the following specific cross-cutting issues such as gender, female genital mutilation (FGM), sexual and gender-based violence (SGBV), and disability condition, insecurity, evictions, climate

change risks, pandemic outbreaks, poverty among others precisely. Other than for mere data disaggregation reasons such as by gender, it was hard to detect in the project if there were specific advocacy and awareness attempts to address these cross-cutting needs specifically and budgeted for even though some weighed heavily on education and health outcomes.

However, an analysis based on the Moser Conceptual Framework and Women's Empowerment Framework reveals that the project addressed (by default) different needs of varying groups. For example, girls and some boys got empowered through education bursaries who were mostly disadvantaged and left behind. CWDs were rescued from harsh negative cultural perceptions in families and were accorded an opportunity to access education where the disability condition could allow, and in cases where it needed special care the parents were informed as such. Medical care needs especially for women and children were addressed and also advised for all gender groups e.g., antenatal and postnatal care access. The communities were sensitized about equal education rights for boys and girls. Such were seen as useful and practical as gender aware themes in the project, but the design was not specific in tackling each ones specific /unique needs. For example, no advocacy was aimed precisely to provide girls with sanitary towels to keep them in class. WASH infrastructure was not advocated specifically to address special needs of disabled children and girls during menses. Forced marriage /early marriages were never the main focus of the design, FGM with its harsh effects on girls' education and health was never given special attention even though these were communities deeply afflicted by such practices.

The evaluation learned that Female Genital Mutilation (FGM) remains a deeply seated vice affecting school going girls in these communities. It was also the main cause of stigma and trauma for school going girls, even for married women, who have not undergone the practice as they are generally marginalized in the community. It could be felt in the community interviews that participants were uncomfortable talking about it. EMHRD & CHV interview participants had the following to report:

> *"In this community a woman who does not undergo FGM remains a girl. She cannot speak amongst people, even her own daughter who has undergone FGM will call her a child. If her son gets circumcised, she cannot make food for the elderly men, they will not eat her food. She is shunned by her fellow women."*
>
> *"Communities shy away from the topic (FGM) and no one wants to talk about it, not even leaders in the area. Who can discuss it, and yet it is eating away the society? The law is there but if the enforcers, the leaders, who are supposed to stump it out are silent, who are you? A mere medical worker, you just do your part by offering treatment & counselling. and you leave what you cannot".*
>
> *"….. those who want to stop it fear to be cursed by the elders, or you risk an assault from the youth. Therefore, it is a complicated matter in my own community".*

Interviews held with CHVs and EMHRDs revealed that their culture still embraces the practice which has been outlawed and illegal in Kenya. It was interesting to note that girls and women who have not undergone the practice are badly stigmatized. Culturally they are marginalized as they cannot participate in community forums, and married women who have not undergone the practice are termed immature and treated with disdain, often regarded as children not worth to even cook for the elders. Negative beliefs continue to affect the community about FGM and young girls' (12-14 years) are being targeted to undergo it. In some FGD with a community it was highlighted that the practice is reducing as school girls avoid going for the practice as they find alternative places to be (school and church) and avoid interacting much with the village peers. What was disturbing was that even after they marry and produce children, they themselves end up undergoing this rite of passage because of the pressure of stigmatization since without undergoing FGM you do not belong. The patronizing culture needs tackling to ensure health outcomes of such programs like the just completed project, and to empower girls and women to resist for life. Girls who are in school try to avoid these practices, the evaluation quotes from a CHV interviewed:

> *"……. The girls who were taught, I no longer see them attending the traditional ceremonies, they spend more time in school and in church. They are also more responsible and have avoided in engaging in relationships with boys".*

Some EMHRDs are suggesting that for the practice (FGM) to be contained, it will require more specialised partners such as the anti-FGM society of Kenya to step in and stamp this ill practice out of their community. Where this practice is reportedly on the decline in some EMs such as the Endorois as well as parts of Ogiek Narok, the statistical level of reduction could not be established at the time of the evaluation.

Again, it was interesting to note that polygamy is rampant in the community and is acceptable by the society. The main reason being that men marry additional wives especially from communities without strong culture of FGM because they are looking for sexual pleasure which they cannot find in their own circumcised women. This was rather puzzling, but the evaluation thinks that this could also be used as an opportunity where the men could be used as advocates against the practice since they understand the importance of not having FGM on women in this way.

On another hand Sexual and Gender Based Violence (SGBV) were found to be prevalent in some communities, mostly triggered by alcoholism and poverty. A EMHRD revealed that his pregnant cousin sister was murdered by her husband in cold blood by stabbing her right in the stomach with her 8 months' unborn foetus, just after a minor domestic quarrel. It was noted that GBV is a challenge especially where women's rights are trampled upon and it is predominantly a male dominated /patriarchal society. Only in the Sengwer community does this vary; where men are not allowed to beat their women, otherwise the elders' council has tough measures of punishing the man who does such a violence to a woman (his wife).

As far as evictions which affected some communities severely during the project implementation, it was also not seen in the budget plan any forecasted budgets to deal with such emergencies to provide for the families in the project locations. It was also not forecast to deal with eruptions such as flood displacement of the project communities, the COVID 19, and destabilization of project communities from such occurrences. Therefore, the project design was not precisely sensitive to emergencies that may affect the communities in order to remain relevant to them in the face of calamities and disruptions.

Gender behaviour for health and education access

The project influenced and reinforced positive behaviour among various groups. For example, women who were initially reluctant to go to health centers for hospital assisted delivery, with the reasons that they could not be attended to by men or by women who had not undergone FGM begun going to health centers for delivery. It was reported by a female nurse in Sengwer that a woman with fistula got assisted through a referral facility arrangement after suffering for a long period and recovered. In some communities, men were perceived to be hardy and going for healthcare at a medical facility is a sign of weakness but through the project awareness such mentalities changed.

Women's involvement in decision-making emerged strongly as a gender issue that was well strengthened. During public barazas women were given opportunities to participate and to speak in project discussions. They were also empowered to participate in public participation. A sub grantee representative indicated that women would raise hands and volunteer to speak during public participation. They aired views affecting them as women. Women were not discriminated against for leadership positions. According to them selection of a leader was based more on their abilities than sex.

Women were able to challenge beliefs of men about family planning, access to medical care as opposed to traditional practices, more girls got an opportunity to access higher education through bursaries, CHVs and EMHRDs recruited were of equal gender types, in fact more women were recruited as CHVs than men.

The evaluation also found that there is low uptake of educational services beyond a certain level in the Awer Community by boys and male youth. The evaluation quotes:

> *"There may have been no deliberate target of the boy child, but 'even when we get bursaries or scholarships to support the boys to further their education, most of them prefer to join the Kenya defense forces or the Kenya police as opposed to going back to school. They feel it's better to get directly to these jobs as opposed to going back to school as they feel there are even no jobs after they leave school.'*

Women practical needs and women empowerment
The project was not about women practical needs; however, it tackled one practical need, i.e., need for medical care. Even though it did not construct clean water for access, the knowledge on WASH was useful as it equipped women to have knowledge on clean water and general hygiene which are closely linked to good health.

3.6 Coherence

Government programs, policies, initiatives, and community capacities
Several provisions that guarantee the right to healthcare are enshrined in the Constitution of Kenya (2010). Article 43 (1) (a) provides the right to every person to enjoy the highest attainable standard of health, including the right to healthcare services, including reproductive health care. Further, a person has a right to reasonable standards of sanitation; to be free from hunger and have adequate food of acceptable quality; and to clean and safe water in adequate quantities. Article 43 (1) (b) provides that a person shall not be denied emergency medical treatment. Kenya's Health Policy 2014–2030: Towards attaining the highest standard of health guides the health sector towards meeting the constitutional threshold for health as expressed by the Kenyan citizenry.

Equally, the constitution gives privilege on rights to education. Article 53 (1) (b) states that every child has a right to free and compulsory basic education, and Article 55 (a) the State shall take measures, including affirmative action programmes, to ensure that the youth access relevant education and training. Article 56 (b) states that "Minorities and marginalized groups have a right to be provided with special opportunities in the field of education".

To give effect to the constitution the government established the Basic Education Act (No 14 of 2013) to regulate the provision of basic education and adult basic education. The Children's Act also acknowledges and protects every child's right to education. These and several other laws guarantee the implementation of the right to education. In its recent Medium Plan Term of Vision 2030 (2018-2022[1]) capped as BIG FOUR Agenda and Policy Frameworks have strong mention on the right to education. It is within this period that the Competency based education and training policy frameworks were enacted, and CBC began being implemented. Several other policies and status have supported the right to education by all Kenyan citizens.

The project was well aligned with the Kenyan legal and policy frameworks that relate access to right to education and health among all Kenyans with the emphasis, laid in promoting of marginalized communities especially Article 56 (b) of the constitution. The project therefore complemented multiple existing Kenya government education and health programme priorities such as the universal primary education, professional education through technical and vocational education to disadvantaged communities, the competency-based curriculum education, universal access to primary healthcare, reproductive health care programs among others. The project also complemented the devolution agenda for these sectors besides the national level priorities.

Duplication
By recognizing the critical needs of the underserved EM communities, the project advocacy and awareness strategies were plausible. There were no partners in the area the time of the implementation doing exactly the same thing with the same people. Therefore, there was no duplication of resources. CHVs were recruited, trained /skilled and deployed during the project period, and this cannot amount to resource duplication as Government embarked on nationwide recruitment exercise during the project. It should be looked at as complementary since the CHVs were purely voluntary staff deserving full compensation as opposed to stipends. They were also empowered to still serve in the same community where they live.

Program viability without government
The advocacy was centred around existing policy frameworks and seeking their rights in tapping into these provisions. Therefore, without the supportive mechanism of the government, the program overall goal would have remained redundant, as in itself did not aim at establishing physical, human and supplies delivery but only complement what was proceeding to the counties within these institutional frames of government.

3.7 Sustainability

EMHRD /CHV Activities

Education and health remain on top of government agendas, and community structures that support these initiatives positively will continue to be recognized in achieving the national and county development objectives. At the time of the evaluation, four (4) of the project communities (Awer, Ogiek Mau, Sengwer and Ogiek Chepkitale) have reported that the project CHVs have been absorbed by the county health departments. This was possible through the national recruitment program for CHPs in all villages to mainstream primary healthcare service to the people of Kenya. In Baringo this process has been halted temporarily but should be implemented in future given that it is a national government directive to recruit and train in all villages. There is a high likelihood that CHV community activities will continue past project closure.

The project friendly and non-confrontational approaches to engage key stakeholders has created opportunities for EMHRDs to interact and engage further with duty bearers and decision makers. Such relationships are likely to continue past the project period. An interview with a HRD in Narok North highlights that the area Woman MP is supportive of the project initiatives and promised to support more girls in the area with education bursaries. The HRD has been tasked to continue mobilizing his community and reach her office for more opportunities that might arise.
It was learned that most of these EMHRDs are not only dependent on advocacy works of the project, but have other occupational careers, and were voluntarily contributing to this work. Interviews with them revealed that they are willing to continue in their advocacy works and network with their peers elsewhere in order to serve their communities as they are part and partial of their struggle for equity and justice. Similar sentiments were expressed by the CHVs in all interviews conducted.

Community interview participants expressed that the already established project initiatives should be maintained and EU should not exit at this stage just yet; that the project is exiting at time when they are just beginning to see its fruits, and how deeply lost they were without knowing their rights, and the collaboration made them to be recognized by their county administrations who had always neglected them.
Sub-grantee organizations will continue to support the EMHRDs for critical advocacy activities using basic funds.

Despite these hopes, the continuity of the EMHRD activities stands a test in the face of limited support locally, especially in the Awer Community. EMHRD stated:

> *'Working in this community requires facilitation, the houses are far apart, there is insecurity and funds are needed to enhance mobility. Even moving forward with our petitions may not be easy as it requires mobilization of stakeholders which requires funds"*

Outcomes

The project outcomes and impact are likely to sustain as they are already plugged into existing government program and structures e.g., the CHP programs already nationally launched by the Kenya MoH; and receiving support from the county annual allocations. With continuous advocacy and follow-up with duty bearers the project outcomes are highly likely to continue among beneficiaries.
The sub-grantee organizations can leverage the good working relationships already created with key stakeholders and continue to influence their interest and commitments to the EM community who have been underserved for long periods. Key informant interviews with government administrators highlights a high interest in the works of the CHVs and EMHRDs, and there is hope that the project results will endure. A health practitioner in Nakuru County stated:

> *"The work of the CHVs has eased our service coverage to these communities, firstly being community members. The able administration of her excellency, Hon. Susan the county governor of Nakuru County, has emphasized the access to quality healthcare by all residents of Nakuru. Through her office, we have received enough supplies in our facilities and the CHPs have played a critical role in community outreach, sensitizing communities about the importance of primary hygiene and sanitation. I would say that Njoro is an almost zero open defecation*

area, and thanks to the CHPs. We will continue to work closely with these already trained CHPs and we have integrated them into the county program".

Unintended effects, knowledge practices, scaling up, capacity and partners

Communities have understood the importance of accessing medical care, as well as education services for all including by girls. Knowledge on health and WASH have largely been understood, and you could confirm this by their expressions such as use of attendance of antenatal care, postnatal care, use of latrines, washing of hands after visiting latrine, not washing clothes by the riverbank, boiling of water for drinking, covering drinking water, personal hygiene, seeing a medical officer when sick, providing good nutrition to children and expectant mothers among others. Knowledge on education is also firm among the communities and they have felt the importance of educating all their children, as some have succeeded in life and are now exemplary to their communities.

Focus group discussions with community members revealed that women have acquired knowledge on reproductive health and are willing to embrace this practice, especially family planning. However, this practice has been met with some resistance especially by men who are strongly opposed to it and wanting their wives to continue producing children given their already minority status. Older women equally are opposed to family planning, some challenging that practice based on biblical interpretation of God's plan for procreation. Despite these obstacles, some women have persuaded their husbands to the change of mindset around family planning and the community is slowly beginning to transition. There is potential for scaling these results and the Sub-Grantees should continue to identify opportunities to further their achievements.

"…. How can we space children when we are already very few? It is not fair for us to be given family planning services, we need to increase in number so that we can have a voice even in public participation, where many times we are overwhelmed. I cannot allow my daughter in-law to access family planning services, but I know she will convince her husband (interviewee's son) to allow her access family planning. The most stubborn ones are those who have gone to school, they are the ones gong for family planning."

The project participatory approach has created local ownership among community members as it rightly addressed their health and education needs. The evaluation quotes from a few participants:

"The project helped us to realize that we have rights to Education and Health since we are Kenyan Tax payers too. We brought Sengwer community near other communities in this county, they were not agitating for their rights"

"We were trained on budgeting process, we did not know there is even public participation where we could air our views on what our community needs, and we have since understood the budget cycle. We were taken through the budget cycle for county and national government and laws governing the process which broadened our understanding of the issues around budgets.

"We didn't have a programme to bring stakeholders together to discuss issues that affect our community, this was made possible by the project".

This was well demonstrated in the coordination of health and education initiatives in the community between the local administration and EMHRDs, CHVs and sub-grantees CBOs, the health facilities community outreach through CHVs. The government key stakeholders have provided platform for EMHRDs and CHVs to interact, present petitions, participate in public budget processes, and have embraced the initiatives by offering bursaries and favorable financial allocations to some of these communities.

The project approach of training local capacity in the community through the EMHRDs and CHVs as well as Sub-Grantees has enhanced the skills of these groups and will likely enable them to continue with advocacy. The knowledge gained has built confidence in them and they will ensure there is visibility in county budgetary processes and negotiate for their share of the cake. Community members are showing signs of enthusiasm as far as participating in public budget forums as was witnessed in the last financial year county budget processes.

Additionally, the project EMHRDs, CHVs and Sub-Grantees are based within the community, and have expressed determination to continue with the started initiatives. A general feeling about their capacities is that they are capable of engaging leaders in constructive conversations as they are able to express themselves assertively, and confidently on what they have understood about their rights, be it constitutional or SDGs as they have demonstrated the knowledgeable in these aspects.

Based on the local capacity structures the project worked through, there is high potential of scaling up of this project. Realizing the fact that a 3-year project with low-level funding on critical activities is able to achieve so much within a limited resources base, there is therefore undoubted potential of this project to be scaled especially in areas facing similar challenges but that were never reached by the completed project.
In terms of potential partners for extension of project activities into the future, the Government especially the county government administration remains a key pillar as services demand are coming from that quarter. Good working relationship established in the project with county governments needed to be strengthened and galvanized. Professional advocacy activities to these officers yielded results and needs to be continued. Existing EMHRD networks be explored by sub-grantees to continue advocating, and the networks existing nationally, regionally and internationally continue to be essential.

4. Conclusion

The project *"Ethnic Minority Defenders: Amplifying the Voices of Indigenous Human Rights Defenders to Advocate for the Rights to Health & Education"* was implemented successfully in the project target communities of Awer, Ogiek Mau, Ogiek Chepkitale, Sengwer, and Endorois. The project overall objective to improve access to quality health care and education for ethnic minority communities in Kenya was fairly well met, and especially that the achievements were registered within a short span of time, being an advocacy, knowledge and awareness project, whose immediate impact is at times a challenge within a short period (like the 3-year project). Ethnic minority defenders were strengthened in the project counties, and they made significant contributions in their advocacy programs, empowered communities for budget process public participation, made demand for their rights, engaged decision makers through petitioning and lobbied for education and health access for their communities. The networks created by the project for EMHRDs to interact and fight for their rights enabled the communities to get additional strength locally, nationally, regionally and internationally; and the EMs will continue to utilize these networks for voicing their concerns and challenge government on any unfair treatment.

In terms of medical access most of the communities have gained access to basic medical care by bringing government services nearer to their areas of residence. This has improved health seeking behaviour and general access to critical care which were previously non-existent. Reproductive healthcare has gained some acceptance with impacts on the quality of health of mothers and their children. Antenatal and postnatal care service access has improved, and CHVs have served important role in ensuring this is achieved in the communities. WASH practices have also improved in most of the project communities as a result of the project initiatives. Pregnant women now have increased access to assisted delivery by medical practitioners than as was the case being left in the hands of traditional birth attendants.

As far as educational access, learners were provided with educational access facilities in some communities where none existed or where they were distantly located. Bursaries issued by county administrations and partners enabled access by disadvantaged children to higher institutions of learning. Schools received supplies that were critical for educational outcomes. Most of these were achieved through petitions raised by EMHRDs, thanks to the project's capacity building and general mobilisation in the communities.

Therefore, these outcomes are a demonstration of the project relevance and effectiveness. They have aligned the communities on the path to achievement of SDG 3 and SDG 4, the essence of the rationale on which the EU invested such reasonable resources on behalf of the EMs. It was also a project welcomed by the government who perceived it as a complementary to sector priorities for the achievement of Kenya's Vision 2030 as promulgated by the Constitution

(2010). In spite of these strides, the communities still access health and education services with plenty of limitations, occasioned by multiple factors as communities emerging from many years of marginalization.

The project achieved important output results overall and contributed to critical outcomes essential for community access to health and education. The emerging project impacts such as reduced maternal and child mortality through access to assisted delivery, and improvement in educational access by a fraction of vulnerable children in target communities are essential. The project was generally efficient and coherent with educational and health policies and laws governing these sectors. The project sustainability potential is very high, and it its general implementation was coherent with existing government programs, policies and statutes.

5. Recommendations

The recommendations made below are based on the successes and the learnings drawn from the just completed intervention important for future intervention.

- Overall, the project was relevant to communities needs and was appropriate in terms of design and intervention logic even though there were limitations that required improvements during the project cycle, for example:
    - limited budget capacity to address sufficiently priority needs
    - limited cross-cutting themes addressed
    - limited stakeholder involvement in design and decision-making
    - Limited learning discipline and stakeholder feedback
    - Minimal monitoring and evaluation discipline
    - Ambiguous and unaligned indicators towards the measurement of SDG 3 and SDG 4 that the project chose to address
    - The project theory of change needed periodic review and cross-checking for consistency and adaptation to emerging learnings during project implementation which were slightly adhered but limited.
- Future project planning processes, subject to available resources, needs to take into consideration participatory approaches where stakeholders have an input before they are engaged, specifically the county administration on whom the project success heavily relied. Their initial contribution in design phase and acceptance to work closely with the EMHRDs /communities initially on their issues would be essential.
- Participatory project implementation, monitoring reviews, learning visits and learning events and stakeholder feedback which were largely limited should be incorporated in future designs. The project's horizontal and vertical integration needs to take into account stakeholder participation, visibility and clear accountability by all stakeholders so that collaborations are results-based, auditable and useful to the needs of the primary beneficiaries.
- Human resource capacity for project level monitoring and evaluation is needed alongside operations teams both at OPDP and subgrantee levels, to have a seamless tracking of project indicators and collective reporting on results throughout the process. It is important that learning should inform the way future projects are approached and monitoring culture should be reemphasized.
- Different strategy to engage legislators on petitions to the parliament are needed. The learning from this project implies that the communication channels and planned meetings were never effective, and yet policy instruments are needed in Parliament to ensure the constitutional rights of the EMs are factored in national and county level administrations.
- MRGI and the EU should reprogram and incentivize EMHRDs to advocate against glaring cross-cutting issues that affect the quality of health and education access in these communities. Future interventions should not sweep under the bridge the threats such as FGM, sanitary towels for adolescent schoolgirls, GBV, WASH for CWDs among others.
- Emergency funds to counter project risks could be prioritised in future interventions. The communities are vulnerable to multiple shocks, and it would be appropriate if MRGI and OPDP network widely to partner with organisations prior to new projects. The EU could also weigh in on these themes if they are to secure the welfare of the communities holistically. Abrupt evictions, floods, insecurity and COVID-19 were typical examples that affected the completed project.

- MRG is an advocacy organisation basing its work on raising awareness of rights and community claims for equal treatment. As such it does not get involved in providing physical infrastructure, believing the sustainable and effective way to do this is for the relevant duty bearer to act. Nonetheless, perhaps MRG could consider whether including a partnership with agencies that provide direct investments in education and health could be possible; those with the resources to build schools or equip clinics could have an added value to the overall project effort. A tripartite initiative involving county authorities, hands on service providers, plus community activists could be one to consider.
- A systematic project exit strategy and hand-over procedures are needed in future projects to ensure accountable and consistent service responsibility by the county administration as the project closes.
- Future interventions should consider access quality and stability beyond infrastructural presence in order to address the current quality concerns in service access.